

# Quality of mental health care indicators to improve care

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The relevance of measuring quality of mental health care is widely recognized and a number of authors have defined quality of health care by describing this concept according to a set of dimensions and using different indicators. Despite the growing interest around these issues, in mental health care there is still a lack of agreement on the dimensions and measures which should be used as indicators of quality of care (Hermann *et al.* 2006). This is due to the differences in organization of health care systems, in policy priorities and in data sources available among countries (Amaddeo & Tansella, 2011).

According to the Health Care Quality Indicator Project of the Organization for Economic Cooperation and Development (OECD), quality of care can be defined as ‘the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge’ (Lohr & Schroeder, 1990; OECD, 2004; Arah *et al.* 2006). Several countries have implemented projects and initiatives to define and evaluate quality of care in health and mental health systems. The aims of such projects on quality of care were to tackle growing cost containment pressure, concerns about patients’ treatment choice and rights, and demands of transparency. Interest in this field is rising also due to advances in information technology systems monitoring the performance and utilization of services.

According to Danabedian’s framework (1988), quality of care could be described by using three main dimensions: (1) input, the structural characteristics of healthcare organization; (2) process of care, the consumer’s interaction with the healthcare system which includes technical and interpersonal components of care; and (3) outcome of care, which reflects the results of treatment. Quality should be assured in all these phases and a balance across input-process-outcome is indicated to improve quality of care (NMHWG

Information Strategy Committee Performance Indicator Drafting Group, 2005).

Thornicroft & Tansella (2009) declined the three dimensions of quality of care in the field of mental health. Inputs consist of visible (mainly staff, facilities and budget) and invisible (experience, qualification and skills of staff, working relationship, legal and policy framework) resources. As suggested by the World Health Organization (2005), an appropriate human resources policy for mental health should be developed; continuing education, training and supervision should be developed for the provision of the best quality care that meets users’ needs and a motivated workforce will be more cost-effective. Other important input issues are the balance of expenditure between hospital and community services and the dissemination of clinical guidelines and protocols and higher level policy inputs.

Processes represent a range of actions which take place in the delivery of mental health care. The measurement of processes helps to identify areas of relative over and under provision or whether people receive care that is evidence-based or conform to consensus expectations about quality. Surprisingly, while the pathway from evidence generation to evidence synthesis and guideline development is highly developed and quite sophisticated, the pathway from evidence-based guidelines to an evidence-based practice is much less developed (Barbui & Tansella, 2012).

Moreover, process measures at national/regional level, such as admission rates, allow international comparison. An important process issue is individuals’ pathways to and through mental health services (the term is connected to accessibility and continuity domains of quality of care).

Outcomes are usually considered to be changes in functioning, in morbidity or in mortality and, in a narrowed definition, they refer to changes in health status. They can regard different aspects: employment status, physical morbidity, suicide and self-harm, homelessness, mortality, symptoms severity, impact on care givers, satisfaction with services, quality of life, disability, met and unmet needs for care (Ruggeri *et al.* 2001; Thornicroft & Tansella, 1999). Suicide rate is a commonly used outcome at national/regional level; all

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the outcomes above can be local level outcomes, but according to the authors they are not currently used at this level. The majority of these outcomes can be assessed at individual level using several scales. According to Slade *et al.* (2005) interventions to reduce symptoms have an important role, but an evidence-based service is characterized by a focus on the user's perspective in assessment, the systematic identification of the full range of health and social care needs of the user, the development of innovative services to address these needs, and the evaluation of service impact on quality of life. Moreover, a longitudinal and more regular outcome measurement performed using a broad range of measures can significantly improve quality of life and/or reduce psychiatric admissions (Smith *et al.* 2009).

In this issue of *Epidemiology and Psychiatric Sciences*, we publish two editorials on quality of mental health care measurement. The first Editorial, written by Moran *et al.* (2013) from the OECD, points out the importance of measuring the quality of mental health care and summarize the international experiences in this field including those directly made by the OECD. The authors report as health care is often not delivered in accordance with evidence-based and commonly agreed professional standards, resulting in poor quality and unsafe care that harms tens of thousands of people every year, together with the squandering of scarce health care resources. Mental health care is not exempted from this problem, with far-reaching and considerable consequences for individuals, families and society.

In 2008, the OECD assessed the availability of information to measure and compare quality of mental health care across OECD countries and found that the data sources most widely available across countries at that time were hospital administrative databases, national surveys and national registries.

In the second editorial, Lora (2013), moving from the experience of two Italian projects on quality of care measurement (the SIEP-DIRECT Project and the QuISMI project), describes the challenges of measuring quality of mental health care. The author explains that the Italian experience in the use of clinical indicators is still very sporadic and 30 years after the psychiatric reform, inequalities still remain, not only in terms of resources and service delivery but also in terms of information technology and the use of information systems. The possibility to measure quality of care is related to the availability of good information datasets. Antonio Lora suggests three steps to take in the future: first, to implement national mental health information systems and improve information technology; second, to define a common set of clinical indicators, agreed at the regional and national levels and useful for

benchmarking and comparing mental health services; and third, to build a system for quality improvement.

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