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Ensuring and improving quality in community mental health care

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Summary

The definition of good quality of mental health care is complex. It depends on the perspective, the underlying values and the interest of the person assessing quality. For research and clinical purposes a reductionistic approach is inevitable. Approaches for ensuring and improving quality of community mental health care, such as outcome management, ISO 9000 guidelines, and total quality management, are critically reviewed. Quality management approaches in mental health care have led to the conclusion that programmes developed for other types of services can be effectively applied to community mental health care, but that the motivation for change and the involvement of all levels of the organization are more important than technical aspects. For various reasons, managing quality on the basis of external standards and through external pressure alone is likely to fail. It is argued that confidence of staff and the quality of their relationships with patients need to be considered, and a model for distinguishing interventions on three levels is proposed.

Introduction

Reforms of mental health care have led to the closure or down-sizing of large mental hospitals and to the establishment of so called community mental health care (CMHC) in most western industrialized countries over the last 50 years. There is no universally agreed definition of what precisely constitutes CMHC. Yet, there seems to be some consensus that CMHC is delivered by services based in the community and that multi-professional teams are a central component of it. These teams may be generic with catchment area responsibility, or have specific remits for targeting defined sub-groups of patients, e.g. rehabilitation teams or assertive outreach teams (Hanily, 1995; McGrew & Bond 1995; Slade *et al.*, 1995; Pugsley *et al.*, 1996; Hadley *et al.*, 1997; Harper & Minghella, 1997).

Regardless of how CMHC is operating exactly, ensuring its quality and improving it as much as possible are essential tasks for initiatives on a political, administrative, managerial, and clinical level.

What is good quality?

Any attempt to improve quality in CMHC requires an implicit or explicit definition of what good and poor quality is. There seem to be some obvious features describing good quality that most people would easily agree on: e.g. services should respond quickly to problems arising in the catchment area; they should apply evidence-based treatment methods; they should be effective as well as cost-effective. A more thorough and precise consideration of what characterizes good quality, however, reveals that the issue is in fact a complex one. For illustrating this, an example shall be given that specifically applies to hospital care, but flags up problems that are relevant to all mental health services.

In 1994, the Federal Ministry of Health in Germany was concerned about the quality of psychiatric hospital care, and commissioned a group to develop a procedure for assessing it (Kunze & Priebe, 1998). The group had 34 members from different backgrounds, including psychiatrists, psychologists, nurses, managers, patients and their relatives. They worked for 2 years and came up with a result. Firstly, the group divided the practice of hospital care into 28 areas. The areas covered most procedures and actions taken in a psychiatric hospital, such as admission and discharge, drug treatment and other forms of treatment, management of staff, and public relations. Secondly, the group outlined 23 quality aims in four categories: treatment goals (e.g. improvement of psychopathology); primary intentions (e.g. protection of patient's human dignity); means and organization (e.g. individualized treatment planning); optimal use of resources (e.g. protection of personal resources of staff and staff development). Each of the 23 quality aims may be applied to each of the 28 areas of practice, resulting in a two-dimensional model with 644 cells. This two-dimensional model was then extended by a third dimension. For any application of a quality aim to an area of practice, questions may be asked on four levels: (a) individual care process; (b) individual treatment outcome; (c) care unit; (d)

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the whole institution. Thus, a three-dimensional model with 2576 cells was created. Each cell represents the application of a quality aim to an area of practice on one of the four levels. The model is intended to be used for developing questions. The user of the model is free to find questions for each cell. Depending on the circumstances, there may be cells for which reasonable questions cannot be developed, whilst for others there are many different questions that make sense and address relevant quality issues.

This systematic model for assessing quality helps to generate questions, but does not provide a single answer. If one wanted to go through the whole model step by step and to address each cell—which is not intended by the authors—assessing quality would be an extremely complicated, time-consuming and in practical terms not a feasible exercise. Yet, what the model demonstrates very well, is that a somewhat comprehensive and thorough approach to quality assessment leads to a very long list of relevant different facets. What the model does not address yet, is the problem of who gives the answers. Various research studies have shown that clinicians' and patients' assessment of the same treatment may be very different. For instance, independent ratings by clinicians and by patients of the patients' needs in a given treatment situation revealed, at best, weak to moderate correlation coefficients, sometimes failing to reach statistical significance (e.g. Hoffmann & Priebe, 1996). Thus, clinicians' and patients' assessments of quality appear distinct, and both matter. Patients' global assessment of treatment in CMHC has repeatedly been shown to predict relevant outcome criteria and, therefore, to have some validity (Priebe & Gruyters, 1995; Priebe & Bröker, 1999). Other raters such as patients' carers, managers or independent observers, may express views that are different from both, the clinicians' and the patients' assessments. Thus, when it comes to statements on quality and not just questions, the above model with more than 2500 cells would have to be multiplied by the number of different perspectives.

Other authors proposing a systematic approach to the assessment of quality of psychiatric services also identified a wide range of relevant indicators that may be rated in different ways depending on the perspective. For the World Health Organization, Saraceno *et al.* (1993) described 10 sets of indicators: policy indicators, context-framework indicators, resource indicators, programme indicators, average activity indicators, costs indicators, process indicators, patient outcome indicators, satisfaction indicators, and impact indicators.

For research and for clinical purposes, a reductionistic approach is inevitable. Uys *et al.* (1997) developed questionnaires for assessing the quality of public sector psychiatric services based on consumer expectations. The consumer questionnaire covers access, finances, technical quality, communication, staff attitudes, consumers' attitude towards care, and incidents. Provincial directors of mental health are to give ratings on management, planning, utilization data, financial data, research evaluation, and special need patients. These 13 categories are intended to allow a reliable assessment of quality of care.

Whoever rates the quality of a given service, the assessments will be affected by underlying values. Drake *et al.* (1999) compared the effects of two rehabilitation programmes for patients with severe mental illness. One used conventional rehabilitation strategies in sheltered settings, the other one aimed at employment of patients in competitive jobs. Not surprisingly, the first programme achieved a higher rate of patients in sheltered employment, the other one put more patients in competitive employment. The authors conclude that any comparison of the effects of the two programmes depend on the values and general aims for mental health care: do we want patients to be in sheltered employment, or do we prefer them to be in competitive jobs? The question addresses the general issue of what mental health care services are commissioned to do and aim towards. The aims of mental health services seem to change over time and to vary across nations. CMHC was initiated for achieving several purposes such as securing patients' human rights and delivering a more effective treatment. Economic aspects became more relevant in the 1980s and 1990s, when the idea that community care was better *per se* and more humane than traditional hospital care featured less in the literature. Now, containing risk of suicides and, in particular, homicides of psychiatric patients living in the community is regarded as a predominant aim for mental health care by politicians and by some of the media in the UK, whilst it plays a comparatively minor role in other European countries (Priebe, 1999). These aims and values can be influenced, but not set by mental health care professionals. They are formed within a society in line with the Zeitgeist and probably depend on historical, cultural, social, political and economic factors.

It may be concluded that there is no simple, uniform or universally valid definition of good quality in CMHC. Attempts to ensure and improve quality, therefore, deal with different, inconsistent, complex and changing notions of good quality.

Outcome management

A simplified and straightforward approach for ensuring quality appears in the regular assessment of outcome criteria. Research has developed a number of widely accepted outcome criteria and more or less reliable methods for assessing them. These include observer rated and self-rated scales for assessing indicators of psychopathology, quality of life, social networks, and treatment costs just to name a few. It

has been repeatedly proposed to assess outcome criteria not just in research studies and unusual model services, but as part of routine care. Consistent feedback of the results to commissioners, managers, clinicians, and users in CMHC is a first step towards outcome management. Information about outcome should enable everyone involved in the commissioning and running of services to reflect on their own practice, to identify strengths and weaknesses, and to think about specific interventions and amendments for improving performance. Although the idea of outcome management sounds straightforward and simple, its implementation in practice has posed various hurdles and difficulties. Because of these problems, systematic outcome management has not been widely established yet, neither on the level of services and programmes nor within individual care processes. Nevertheless, the call for implementing and testing ways for outcome management is widespread in the recent literature, and suggestions have been made for addressing the various problems (Srebnik *et al.*, 1997; Clardy *et al.* 1998; Huxley, 1998; Marks, 1998; Harrison & Eaton, 1999; Salvador-Carulla, 1999). It seems fair to assume that we will see the implementation of various forms of outcome management in CMHC in the near future. Hopefully, there will also be systematic empirical studies, e.g. in the form of randomized controlled trials, testing its effectiveness for improving outcomes on a patient and on the service level, and identifying the mediating processes involved.

Quality management

Concerns as to whether outcome management will in fact be effective may be related to experiences in the manufacturing and service industry since the mid-1970s. During this time, several companies producing goods that were not competitive looked for ways to improve their products. The result was that just assessing the quality of the final product, e.g. the quality of a complete car, does not necessarily lead to any improvement. If the quality of the product is demonstrated to be poor, that may make managers and workers alike feel bad and possibly incompetent. Yet, it does not automatically improve the structures and processes determining the quality of the car and does not very much help to produce a better one. That experience led to the development of systems for quality management that were first applied in the manufacturing industry and later became popular in the service sector as well. An example is the programme described in the guidelines ISO 9000–9004, which are standardized across Europe (e.g. Ellis, 1996; Moore, 1999). Certification according to the ISO 9000 group guidelines is often regarded as a pre-requisite for doing contracts with other companies in the industry. The guidelines define a set of formal rules on how to manage quality independent of what the product is or what the service delivers; e.g. the rules demand that the company or service has a handbook on quality management, a designated person responsible for it and accountable directly to the top level of management, regular meetings on quality issues, etc. Some health services have sought and received certification in line with the ISO requirements. In a health care system adopting some sort of free market, such certification can be an advantage in competition with other providers. Whether, and if so, to what extent that quality management programme is actually effective in improving the quality of mental health care services, remains an open question.

It may be concluded that outcome assessment and feedback alone cannot improve quality if there are no mechanisms in place for ensuring that appropriate interventions are designed and taken for modifying the structure of and processes in CMHC. As the example of the ISO guidelines highlights, quality management has developed into a field of expertise and a branch of business in its own right. Experts in quality management may or may not be familiar with what mental health services do, but feel competent to apply their knowledge and skills to any service.

Various attempts have been made to implement total quality management (TQM) in mental health services, most of them in the US. McFarland *et al.*, (1996) report positive experiences with an approach for TQM in a community mental health centre using the Baldridge criteria as a framework. The Baldridge health care categories focus on leadership, information and analysis, strategic planning, human resource development and management, process management, organizational performance results, and satisfaction of patients and other stakeholders. The authors state that the criteria enabled them to identify areas for improvement, to formulate a strategic plan on the basis of a self-assessment, as well as to evaluate and to learn from their plan. They conclude that 'the criteria have helped us to move . . . to a systematic approach that is . . . conducive to the sweeping changes required in today's health care environment'. On the basis of experiences in Australia, Birleson (1998) advocates the learning organization model for mental health care services focusing on the organizational elements leadership, organizational design, work design, perception, information processing, communication, and motivational systems. He feels that the model 'offers a . . . comprehensive framework for designing adaptive mental health services and supporting quality management practices'. The few examples may show already that different quality management programmes overlap substantially and may just use different words for naming similar mechanisms. The reader of the literature on quality management in mental health care might sometimes be puzzled about what the concepts, often described in vague and general terms,

actually mean in daily clinical and managerial practice, and what the relevant differences are between them.

There is hardly any doubt that quality management programmes can be applied to CMHC just as well as to other health and non-health related services. The experiences, however, have not been uniformly enthusiastic. It seems that the mere techniques of quality management programmes have to be supported by a willingness of the whole organization to change and to improve (Chowanee, 1996). Whether the philosophy and techniques of quality management work in mental health care appears more a 'question . . . of motivation than of fit' (Sluyter, 1996). Successful quality management requires unequivocal and ongoing leadership support and accompanying changes in the culture of the service and the service provider organization. Otherwise quality will be managed mainly on the basis of external standards alone. Such an approach has been found to have several distinct limitations as described by Sluyter (1998):

(a) Reliance on external standards to define quality allows the organization to shift responsibility for quality issues to external authorities.
(b) Chasing external standards creates a 'compliance mentality' throughout the organization.
(c) Quality is defined more by professional standards than it is by the customers of the organization or system.
(d) Deficiency reports are often used as a kind of 'club' with which to beat people over the head, thereby reinforcing punitive organizational cultures.
(e) Such reports may also become ends in themselves rather than a useful means for improving processes in systems and providing better service.

For someone presently working in CMHC in the UK, the above remarks may appear a fair reflection of the effects that current initiatives for improving quality such as the National Service Framework or Clinical Governance have on services and on the people working in them.

Beyond mere techniques

The experiences that have been made in industry for almost three decades and in attempts to apply quality management to mental health services in the US, indicate that mere control and pressure on services to meet external standards does not significantly help to improve quality. In fact, they might even be detrimental. Some potential negative effects were summarized by Sluyter (1998, see list above). Others—related ones—are the development of different languages and the undermining of confidence of staff.

If quality management adopts a strong and exclusive top down approach with the main motivation coming from outside the services themselves, those approaches may over time develop a separate language which is not spoken by staff in the services. There is an official rhetoric with politically highly correct buzzwords like 'partnership', 'modernization', 'evidence-based', 'user-involvement', 'inter-agency working', and 'needs led service' (examples taken from the UK). This sort of official language can be put on by everyone familiar with it, if and when needed—a phenomenon well known from the former communist regimes in eastern Europe. Nevertheless, the terms lose their real meaning, and the lack of communication with people on the ground prevents an adjustment of the official language. Thus, initiatives for quality improvement adopting that rhetoric do not have any credibility and are perceived as unrealistic and 'nothing to do with us'.

A more fundamental problem is the effect external control may have on the confidence of staff. Mental health care requires both, techniques in the form of skills, on the one hand, and personalities with competence and confidence, on the other hand. Currently, the former aspect may be seen as dominating the Anglo-American literature, whilst the latter is more reflected in the traditional French and German teaching of psychiatry (Jaspers, 1965). The two aspects may be seen as equally important and difficult to balance. One can argue that CMHC is administered in—and defined by—the relationship of a mental health professional and a patient. This relationship is central for engaging in treatment and for delivering it. Figure 1 shows a simplified model of processes in community mental health care.

Characteristics of the service (e.g. accessibility, funding), of the clinician (e.g. professional background, mood on the day), the patient (e.g. symptoms, social characteristics), the treatment (e.g. requiring regular contacts, side-effects), and the situation (e.g. features of the meeting room, time of the day) all influence and determine a process at the centre of which there is a dyadic relationship between the clinician and the patient. The process leads at worst to non-adherence and otherwise to an outcome that one way or another consistently influences any of the factors described before. The therapeutic relationship is a sort of black box in the middle, understudied in research (McCabe *et al.*, 1999) and almost neglected in current quality management approaches. For establishing a positive and helpful relationship with mutual respect and trust, staff have to feel confident to utilize their personal potentials. Externally initiated quality management initiatives may carry the inherent message that staff need to be controlled and that they are so poorly motivated or lazy that they would do worse if they were not aware of being controlled.

A good example of this may be the Confidential Enquiries into Homicides and Suicides by People with a Mental Illness in the UK. Recently praised in

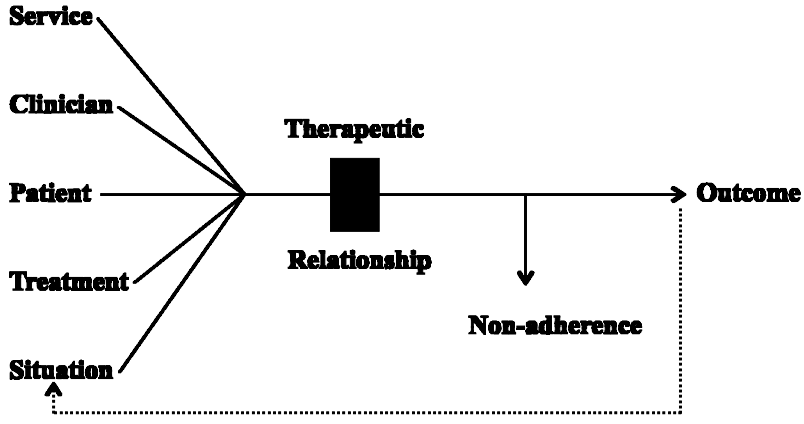

Figure 1. *Process in Community Mental Health Care*

a review by Thompson (1999), the enquiries can facilitate openness and identify failures and weaknesses in a mental health care service. They also make anyone who has been actively involved in the given case a defendant and potential culprit. They proactively promote a blaming culture and make it more difficult for staff to cope with very difficult experiences such as the suicide of one's own patient.

Levels of intervention

In the above example, one intervention, i.e. an enquiry, is likely to have different effects on different levels of the health care system: it might help to gain relevant information for improving services, and it might—at the same time—make staff irritated, angry and frustrated. Quality management programmes in mental health care need to involve all participants on various levels 'from the board room to the community room' (Community Health Improvement Partners, 1998). The interventions for improving quality in CMHC can be described on—at least—three distinguishable levels: the general level of health care and the given mental health care system, the services in CMHC, and the clinical practice (Burns & Priebe, 1996). In light of the complexity of the quality issue as outlined above, only a few examples can be given for each intervention level.

The supportive background for good quality in CMHC is very wide. A good educational system is likely to produce better educated—and not just better trained—staff with many obvious positive implications. A more systematic and specific training—and not just more difficult to pass exams—for all professionals in CMHC would also be helpful. The basic training and education acquired at a young age and determining a professional identity and competence can hardly be matched by training courses on identified gaps in knowledge or skills at a later stage in the career. Better funding for health care can lead to higher salaries, which would facilitate staff recruitment and retention and improve the social prestige of the profession. Funding is also required for sufficient supporting services in CMHC so that keyworkers in their coordinating role have something to coordinate and can draw on other resources. Whether more money is spent on CMHC, has to be decided by politicians and—indirectly—by the public. Political will is also needed for establishing a structure within the given mental health care system that facilitates effective work of services. Politicians and media seem particularly influential for this level, but are not in control of it. The wider level has to be addressed if major changes in the quality of CMHC are aimed at, and it should be acknowledged that CMHC does not work in isolation, but as part of a complex society. Its quality can only be as good or as bad as the rest of society wants and allows it to be.

The structure of services are the first target of interventions in most quality management programmes. The composition of a team, the skills of the team members, the clarity of the hierarchical structure and the decision-making processes, the treatment philosophy of the service, the case load and many other features can be analysed and changed if the mechanisms for quality improvement are in place and if the necessary resources are available.

What appears sometimes overlooked in the literature, is the level of clinical practice. Whether a service formally follows one structural model or another, may be important. Equally relevant, however, is what clinicians actually do with their patients. What sort of care is delivered, what are the clinical and non-clinical activities of staff, and what sort of therapeutic relationships are established? In a way, clinical practice may be more difficult to change than structural elements, yet, it is what counts for the patients when it comes to quality. Research providing evidence for quality improvement, often tries to link the structure of services with individual patient outcome. The result is that many studies fail to yield empirical evidence that one organizational structure leads to a better outcome than another, unless the differences are so marked—e.g. office-based practice versus assertive outreach teams in the US—that the findings are almost trivial. Important information on the mediating effects of clinical practice may be lost

in those studies. A theory-driven and hypotheses led approach for studying how to influence clinical practice through changes of structure may be distinguished from studies relating different clinical practices to individual outcomes. Such a step-wise approach to research may produce more relevant bits of information than attempts for overall evaluation of a service in one go.

Conclusions

Different people are likely to have different views on what good quality in CMHC is. A way out of the dilemma of finding a universally valid definition of quality may be provided by radical constructivism. According to that philosophy, quality can be seen as a construct. Constructs are maintained, modified or given up not because they are true or false, but because they are more or less useful to the one holding them. The usefulness of a construct depends on the perspective and the interests of the individual. Interests of different parties involved in CMHC such as politicians, patients, mental health professionals, and insurance companies, vary. All the interests are legitimate, but are likely to be associated with different priorities for quality assurance and quality improvement. This perspective of radical constructivism does not lead to new ways for tackling quality, but it might help to understand why there is no overall accepted and eternal definition of quality and no single 'right approach' for ensuring and improving it.

Over the next years, we are likely to witness the wide implementation of quality management programmes and techniques, with outcome management being one element. Further development of CMHC would benefit if existing experiences of quality management programmes in health care and in other services would be considered in this process. The most important message appears to be that ensuring and improving quality in CMHC should be seen as a philosophy of change and a comprehensive exercise involving all levels of the health care system, and not just as a mere technique to be applied through external pressure.

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