

QUALITY IMPROVEMENT FOR MENTAL HEALTH



World Health Organization, 2003

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to ensure that scarce resources are
used in an efficient and effective way.
Without quality there will be no
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This module is part of the WHO Mental Health Policy and Service guidance package, which provides practical information to assist countries to improve the mental health of their populations.

What is the purpose of the guidance package?

The purpose of the guidance package is to assist policy-makers and planners to:

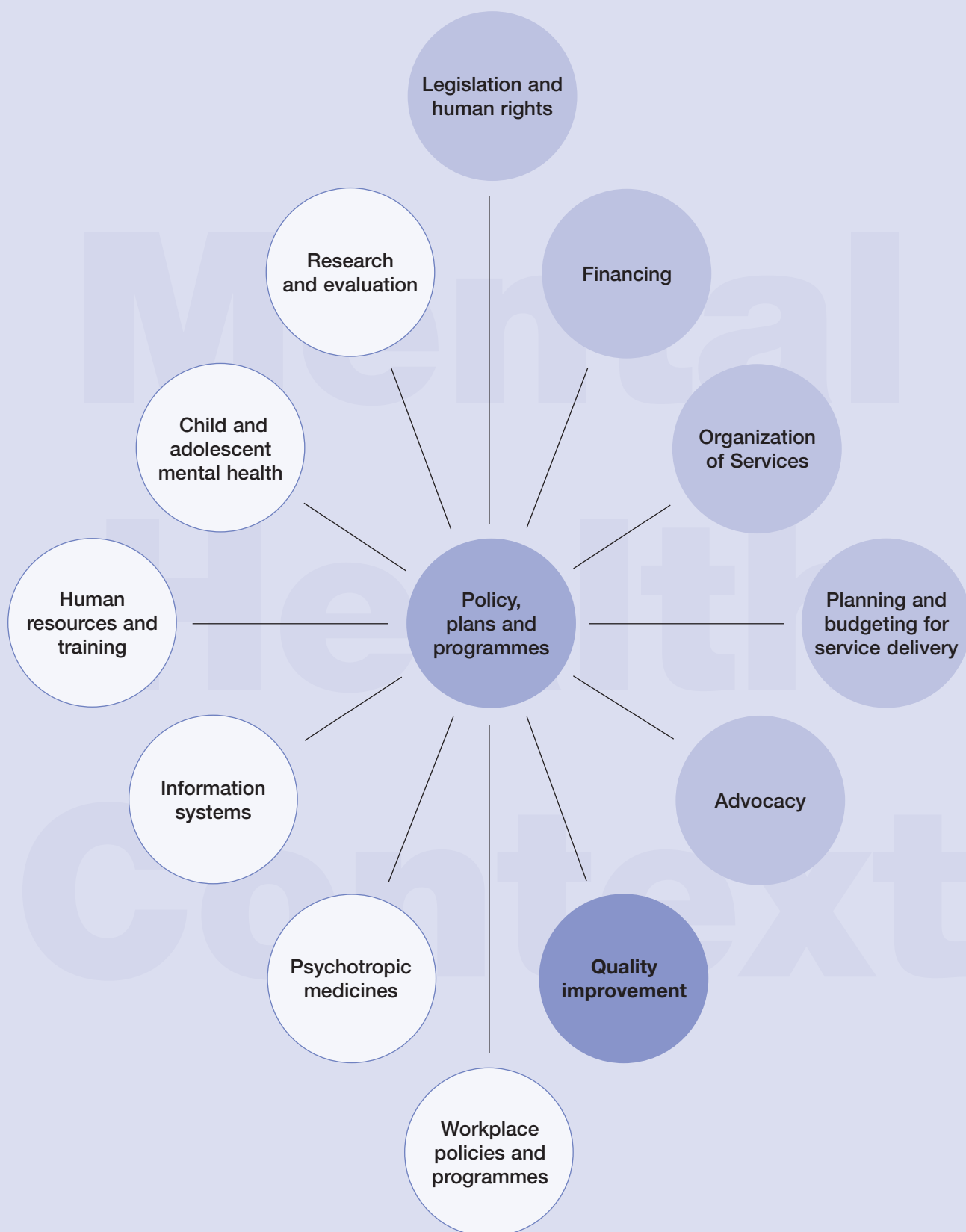
- develop policies and comprehensive strategies for improving the mental health of populations;
- use existing resources to achieve the greatest possible benefits;
- provide effective services to those in need;
- assist the reintegration of persons with mental disorders into all aspects of community life, thus improving their overall quality of life.

What is in the package?

The package consists of a series of interrelated user-friendly modules that are designed to address the wide variety of needs and priorities in policy development and service planning. The topic of each module represents a core aspect of mental health. The starting point is the module entitled The Mental Health Context, which outlines the global context of mental health and summarizes the content of all the modules. This module should give readers an understanding of the global context of mental health, and should enable them to select specific modules that will be useful to them in their own situations. Mental Health Policy, Plans and Programmes is a central module, providing detailed information about the process of developing policy and implementing it through plans and programmes. Following a reading of this module, countries may wish to focus on specific aspects of mental health covered in other modules.

The guidance package includes the following modules:

- > The Mental Health Context
- > Mental Health Policy, Plans and Programmes
- > Mental Health Financing
- > Mental Health Legislation and Human Rights
- > Advocacy for Mental Health
- > Organization of Services for Mental Health
- > Quality Improvement for Mental Health
- > Planning and Budgeting to Deliver Services for Mental Health



● still to be developed

The following modules are not yet available but will be included in the final guidance package:

- > Improving Access and Use of Psychotropic Medicines
- > Mental Health Information Systems
- > Human Resources and Training for Mental Health
- > Child and Adolescent Mental Health
- > Research and Evaluation of Mental Health Policy and Services
- > Workplace Mental Health Policies and Programmes

Who is the guidance package for?

The modules will be of interest to:

- policy-makers and health planners;
- government departments at federal, state/regional and local levels;
- mental health professionals;
- groups representing people with mental disorders;
- representatives or associations of families and carers of people with mental disorders;
- advocacy organizations representing the interests of people with mental disorders and their relatives and families;
- nongovernmental organizations involved or interested in the provision of mental health services.

How to use the modules

- They can be used **individually or as a package**. They are cross-referenced with each other for ease of use. Countries may wish to go through each of the modules systematically or may use a specific module when the emphasis is on a particular area of mental health. For example, countries wishing to address mental health legislation may find the module entitled Mental Health Legislation and Human Rights useful for this purpose.
- They can be used as a **training package** for mental health policy-makers, planners and others involved in organizing, delivering and funding mental health services. They can be used as educational materials in university or college courses. Professional organizations may choose to use the package as an aid to training for persons working in mental health.
- They can be used as a framework for **technical consultancy** by a wide range of international and national organizations that provide support to countries wishing to reform their mental health policy and/or services.
- They can be used as **advocacy tools** by consumer, family and advocacy organizations. The modules contain useful information for public education and for increasing awareness among politicians, opinion-makers, other health professionals and the general public about mental disorders and mental health services.

Format of the modules

Each module clearly outlines its aims and the target audience for which it is intended. The modules are presented in a step-by-step format so as to assist countries in using and implementing the guidance provided. The guidance is not intended to be prescriptive or to be interpreted in a rigid way: countries are encouraged to adapt the material in accordance with their own needs and circumstances. Practical examples are given throughout.

There is extensive cross-referencing between the modules. Readers of one module may need to consult another (as indicated in the text) should they wish further guidance.

All the modules should be read in the light of WHO's policy of providing most mental health care through general health services and community settings. Mental health is necessarily an intersectoral issue involving the education, employment, housing, social services and criminal justice sectors. It is important to engage in serious consultation with consumer and family organizations in the development of policy and the delivery of services.

Dr Michelle Funk

Dr Benedetto Saraceno

Everyone in need should have access to basic mental health care. This key principle, identified by the World Health Organization, requires that mental health care be affordable, equitable, geographically accessible, available on a voluntary basis and of adequate quality.

What is quality?

In mental health care, quality is a measure of whether services increase the likelihood of desired mental health outcomes and are consistent with current evidence-based practice. This definition incorporates two components. For people with mental disorders, their families and the population as a whole, it emphasizes that services should produce positive outcomes. For practitioners, service planners and policy makers, it emphasizes the best use of current knowledge and technology.

Improved quality means that mental health services should:

- > preserve the dignity of people with mental disorders;
- > provide accepted and relevant clinical and non-clinical care aimed at reducing the impact of the disorder and improving the quality of life of people with mental disorders;
- > use interventions which help people with mental disorders to cope by themselves with their mental health disabilities;
- > make more efficient and effective use of scarce mental health resources; and
- > ensure that quality of care is improved in all areas, including mental health promotion, prevention, treatment and rehabilitation in primary health care, outpatient, inpatient and community residential facilities.

In many countries, services for people with mental disorders remain minimal and do not measure up to these principles. Community-based care is not available in 37% of all countries. Certain essential psychotropic drugs are not available at primary care level in almost 20% of countries, with marked variability within and between countries. About 70% of all people have access to less than one psychiatrist per 100,000 population.

In a context where resources are inadequate and mental health is emerging as a newfound priority, a concern for quality seems premature if not a luxury. Quality may seem more of an issue for well-established, well-resourced systems than for systems which are in the process of establishing themselves.

Why is quality important for mental health care?

Quality is important for all mental health systems, from a variety of perspectives. From the perspective of a person with a mental disorder, quality ensures that they receive the care they require and their symptoms and quality of life improve. From the perspective of a family member, quality provides support and helps preserve family integrity. From the perspective of a service provider or programme manager, quality ensures effectiveness and efficiency. From the perspective of a policy maker, quality is the key to improving the mental health of the population, ensuring value for monies expended and accountability.

These are essential requirements of any mental health service, whether the service is in its infancy, with minimal resources, or well established, with plentiful resources. Quality of care is important, not only to reform past neglect, as seen in historical

abuses of human rights in psychiatric institutions, but to ensure the development of effective and efficient care in the future. Building the quality of mental health care, even in circumstances of minimal services, provides a strong foundation for future service development.

Aims of this module

This module aims to:

- (1) ensure that quality is placed firmly on the policy agenda for mental health care;
- (2) provide practical guidance for the implementation of quality improvement mechanisms in mental health services at the national and local levels.

The introduction provides a rationale for the importance and value of quality in mental health care. It also provides a conceptual introduction to the issue of quality improvement and some of the approaches that have been developed in order to improve quality. A step-by-step programme is then presented which should assist countries to improve the quality of mental health care.

Step 1: Align **policy** for quality improvement.

Step 2: Design a **standards document**.

Step 3: Establish **accreditation procedures**.

Step 4: **Monitor** the mental health service by using the quality mechanisms.

Step 5: **Integrate quality improvement** into the ongoing management and delivery of services.

Step 6: Consider systematic **reform** for the improvement of services.

Step 7: Review the **quality mechanisms**.

The steps in improving quality are cyclical. Once policy, standards and accreditation procedures are established, improving the quality of care requires the ongoing monitoring of services and the integration of quality improvement strategies into management and delivery. On a less frequent basis it is necessary to review of the policy, standards and accreditation procedures themselves (step 7). This allows policy, standards and accreditation to be adapted in accordance with what is learnt from the quality improvement process.

Step 1. Align policy for quality improvement

Policy-makers have a key role in the quest for quality. They are in a position to establish the broad parameters of quality through consultation, partnerships, legislation, funding and planning.

- **Consultation.** Consultation is necessary with all mental health stakeholders, both in the development of policy and in all subsequent quality improvement steps. Consultation has three critical functions: obtaining input from various stakeholders, sharing information across stakeholder groups and building a common understanding. The development of such an understanding is an essential task of policy-makers. The development of quality improvement mechanisms presents unique opportunity to draw all mental health stakeholders together in order to carve out a vision of service delivery.
- **Partnerships.** Active steps should be taken by policy-makers to develop partnerships with professional groups, academic institutions, advocacy groups and other health and social service sectors. These partnerships form the backbone of the quality improvement process and enable long-term sustainability.

They build consensus and consistency in messages related to the need for quality and can also serve to mobilize resources and other necessary supports.

- > **Legislation.** Policy-makers should promote legislation that reflects concern for and emphasis on quality. Models provided by WHO are useful for this purpose.
- > **Funding.** Financial systems for mental health care should be aligned so that they maximize quality and do not become an obstacle to quality improvement. Improved efficiency is an essential goal in relation to both quality improvement and cost containment.
- > **Planning.** Quality processes can inform planning by providing a knowledge base for evidence-based practice. In the course of planning, several issues pertaining to resource allocation and priority-setting have a bearing on quality.

Step 2. Design a standards document

Once policies have been aligned for quality the next essential step is to develop a set of standards against which services can be measured.

- > In order to do this, planners and managers should establish a working group, consult with relevant stakeholders and draft a standards document.
- > The standards document should cover all aspects of a mental health service, identified by particular domains.
- > Criteria for each standard should be specified.
- > These criteria should provide a means for rating existing services, a process that can be helped by the use of WHO documents.
- > The rating of services should be supplemented by observations on the quality of all aspects of mental health care.

Step 3. Establish accreditation procedures

Accreditation provides the opportunity to assess the quality of care delivered by a mental health service and to provide the service with the appropriate legal recognition. Accreditation is essential because it makes quality a cornerstone of the official licensing of mental health services or facilities.

The following tasks are essential for the establishment of accreditation procedures.

- > Service planners should ascertain whether any accreditation procedures already exist which can be used to assess current services. Outdated procedures should be reformed in keeping with the evidence for the most clinically effective and humane forms of mental health care.
- > Accreditation procedures should be developed if there are none. The standards document developed in step 2 can be used as a structure to provide criteria and a rating system for assessing services and conferring the appropriate legal status.

Step 4. Monitor the mental health service by using the quality mechanisms

Mental health services should be monitored in order to assess the quality of care. This monitoring can take the following forms:

- > use of standards to assess the service annually;
- > use of accreditation procedures to assess and accredit new service developments and to review the ongoing functioning of services;
- > routine information-gathering through existing information systems, particularly by means of performance and outcome indicators;
- > consultation with independent organizations for people with mental disorders, carers and advocacy groups in order to receive their assessments of services.

Step 5. Integrate quality improvement into the ongoing management and delivery of services

It is essential that services keep improving care by continually striving for optimal quality. This can be achieved by:

- > managing annual service quality reviews;
- > including quality checks in service planning targets;
- > building quality improvement into clinical practice through evidence-based practice, clinical practice guidelines, teamwork and continuing professional development;
- > improving quality when services are being commissioned;
- > audit.

Step 6. Consider systematic reform for the improvement of services

An assessment of the quality of a mental health service may indicate a need for systematic reform or improvement. This step may require concerted planning and coordination by various sectors.

For large-scale reforms, e.g. the transformation from institutional to community-based care, a system approach is the most beneficial.

Step 7. Review the quality mechanisms

Once quality mechanisms are in place they should be reviewed less frequently than services, which are reviewed annually. A review of quality mechanisms may occur at the same time as a review of service targets at local level, i.e. every 5-8 years.

A review of quality mechanisms is necessary in order to update them in accordance with evidence on the most effective methods of quality improvement. To this end, mental health service managers or quality improvement officers should keep themselves well informed about developments in quality assurance, quality improvement and quality management. Lessons from the quality improvement process in service delivery and management should be incorporated into the subsequent modification of policy, standards and accreditation procedures.

Links with improvements in information systems should be maintained wherever possible in order to ensure that quality assessment makes full use of available information and that information systems gather data that are appropriate for ensuring care of satisfactory quality.

It is essential to provide ongoing training for managers and mental health workers in mental health care of good quality so as to sustain the momentum of early quality improvement initiatives. The development of quality improvement requires continual striving by mental health services to enhance their effectiveness and efficiency.

Conclusion

This module provides practical guidance for (1) the alignment of policy with the objectives of quality improvement and (2) the subsequent development of several quality improvement mechanisms. These mechanisms include standards, accreditation procedures, the monitoring of services, continuous quality improvement, the systematic reform of services and reviews of quality mechanisms.

Countries should adapt this guidance according to their specific circumstances and needs. For countries with few or no quality improvement mechanisms or policy this module provides guidance for establishing them. For countries whose policy is consistent with quality improvement objectives it provides practical guidance on the subsequent steps of developing standards and accreditation procedures, monitoring and continuous quality improvement. For countries with policy and standards in place it provides guidance on the ways in which the quality of mental health care can be further raised through continuous quality improvement methods.

By improving the quality of care, countries should be able to increase the likelihood that the outcomes of care will reflect the desires and aspirations of the populations served. The ultimate goals of quality improvement are to respect the rights of people with mental disorders, to ensure that they are provided with the best available evidence-based care, to increase self-reliance and to improve the quality of life.

How to use this module

This module has two purposes:

- (1) to ensure that quality is placed firmly on the policy agenda for mental health care;
- (2) to provide practical guidance for the implementation of quality improvement mechanisms in mental health services at the national and local levels.

The Introduction explains the importance and value of quality in mental health care and provides a conceptual guide to the issue of quality improvement and some of the approaches that have been developed in order to improve quality. The step-by-step programme outlined below should assist countries to improve the quality of mental health care.

Step 1: Align **policy** for quality improvement.

Step 2: Design a **standards document**.

Step 3: Establish **accreditation procedures**.

Step 4: **Monitor** the mental health service by using the quality mechanisms.

Step 5: **Integrate quality improvement** into the ongoing management and delivery of services.

Step 6: Consider systematic **reform** for the improvement of services.

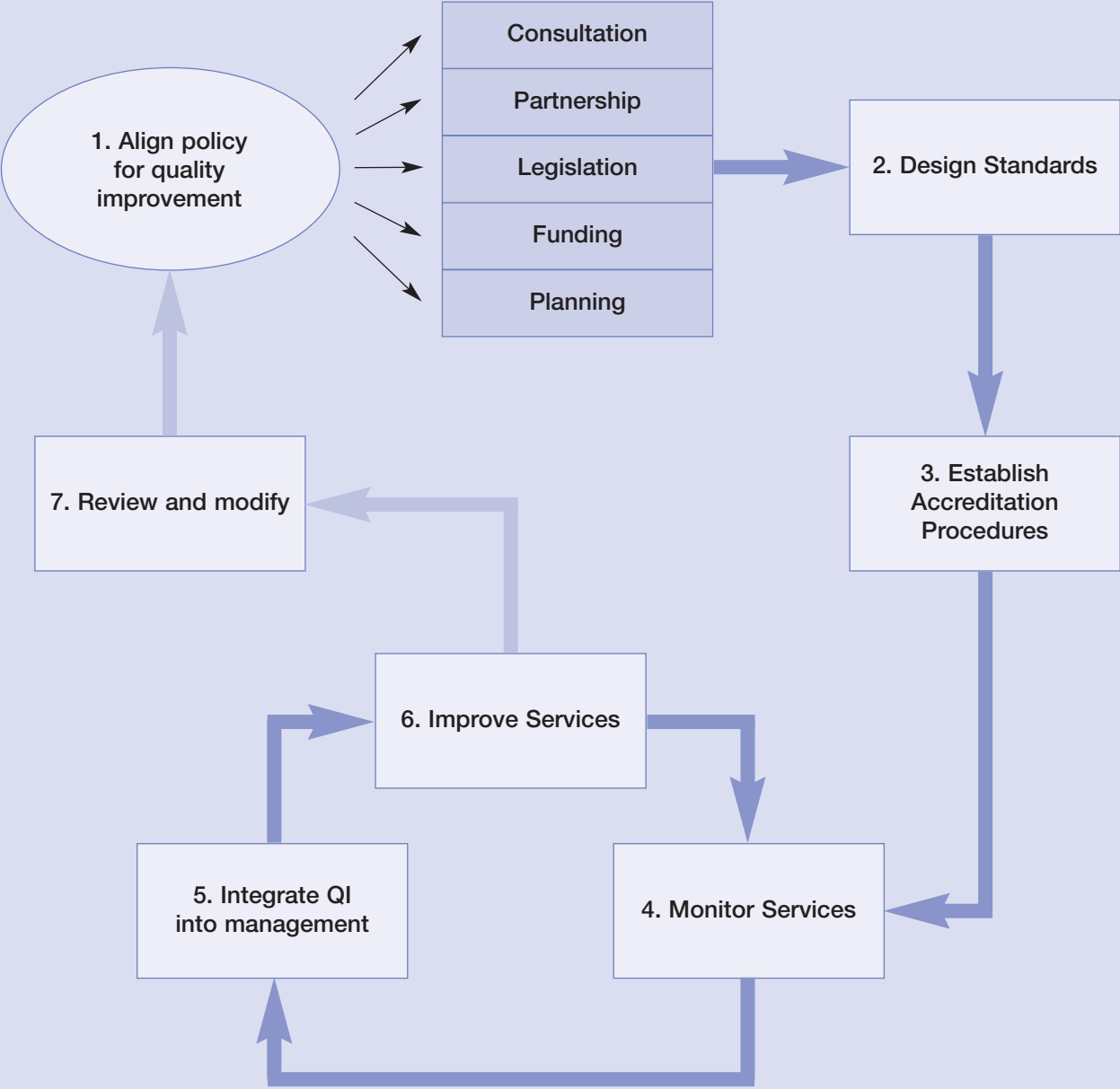
Step 7: Review the **quality mechanisms**.

The steps in improving quality are cyclical (Figure 1). Once policy, standards and accreditation procedures are established, continually raising the quality of care requires the ongoing monitoring of services and the integration of quality improvement strategies into managing and improving services. On a less frequent basis a review of the policy, standards and accreditation procedures themselves is necessary (step 7) as indicated by the dotted arrows in Figure 1. This allows policy, standards and accreditation to be adapted in accordance with what is learnt from the quality improvement process.

These steps do not need to be followed rigidly. For example, it may be possible to develop a standards document as part of the policy alignment process. It may also be possible to conduct in-service training on quality improvement for mental health workers while accreditation procedures are being established. However, all these steps are necessary so that policy-makers and planners can provide a framework and support for quality improvement.

This module provides a step-by-step programme that should assist countries to improve the quality of mental health care.

Figure 1: Quality improvement in mental health care



Target audience

This module is intended for **policy-makers** and planners who wish to improve the quality of mental health care in their countries. For policy-makers it provides a rationale for the importance of quality in mental health policy. Guidance is provided for the development of policy for quality improvement. For **planners, administrators** and **mental health workers**, practical guidance is provided for the implementation of quality improvement mechanisms in national and local mental health services.

The module is also intended to be used by **people with mental disorders, their families and representative organizations** as a basis for active participation in the improvement of the quality of mental health care. Such improvement requires a partnership between all stakeholders in mental health. In this sense the module has an important advocacy function and should be read in conjunction with the module entitled *Advocacy for Mental Health*.

Countries may encounter a range of **scenarios** when assessing their capacity to improve quality in mental health services.

Scenario A. For countries with few or no quality improvement mechanisms and little in the way of policy, this module provides guidance for establishing them. Starting with the importance of reforming policy in line with quality improvement objectives, detailed steps are indicated on designing a standards document, developing accreditation procedures, monitoring services and improving the quality of care.

Scenario B. For countries whose policy is consistent with quality improvement objectives the initial steps of policy development may not be necessary. This module can therefore be used to provide practical guidance for the subsequent steps of developing standards and accreditation procedures, monitoring services and achieving continuous quality improvement.

Scenario C. For countries with policy and standards in place this module provides guidance on the ways in which the quality of mental health care can be further improved through continuous quality improvement methods.

Ultimately, the module should be adapted by countries to their specific circumstances. For this reason it does not provide global standards of care. In order to ensure mental health care of a quality that is appropriate for the specific conditions encountered, countries should develop their own mechanisms for assessing and improving the quality of mental health care. This module is intended to assist with this process.

This module is intended for policy-makers and planners who wish to improve the quality of mental health care in their countries.

The module should be adapted to countries' specific circumstances.

1. Introduction

Everyone in need should have access to basic mental health care. This key principle, identified by the World Health Organization, requires that mental health care should be affordable, equitable, geographically accessible, available on a voluntary basis and of adequate quality.

Everyone in need should have access to mental health care of adequate quality.

What is quality?

In mental health care, quality is a measure of whether services increase the likelihood of desired mental health outcomes and are consistent with current evidence-based practice (adapted from (Institute of Medicine, 2001a)). This definition incorporates two components. For people with mental disorders, their families and the population as a whole, it emphasizes that services should produce positive outcomes. For practitioners, service planners and policy makers, it emphasizes the best use of current knowledge and technology.

Improved quality means that mental health services should:

- preserve the dignity of people with mental disorders;
- provide accepted and relevant clinical and non-clinical care aimed at reducing the impact of the disorder and improving the quality of life of people with mental disorders;
- use interventions which help people with mental disorders to cope by themselves with their mental health disabilities;
- make more efficient and effective use of scarce mental health resources; and
- ensure that quality of care is improved in all areas, including mental health promotion, prevention, treatment and rehabilitation in primary health care, outpatient, inpatient and community residential facilities.

Quality improvement is a way of making efficient and effective use of scarce mental health resources.

In many countries, services for people with mental disorders remain minimal and do not measure up to these principles. Community-based care is not available in 37% of all countries. Certain essential psychotropic drugs are not available at primary care level in almost 20% of countries, with marked variability within and between countries. About 70% of all people have access to less than one psychiatrist per 100,000 population (Atlas, 2001).

In a context where resources are inadequate and mental health is emerging as a newfound priority, a concern for quality seems premature if not a luxury. Quality may seem more of an issue for well-established, well-resourced systems than for systems which are in the process of establishing themselves.

Is quality a luxury item?

Why is quality important for mental health care?

Quality is important for all mental health systems, from a variety of perspectives. From the perspective of a person with a mental disorder, quality ensures that they receive the care they require and their symptoms and quality of life improve. From the perspective of a family member, quality provides support and helps preserve family integrity. From the perspective of a service provider or programme manager, quality ensures effectiveness and efficiency. From the perspective of a policy maker, quality is the key to improving the mental health of the population, ensuring value for monies expended and accountability.

Quality is fundamental to both established and developing mental health systems.

These are essential requirements of any mental health service, whether the service is in its infancy, with minimal resources, or well established, with plentiful resources. Quality of care is important, not only to reform past neglect, as seen in historical abuses of human rights in psychiatric institutions, but to ensure the development of effective and efficient care in the future. Building the quality of mental health care, even in circumstances of minimal services, provides a strong foundation for future service development. Further advantages of quality improvement are set out in Box 1.

Box 1. Advantages of quality improvement for mental health

1. A focus on quality helps to ensure that resources are used properly.

In most systems, resources are not used optimally. Some systems overuse many services, i.e. services do not result in improvement or even cause harm. Other systems underuse services, i.e. systems fail to provide what people need. In either case the lack of a focus on quality results in resources being wasted. Quality improvement provides the opportunity to use resources efficiently.

2. A focus on quality helps to ensure that the latest scientific knowledge and new technologies are used in treatment. In the last decade, major scientific breakthroughs have occurred in medications and treatments for mental disorders. The World Health Report (World Health Organization, 2001a) documents treatments that work, but also points out that there is a huge gulf between the knowledge base and what is implemented. A wide variety of community-based services are of proven value for even the most severe mental disorders. A focus on quality helps to change the old way of operating and could even propel the system forward by taking advantage of the new treatments and technologies that have emerged.

3. A focus on quality helps to ensure that people with mental disorders receive the care they need. Good quality is vital for people with mental illnesses. Psychiatric and neurological conditions account for 28% of all years lived in disability. Statistically, this represents the aggregate burden of persons with mental illness. At the individual level it indicates the disproportionate burden borne by persons with mental illness. This burden is exacerbated by the stigma, discrimination and violation of the rights of persons with mental illness in many parts of the world. Traditional beliefs about the causes and remedies of mental illness still hold sway, resulting in reluctance or delay in seeking care. In the USA, for example, the majority of people who need treatment do not seek it (United States Department of Health and Human Services, 2000).

4. A focus on quality helps to build trust in the effectiveness of the system. Satisfactory quality builds societal credibility in mental health treatment. It is the basis for demonstrating that the benefits of treatment for mental disorders outweigh the social costs of having such disorders. Without satisfactory quality the expected results are not obtained. Funders, the general public and even persons with mental illnesses and their families become disillusioned. A lack of quality helps to perpetuate myths about mental illness and negative attitudes towards people with mental disorders.

5. A focus on quality helps to overcome barriers to appropriate care at different levels. The perception of quality and effectiveness stimulates some people with mental disorders to seek treatment and reduces negative attitudes in others. Quality becomes a mechanism to ensure that care is appropriate on the basis of existing knowledge. Furthermore, the appropriateness of care, i.e. care whose level matches the level of need, without overuse of inappropriate services or underuse of needed treatments, ensures that limited resources are used both responsibly and effectively.

6. A focus on quality is a systems issue. Quality improvement provides the opportunity to improve mental health care in a systematic way. For this reason the role of policy-makers is critical. While local systems focus on ensuring satisfactory quality by monitoring the adequacy of clinical care, policy-makers have to provide the national framework and supports that make such care possible. Policy-makers (or mental health planners) should provide leadership and should champion good quality in order to facilitate this systematic improvement.

Approaches to quality

Different approaches have been developed to improve quality in mental health care.

1. Quality Monitoring

The traditional approach to monitoring quality (often referred to as Quality Assurance (QA) involves the development of a set of service standards, and the comparison of current services with the established standards. If standards are met, services are thought to be of adequate quality. If deficiencies are identified, plans of correction are developed to address the problem (WHO, 1994; WHO, 1997).

Using this approach, quality can be evaluated based on structure, process and outcomes (Donabedian, 1980). Structural quality evaluates system capacities (e.g., staff qualifications, staffing ratios, financial resources, infrastructure). Process quality evaluates the interactions of the service delivering system with the person with a mental disorder (e.g., types and amounts of service, medication types and amounts, hospitalizations) and outcomes quality evaluates the changes which the recipient of services experiences (e.g., improved functioning, reduction in symptoms, quality of life). Any quality monitoring system should cover all three areas. In many countries, the emphasis has been on structural and process components. Only recently has there been an increased emphasis on outcomes.

2. Total Quality Management/Continuous Quality Improvement

More recently, based on techniques introduced in manufacturing and industrial sectors to improve productivity and reduce costs, concepts of total quality management and continuous quality improvement have been introduced into mental health systems (Juran, 1988; Juran, 1992). These new techniques are not based on external reviews but are incorporated into the management of the mental health organization so that it has an inbuilt mechanism for identifying and addressing problems. That is, quality management and improvement attempt to anticipate and prevent problems; managers and supervisors are proactive; and the organizational culture is one of responsiveness and empowerment of staff to participate and assume responsibility for problem identification and solutions.

For example, in Australia, total quality management techniques have been applied to implement structural reforms in the mental health system to emphasize early intervention and prevention (Tobin, Yeo, & Chen, 2000) and to introduce cultural change in a children's mental health programme (Birleson, 1998). Continuous quality improvement means that organizational restructuring may be necessary, requiring national and local policy support, as well as the engagement of people with mental disorders and mental health workers.

3. Balanced Scorecard

A third approach, which includes some aspects of these approaches is that of a balanced scorecard. Increasingly, there is recognition that mental health service planners and managers need to balance a range of considerations when improving the quality of care. Process measures need to be considered to determine whether a person with a mental disorder is getting evidence-based treatment. Outcome measures can assess whether that person is getting better. At the same time costs need to be controlled so that services are delivered within a specified budget (Hermann, Regner, Erickson, & Yang, 2000). Thus managers need to monitor performance in multiple domains: the “balanced score card” is a model that facilitates performance management in several areas simultaneously (Kaplan & Norton, 1996).

Approach of this module

This module will adopt an integrated approach in which aspects of all of these methods will be used. The advantage of the quality monitoring approach is that it provides a set of standards and accreditation procedures which are agreed upon by the population and constitute a recognised norm, against which services can be measured. This is essential for all mental health services. The advantage of the quality improvement approach is that it does not allow for complacency once a standard is achieved. Quality improvement is a continual process, which requires the active participation of all stakeholders in the ongoing improvement of services. Quality improvement also encourages the restructuring of services where appropriate. The advantage of the balanced scorecard is that it reminds policy makers and planners that a range of considerations need to be balanced during the process of improving the quality of care. These include considerations of cost, structure, process and outcome. The need to continually improve quality, while maintaining a balanced scorecard, is essential.

These approaches will be integrated in this module in the following way.

- Guidance will be provided as to how quality improvement can be place on the mental health policy agenda and linked with legislation and funding mechanisms;
- Practical steps for developing service standards, accreditation procedures and methods for assessing current care will be set out; and
- Guidance will be provided for continually improving the quality of care, taking into account a range of considerations and the needs of a variety of stakeholders.

The module will now set out actions which need to be taken by policy makers and planners, to ensure a systematic, sustainable commitment to quality.

2. Quality improvement:

from policy alignment to review of mechanisms

Step 1. Align policy for quality improvement

If countries wish to improve the quality of mental health care, their policies have to be aligned so as to support rather than oppose such progress. Step 1 does not provide details on mental health policy development. (For a more detailed account of these issues, see *Mental Health Policy, Plans and Programmes*.) Instead, it outlines ways in which policies can be aligned for quality improvement, through consultation, partnerships, legislation, funding and planning.

In order to be aligned, policies have to incorporate specific statements about quality improvement in their values, principles and strategies. This requirement includes all aspects of promotion, prevention, treatment and rehabilitation. In addition to the specific mention of quality improvement, policy-makers should identify elements of policies, regulations and financing which can favour the implementation of a quality improvement system.

In order to assist the alignment process, policy-makers should develop the following key attributes.

- **Awareness of quality.** In order to combat stigma and misconceptions related to mental disorders and people with mental disorders, policy-makers should actively stimulate campaigns so that the general public, other legislators and funders are aware of the potential of evidence-based treatment and the need for quality.
- **Advocacy for quality.** Policy-makers should be advocates for quality in all forums. As they advocate they should be aware of the evidence base, examples of success, models that work, reasons for failures and potential barriers. As advocates they should use the available expertise and should also act as guardians monitoring the status of the mental health system. This dynamic role makes it possible for policy-makers to bring about meaningful change.
- **Strategic quality development.** In an environment of competing needs, quality initiatives for mental health may have to be tied to such initiatives in other areas. As has been demonstrated in South Africa, it is sometimes necessary and strategically advantageous to select natural partners and link mental health programmes to them, rather than to attempt to attract resources to mental health itself. For example, initiatives related to improvements in education, social welfare or criminal justice systems may provide opportunities for improving the quality of mental health services (Freeman, 2000).

Task 1: Consultation

The first task in aligning policy for quality improvement is to consult with all stakeholders in order to develop a common vision of quality. This consultation is essential because the quality of care results from interactions and partnerships between many stakeholder groups, including policy-makers, funders, planners, mental health workers, people with mental disorders and family members. These stakeholders have varying needs (Figure 2).

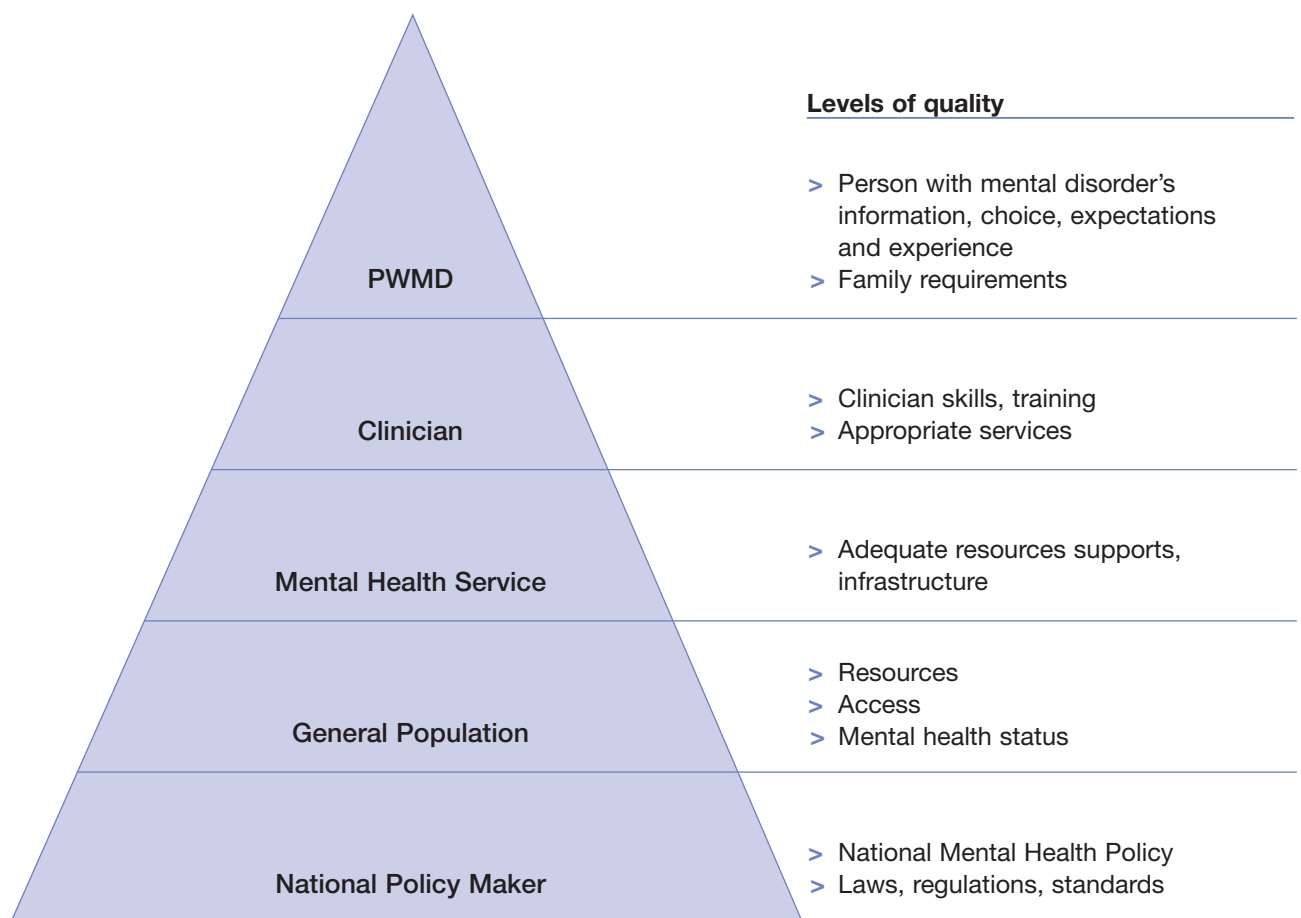
Mental health policies have to be aligned so that they support rather than oppose the improvement of quality.

Three key attributes assist the improvement of quality.

The first task in aligning policy for quality improvement is to consult with all stakeholders in order to develop a common vision of quality.

- > People with mental disorders require access to affordable care of high quality which is responsive to their needs and priorities, fosters self-determination and leads to functional improvement.
- > Family members require access to care of high quality which offers support, education and practical strategies for managing their family members and their own mental health concerns.
- > Mental health workers or clinicians are required to ensure stability, continuity and effective care. In order to achieve this they need appropriate training and skills.
- > The mental health service needs adequate resources (e.g. medications, staff and beds) in order to be able to function.
- > The general population requires access to services and an improvement in its overall mental health status.
- > Funders and policy-makers wish to provide cost-effective care that results in decreased symptoms and an improved quality of life for people with mental disorders and the general population. The role of the policy-maker is to provide leadership and direction and to facilitate satisfactory quality at all these levels through the promulgation of laws, regulations and standards.

Figure 2: The quality pyramid



Consultation has three critical functions: obtaining input from various stakeholders, sharing information across stakeholder groups and building a common understanding. The development of this common understanding is an essential part of the task of policy-makers and offers a unique opportunity to draw all mental health stakeholders together in order to create a vision of the delivery of mental health services.

Stakeholders who might be included in consultation for quality improvement include:

- > mental health workers;
- > people with mental disorders;
- > carers and families of people with mental disorders;
- > service managers;
- > academics or external advisers;
- > professional organizations;
- > nongovernmental organizations and voluntary agencies;
- > community leaders;
- > social or welfare services;
- > housing departments.

When is consultation needed?

Consultation is necessary not only at the start of policy development but also throughout the steps outlined in this module. Consultation can occur through the development of partnerships with particular stakeholders (step 1, task 2), to review legislation (step 1, task 3), negotiate with funders (step 1, task 4), develop a set of national standards for mental health care (step 2), develop accreditation procedures (step 3), monitor services (step 4) or discuss particular aspects of quality management and service improvement (steps 5 and 6).

Such consultation is an extremely important part of quality improvement. Many planners overlook the essentially **political** nature of this undertaking. Quality should be developed through a process of negotiation and consultation.

The development of quality can be threatening for staff and institutions in some countries and should therefore proceed with care. Occasionally, people who believe that it is against their interests to evaluate the quality of services oppose the entire process of quality improvement. Breakdowns in quality can occur through resistance, non-cooperation or a lack of commitment by any stakeholder group. Each group has particular costs and benefits associated with specific strategies related to quality. Proposed quality initiatives may be obstructed if there is not a degree of consensus and mutual understanding.

The progress of quality improvement often depends on the acceptance and support it receives from mental health workers and administrators (i.e. the people who have to implement change). This process requires the political will of all affected parties to be mobilized.

In some cases it may be difficult to ensure equity among all stakeholders. Some groups may wield more power than others and try to ensure that their own interests predominate. For example, mental health workers may have more authority and their views may predominate over those of people with mental disorders. The contribution of people with mental disorders is essential as they are the main recipients of services. In many countries, people with mental disorders suffer from “learnt helplessness” and therefore may not be accustomed to contributing their opinions for fear of reprimand from the people whose help they seek. In this situation, active steps should be taken to promote the self-efficacy and self-reliance of people with mental disorders so that their views are incorporated into quality improvement mechanisms.

Consultation with the full range of stakeholders is essential and offers a unique opportunity to create a vision of the delivery of mental health services.

Consultation can happen during all the stages of quality improvement.

The development of quality is both a technical and a political process.

The contribution of people with mental disorders is essential because they are the main recipients of services.

Ultimately, the quality mechanisms that emerge are a compromise between the interests and needs of the various stakeholders involved in mental health (Box 2).

Box 2. Examples of best practice:
stakeholder participation in the formulation of mental health standards

In the Norms and Standards project in South Africa, researchers under contract to the country's Department of Health consulted with some 300 stakeholders in mental health care, including service providers, managers, people with mental disorders, carers and academics. Questionnaires on service resources were distributed, the nine provinces were visited, consultations were held and focus groups were organized for the formulation of service standards. The process was completed in eight months. The historical context of inequitable fragmented services required the development of national standards in order to redress past injustices. These standards provided a guide for adaptation by provincial and local services (Flisher et al., 1998).

Task 2: Establish partnerships with professional groups, academic institutions, advocacy groups and other health and social service sectors

Through the consultation process, several active steps have to be taken by policy-makers in order to develop partnerships with relevant stakeholders. These partnerships form the backbone of the quality improvement process and enable long-term sustainability.

Partnerships with professional organizations

Professional organizations are uniquely positioned to define the quality of clinical care and other services. They provide expertise and are able to sanction practices that can then be used as guidance for their members. Professional organizations can ensure scientific soundness and clinical relevance. The proper development of practice parameters requires the synthesis of a broad array of information based on scientific studies, research findings, clinical experience and expert opinion.

Professional organizations can also promote minimum requirements for education and training, continuing education and other opportunities for the development of skills. Certification in a profession or specialty helps to define a threshold of competence.

The role of a professional organization in ensuring quality is threefold:

- defining and maintaining competence in its membership;
- defining, standardizing and promoting evidence-based practice and other practice parameters;
- promoting quality improvement through continuing education, and other skills development activities.

Many countries lack well-recognized professional organizations. Quality improvement in these countries should therefore include support for the development of such organizations and the assignment of explicit roles to them in the mental health policy and service delivery system.

Partnerships with academic institutions

The objective of partnerships with academic institutions is to improve the quality and performance of mental health services through education, training, research and evaluation.

Partnerships with stakeholder organizations are critical.

Professional organizations can ensure scientific soundness and clinical relevance.

The education and training of a skilled mental health workforce is essential. In many countries the availability of specialized personnel is poor: there is only one psychiatrist and one psychiatric nurse per 100 000 population in 53% and 46% of countries respectively (World Health Organization, 2001b). The availability of psychologists and social workers in the field of mental health is also poor, their median numbers being 0.4 and 0.3 per 100 000 population respectively in all countries.

Academic institutions are in a unique position to develop the knowledge base and skills needed for building an effective mental health workforce. Policy-makers should help to develop resources that are explicitly dedicated to education and training activities on an ongoing basis.

Besides contributing to the development of an adequate workforce, academic institutions can play a key role in training programmes, the implementation of evidence-based services and the development of innovative practices and models of organizing mental health services and financing.

Such efforts can work well through consultation between policy-makers and service providers at all levels. The objective is to link research and evaluation findings to policy decisions and the delivery and implementation of services. In this way the evaluation of services encourages policy change and improves the quality of services.

Partnerships with advocacy organizations, human rights organizations, and organizations of people with mental disorders and family members

These organizations demand quality and excellence and monitor whether practice and implementation are of a high standard and reflect current scientific knowledge. As such, they are partners in introducing quality initiatives, implementing quality improvement mechanisms and monitoring systems to ensure that quality-related features have been incorporated.

Policy-makers and funders are committed to quality but are often constrained by competing priorities and limited resources. Stakeholder organizations that represent the needs and rights of people with mental illness are in a better political and legal position to argue and advocate for care of good quality and for the resources needed to provide it.

Partnership with stakeholder organizations is critical in the design, implementation and evaluation of quality initiatives. The system exists for consumers and family members: the ownership of the system comes about through inclusion and involvement in defining standards and participation in audits and monitoring activities. This results not only in joint efforts to promote quality but also allows people with mental disorders, family members and advocates to improve their understanding of the realities and constraints under which the system operates.

“Nothing about us without us” has become a rallying cry for some mental health consumer organizations. Apart from the use of scientific evidence, people with mental disorders and their family members can also make key contributions to defining what works and how the mental health system could be improved. Through legislation, regulations or other mechanisms, policy-makers should support the development of the roles of these organizations in their various functions to promote quality.

The relationship between these stakeholder organizations and policy-makers is sometimes adversarial. However, this tension can be healthy (see *Advocacy for Mental Health*). Policy-makers are often constrained by budgets and the competing demands of various stakeholders. People with mental disorders and family members, having the most to gain from better access and quality, are less sanguine and more impatient with

Academic institutions can improve quality through education, training, research and evaluation.

Organizations for advocacy, human rights, consumers and family members are guardians of quality.

“Nothing about us without us.”

bureaucratic realities and political constraints that delay the implementation of necessary services. The goal is a responsive system that provides care of high quality.

Partnership with primary care and social services

The integration of mental health care into primary care has been a significant policy objective in both high-income and low-income countries for some time. Integration allows people with mental disorders to obtain good care when they may not need or be able to see a specialist. It allows health workers to address physical and mental health problems holistically. It also desegregates mental health care and reduces stigma (see *Organization of Services for Mental Health*).

Partnerships with social services are an integral component of quality improvement. The development of housing programmes, employment opportunities and family support initiatives is a key aspect of promoting the quality of life of persons with mental illnesses. Cross-sectoral policy initiatives at the national level should be implemented to support and facilitate partnerships at the local level. This means that these partnerships should operate at the levels of both policy and persons. Local agencies and providers should have mechanisms in place for coordinating supports and services for people with mental disorders. At the national and local levels, policies should be coordinated so that they require and support agency collaboration and interaction at the local level (see *Mental Health Policy, Plans and Programmes*).

Task 3: Align legislation and regulations with quality improvement objectives

National and local legislation can lead to improvements in the quality of mental health care. Legislation can be a means of ensuring minimum standards of access and care, protecting the rights of individuals, ensuring equity, establishing priorities, ensuring accountability and implementing systems for the measurement of performance. Legislation is therefore a tool for shaping and defining a mental health system, its relationship to other sectors and the resources that are allocated to it (see *Mental Health Legislation and Human Rights*).

Governments are often funders of mental health services: legislation defines the broad parameters for the allocation of resources and the standards and restrictions for what is to be funded. Legislation, although not immutable, establishes a stable framework with respect to expectations of access and quality which are uniform across a nation or region.

Legislation can promote quality by:

- supporting minimum standards for access and quality;
- allocating resources for underserved populations;
- promoting training, research and evaluation of the existing workforce and the development of skills in the future workforce;
- ensuring that accreditation systems are in place for providers and organizations;
- developing mechanisms for stakeholder participation in planning and evaluation;
- requiring reports on the mental health status of the general population and the access, quality, cost and impact of care for specific subpopulations;
- allocating resources for research.

A WHO booklet on mental health care law (World Health Organization, 1996) is based on a comparative analysis of national mental health laws in 45 countries. It presents key reference principles and guidance on implementation. The incorporation of these principles into the legal body of jurisdictions is recommended (Box 3). A more comprehensive document (Principles for the protection of persons with mental illness and for the

Partnerships with primary care services are essential for continued quality improvement.

Legislation can promote quality objectives.

Legislation can establish minimum expectations.

improvement of mental health care. UNGA resolution 46/119 of 17 December 1991) should also be used as a guide for the development of mental health legislation.

Box 3. Mental health care law: ten basic principles

- 1. Promotion of mental health and prevention of mental disorders**
Everyone should benefit from the best possible measures to promote their mental well-being and prevent mental disorders.
- 2. Access to basic mental health care**
Everyone in need should have access to basic mental health care.
- 3. Mental health assessments in accordance with internationally accepted principles**
Mental health assessments should be made in accordance with internationally accepted medical principles.
- 4. Provision of the least restrictive type of mental health care**
Persons with mental health disorders should be provided with health care that is the least restrictive.
- 5. Self-determination**
Consent is required before any type of interference with a person can occur.
- 6. Right to be assisted in the exercise of self-determination**
If a patient experiences difficulties in appreciating the implications of a decision but is not unable to decide, he/she shall benefit from the assistance of a knowledgeable third party of his or her choice.
- 7. Availability of review procedure**
A review procedure should be available in respect of any decision made by official (judge) or surrogate (representative, e.g. guardian) decision-makers and by health care providers.
- 8. Automatic periodic review mechanism**
In the case of a decision affecting integrity (treatment) and/or liberty (hospitalization) with a long-lasting impact there should be an automatic periodic review mechanism.
- 9. Qualified decision-maker**
Decision-makers acting in an official capacity (e.g. judge) or surrogate (consent-giving) capacity (e.g. relative, friend, guardian) shall be qualified to do so.
- 10. Respect for the rule of law**
Decisions should be made in keeping with the body of law in force in the jurisdiction involved and not on another basis or an arbitrary basis.

Task 4: Align funding mechanisms

Financial systems for mental health care should be aligned so that they maximize quality and do not become an obstacle to quality improvement. As *Mental Health Financing* suggests, financial systems can and should be aligned with planning priorities through resource allocation strategies, performance contracting, payment arrangements and financial incentives. Often, however, policy-makers have to confront competing needs, even for resources allocated to mental health systems. When this happens, quality becomes as much a factor in the policy arena as it is in a clinical setting.

Funders generally focus on cost containment. Payment methods do not usually ensure satisfactory quality of care or facilitate quality improvement. However, quality improvement is in the interests of funders because it is often associated with improved efficiency and because poor quality can be very costly in various ways.

First, poor quality can result in waste, as when errors are made or processes have to be repeated (overuse). Second, an absence of quality orientation may result in inefficiencies, as happens when two processes can produce the same outcome but the more expensive one is selected (misuse). Third, waste occurs when subclinical dosages of medications are administered because the treatment in question is unlikely to produce the desired results (underuse). Some studies suggest that waste associated with poor quality accounts for 25-40% of all hospital costs (Anderson & Daigh, 1991).

Funders should therefore balance cost and quality. In doing so they should ensure both quality and efficiency. Funders can contribute to the creation of good quality by the following methods.

➤ **Establishment of criteria and reporting requirements related to quality.**

For example, if criteria are established for the responsiveness of a system within specified periods (e.g. providing emergency, urgent and routine care), funders can require information on the proportion of persons who received care within the designated periods. Similarly, if the promotion of a community-based service delivery system is an objective, data can help to track and provide incentives for making an impact in this area. For example, funders could request reports on the number of persons served in community settings, the total expenditures for community-based services, the number of persons in hospital settings discharged into the community, the number of persons served in hospitals, and hospital expenditure.

➤ **Development of payment systems and financial incentives that reward good quality and support quality improvement.** The alignment of payment systems and financial incentives with system objectives is critical (see *Mental Health Financing*). For example, if promoting the use of more appropriate antipsychotic medications is a system objective a special fund for such medications could be created and distributed to different regions of the country in question for the sole purpose of achieving this. Adherence to standards or exemplary quality improvement initiatives could be rewarded by means of a small fund maintained for the provision of incentives. Disbursements could be made to high-performing units or regions.

➤ **Payment for management, administrative and information systems that report, monitor and improve quality.** Reporting for quality monitoring is often an unfunded mandate. Explicit recognition that certain funds are needed for reporting and monitoring can facilitate these activities. For example, if an amount is allocated for reporting performance measures this can help to ensure that such reporting occurs. Furthermore, financial sanctions and rewards could be used for promoting the completeness and quality of data.

Poor quality is costly in several ways.

Funders can contribute to quality through several mechanisms.

- **Ensuring adequate payment levels for clinicians and other providers.** Ultimately, quality depends on the quality of the workforce. Appropriate pay ranges and emoluments are necessary in order to attract personnel of high calibre. In some parts of the USA, for example, psychiatrists are encouraged to work in rural areas by increased pay levels.
- **Alignment of financial incentives with the implementation of evidence-based and other best practices.** For example, in order to promote certain evidence-based practices, the Texas mental health system established minimum requirements for such practices in each region of the state. The purpose of these requirements was to ensure the availability of evidence-based services throughout the state. The funding levels for a region were reduced if it failed to meet the minimum requirements.
- **Reducing the fragmentation of care.** The fragmentation of care often results from having multiple funding streams or different spheres of authority and responsibility. Funders can require the pooling of funds or coordination with other ministries or agencies. An important aspect of such coordination involves ensuring that the funder is coordinating its activities with other funders. Moreover, multiple lines of responsibility and authority can result in inconsistent, if not contradictory, standards and requirements. It is essential to coordinate and align standards and requirements if these are to promote quality and not act as bureaucratic impediments.

Addressing these quality concerns may have significantly different implications for providers. In a fee-for-service system, for instance, the reduction of overuse and misuse may result in lower revenues for providers, whereas addressing underuse could result in higher revenues.

Task 5: Alignment of planning

The major function of planning is to identify needs and define priorities so that the available resources can be allocated for the achievement of established goals and targets (see *Mental Health Policy, Plans and Programmes and Planning and Budgeting to Deliver Services for Mental Health*). The planning process directs resources to meet identified needs and to optimize the impact made by them.

In the course of planning the following issues may be encountered. They all have a bearing on the quality of care. Consequently, quality improvement should always be considered when they are being addressed.

- **Balance between access and quality.** Planners confronted by limited resources have to decide whether to provide current service recipients with better services or use the resources to serve more people. In these settings the context of mental health care may have an impact on quality. For example, standards may be difficult to maintain in situations of high service demand and minimal resources.
- **Quality for whom?** Policy-makers have to decide whether resources should be allocated on a priority basis to persons with severe mental disorders or to the general population; to children, adults or the elderly; or to specific geographical regions.
- **Quality at what level?** Policy-makers have to make provisions for both the quality of direct services and the indirect costs implied in quality management systems, information systems and other administrative processes.

Planning priorities shape quality priorities.

By definition, evidence-based planning includes quality considerations.

Several issues faced by planners have quality implications.

- > **Quality for which services?** Acceptable levels of quality can be defined for different types of services. For example, resources can be allocated to enhance quality in hospital settings, or the same resources can be used to improve and expand services of good quality in the community. In this sense, quality depends on the level of service organization (see *Organization of Services for Mental Health*).
- > **Quality for today or tomorrow?** Resources can be allocated to develop a mental health training programme for the health care workforce of the future or special programmes can be implemented to improve the skills of the existing workforce.

Quality can therefore inform planning by providing a knowledge base for evidence-based practice. As a result the amount of medications, the number of staff and the infrastructure needed at an acceptable level of quality (a level that is likely to produce desired outcomes) help to define the level of need that can be met with the available resources.

Planning thus becomes planning for quality since it is partly based on the evidence base that exists for effective services and the funding of programmes. For example, planning for quality could be based on the following evidence.

- > Patients with schizophrenia and other psychoses are effectively cared for in community settings in both rich and poor countries where psychosocial and psychopharmacological treatments are adequately provided.
- > Community-based interventions and programmes are effective for depression, anxiety and other neuropsychiatric disorders.
- > Common mental disorders, e.g. depression, can be managed effectively with proven regimes.

These issues illustrate the intimate connection between planning decisions and their impact on quality. Ultimately, planning decisions are, de facto, decisions related to the quality of access or care. A clear understanding of such decisions is vital for planners.

Key points: Step 1. Align policy for quality improvement

Policy-makers have a key role in the quest for quality. They are in a position to establish the broad parameters of quality through consultation, partnerships, legislation, funding and planning. Policy can be aligned for quality improvement through the following tasks.

- **Consultation.** Consultation is necessary with all mental health stakeholders, both in the development of policy and in all subsequent quality improvement steps.
- **Partnerships.** Active steps should be taken by policy-makers to develop partnerships with professional groups, academic institutions, advocacy groups and other health and social service sectors. These partnerships form the backbone of the quality improvement process and enable long-term sustainability. They build consensus and consistency in messages related to the need for quality and can also be a mobilizing force for obtaining the resources and other supports that are required.
- **Legislation.** Policy-makers should promote legislation that reflects a concern for and an emphasis on quality. Models provided by WHO are useful for this purpose.
- **Funding.** Financial systems for mental health care should be aligned so that they maximize quality and do not become an obstacle to quality improvement. Improved efficiency is an essential goal of both quality improvement and cost containment.
- **Planning.** Quality processes can inform planning by providing a knowledge base for evidence-based practice. In the course of planning, several issues pertaining to resource allocation and priority-setting have a bearing on quality.

Step 2. Design a standards document

If a decision is taken by a mental health service to improve the quality of care it is essential to set out a formal measurable description of the way in which care should be delivered. This can be achieved through the development of a set of **standards** agreed by all involved in the service.

Standards can be defined as normative qualitative statements about what constitutes acceptable and adequate mental health care (Lund et al., 1998). In other words, they describe how a mental health service should be delivered. A standards document should therefore attempt to provide guidelines on all aspects of mental health care. How this information is arranged varies significantly between countries, depending on local needs, service organization and history.

In many countries, standards have provided a description of the way in which care should be delivered and are a guideline against which services can be assessed. Examples include:

- National Standards for Mental Health Services in Australia (Australian Health Minister's Advisory Committee National Mental Health Working Group, 1996);
- Standards for Psychiatric Care in South Africa (Flisher et al., 1998);
- Canadian Standards of Psychiatric and Mental Health Nursing Practice (<http://www.cfmhn.org>);
- National Services Framework for Mental Health in the United Kingdom (Department of Health, 1999).

In certain countries, standards have been operationalized, i.e. developed with scales that allow services to be **rated** for the quality of care (Australian Health Minister's Advisory Committee National Mental Health Working Group, 1996).

In 1991 a group of experts in mental health care recommended to WHO that instrumentation and methodologies be developed for the comprehensive assessment of the quality of mental health care and services. In response, WHO developed quality assurance checklists (World Health Organization, 1994, 1997). These serve the same function as standards and provide a means of rating the quality of mental health services in quantitative terms.

In order to achieve the greatest possible effectiveness, countries should adapt these checklists to their own circumstances and should develop their own standards. Standards or quality assurance checklists are a means of ensuring that goals set out in policy are implemented in service delivery. They are also a means of assessing the extent to which the targets of service planning and budgeting are implemented in care for people with mental disorders.

The tasks required for the development of a standards document are indicated below.

Task 1: Form a committee or working group

The first task in developing standards is to form a committee or working group that takes responsibility for the production of a standards document from start to finish.

The working group may include policy-makers, mental health workers, people with mental disorders, service managers and carers. It may be relatively small and its members should have skills in writing, research and consultation.

An essential step towards improving the quality of mental health services is to set out a formal measurable description of the way in which care should be delivered.

Standards are a way of formally describing how a service should deliver care.

The first task is to form a committee or working group to take responsibility for the production of the standards document.

Task 2: Consult with all relevant stakeholders

Consultation should happen before, during and after the production of the standards document (Box 4). For example, at the outset a letter could be written to all mental health stakeholders, informing them of the project and asking them to suggest which domains should be covered. The resulting suggestions could be used to produce an initial draft document, which could be sent to the stakeholders with a request for comments and further suggestions. Focus groups could then discuss particularly important areas of the document. Once a final document is produced, all stakeholders in mental health should ratify it.

Box 4. Example: Stakeholder participation in the formulation of mental health standards

The Australian National Standards for Mental Health Services were developed through national consultations involving all professional bodies, people with mental disorders, carers, managers and government representatives (Rosen, 1999). The final document is a set of outcome-oriented standards that cover all mental health services, whether public or private, hospital or community. Indicators provide operational means of assessing whether services are meeting the required standards and are linked to a rigorous external accreditation system. The standards specify degrees of community and hospital service integration as well as acute and rehabilitation service integration, while enshrining the human rights of people with mental disorders.

Task 3: Design a standards document

Format for standards

The next task in designing standards is to decide on the particular **domains** that they are to cover. Initially a provisional list of domains could be made, based on the consultation process. The WHO quality assurance checklists and glossaries indicate domains that can assist with this task (World Health Organization, 1994, 1997). They include:

- > mental health policy
- > mental health programmes
- > primary health care facilities
- > outpatient mental health facilities
- > inpatient mental health facilities
- > residential facilities for elderly people who are mentally ill
- > rights of people with mental disorders
- > community-based support services
- > day hospitals
- > day hospitals for the elderly
- > day centres (psychosocial rehabilitation centres)
- > forensic psychiatric facilities

The domains covered by the WHO quality assurance checklists and glossaries should be adapted by countries in accordance with their local circumstances. The list provided is not comprehensive and other areas may have to be developed by countries, e.g. residential facilities for people with learning disabilities, mental health promotion programmes and services for children and adolescents. Examples from other countries may be used as a guide (Australian Health Minister's Advisory Committee National Mental Health Working Group, 1996; The Scottish Office, 1997; Flisher et al., 1998).

In South Africa, for example, standards were divided into three areas: core standards, standards for care, and standards for specific settings (Flisher et al., 1998). These were further subdivided into 25 standards, corresponding to each of 25 domains. The domains were chosen in an attempt to cover all aspects of the mental health services so as to provide a standard for care delivery (Box 5).

The next task is to decide which domains are to be covered by the standards.

The WHO domains should be adapted by countries in accordance with their local circumstances.

Box 5. Example: Domains covered by mental health standards in South Africa

Note: This is an example, not a recommended format for all countries.

1. Core standards (area)

Domains:

- > Rights and legal protection
- > Safety and risk management
- > Access
- > Privacy and confidentiality
- > Personal interaction and communication
- > User and carer participation
- > Community participation and development
- > Community living
- > Treatment and support environments
- > Language, culture and context
- > Prevention and mental health promotion
- > Resource management and affordability
- > Service development

- > Documentation
- > Mental health worker training and support

2. Standards for care (area)

Domains:

- > Entry and admission
- > Assessment and review
- > Emergency care
- > Treatment, care and therapies
- > Medication and other technologies
- > Psychosocial rehabilitation
- > Discharge and readmission

3. Standards for specific settings (area)

Domains:

- > Hospital care
- > Primary health care
- > Supported accommodation and group homes

When the domains of the document have been decided, criteria have to be set out which describe the conditions that should be met in order to ensure mental health care of satisfactory quality. An example from the WHO checklists and glossaries illustrates how this format may be set out (Box 6).

Specific criteria for each domain have to be described.

Box 6. Example: Criteria for quality assurance checklists

(World Health Organization, 1994)

E. The inpatient mental health facility checklist

PHYSICAL ENVIRONMENT

1. The facility has been officially inspected and meets local standards for the protection of the health and safety of inpatients and staff.
2. The ward space is sufficient for the number of patients admitted.
3. There is reasonable space for specific treatment procedures.
4. There is reasonable space for recreational activities.

Examples of how this format might be adapted to local circumstances is provided by the South African Standards document and the National Services Framework in the United Kingdom (Box 7). In the South African example, a standard for each domain is stated in clear, easily understandable language. For each standard, specific criteria describe the conditions that are required in order to meet it. The criteria also provide greater detail in particular areas where policy is not very clear or guidelines are few (e.g. language interpreting), or in areas where there is a need to emphasize specific neglected aspects of care, (e.g. users' rights and physical environments). Subcriteria relate to frequently overlooked or neglected aspects of care which should be addressed. They also describe mechanisms or processes that may have to be in place in order to achieve a criterion. In this sense they may describe steps towards achieving a standard.

Box 7. Examples of standard and criteria

Example 1: Format for mental health standards in South Africa

3. Access	Domain
The services are accessible to the population of the district or catchment area and to users with severe psychiatric conditions in particular.	Standard
The services seek to ensure that there is equal access to the same quality of comprehensive mental health care for each segment of the population.	Criterion
- The services seek to ensure that the demarcation of health districts and catchment areas does not discriminate against any section of the population or perpetuate racial segregation or social injustice. - The services seek to ensure that language difference does not become a criterion for exclusion or inaccessibility to treatment facilities or programmes.	Subcriteria

Example 2: Standards criteria for the National Service Framework for Mental Health in the United Kingdom

Criteria for standards

Mental health promotion

- Promote mental health for all, working with individuals and communities.
- Combat discrimination against individuals and groups with mental health problems and promote their social inclusion.

Primary care and access to services

- Any service users who contact their primary health care team with a common mental health problem should:
 - have their mental health needs identified and assessed;
 - be offered effective treatments, including referral to specialist services for further assessment, treatment and care if necessary.
- Any persons with a common mental health problem should:
 - be able to contact the local services capable of meeting their needs and providing adequate care at any time of the day or night;
 - be able to ask NHS Direct, as it develops, for first-level advice and referral to specialist help lines or local services.

Effective services for people with severe mental illness

- All users of mental health service who are covered by the care programme approach should:
 - receive care that optimizes engagement, prevents or anticipates crisis and reduces risk;
 - have a copy of a written care plan.
- All service users who are assessed as requiring a period of care away from home should have:
 - timely access to an appropriate hospital bed or alternative bed or place that is:
 - in the least restrictive environment that is consistent with the need to protect them and the public;
 - as near as possible to their homes.
 - a copy of a written after-care plan agreed on discharge, which sets out the care and rehabilitation to be provided, identifies the care coordinator and specifies the action to be taken in a crisis.

Caring for carers

- individuals who provide regular and substantial care for persons covered by a care programme approach should:
 - have an assessment of their caring, physical and mental health needs at least annually;
 - have their own written care plan, devised following discussion with them.

Preventing suicide

- Local health and social care communities should prevent suicides by implementing the above standards.

Operationalizing standards

Standards should be operationalized so that the quality of mental health services can be assessed in measurable terms. This means developing a system for rating a mental health service in accordance with measurable criteria.

The WHO quality assurance checklists and glossaries (World Health Organization, 1994, 1997) provide a method enabling countries to assess the quality of their mental health services by using a rating system.

As illustrated above, these documents outline a checklist of criteria that have to be met in order to ensure satisfactory delivery of mental health services. Each criterion is rated (0 = absent, 1 = partially present, 2 = fully present). The glossaries provide a more detailed explanation of the scoring of each criterion. A total rating is obtained for each section by adding together the appropriate individual ratings (Box 8). Countries can use or adapt these checklists and glossaries to meet their own needs.

Box 8. Example: Quality assurance rating scores for inpatient mental health facilities

Good	127-158
Fair	96-126
Barely acceptable	64-95
Unacceptable	0-63

Ratings are useful because they allow countries or local services to assess precisely how a service is measuring up to the agreed standards. They also provide an incentive for mental health workers to monitor and improve their own care.

Rating scales have several potential shortcomings. When scores are used to summarize various aspects of a facility, care of poor quality may be ignored. For example a “fair” score may indicate a generally fair service or it may indicate that some aspects of care, e.g. sanitation, are good while others, e.g. the supply of medications, are unacceptable. This reflects problems associated with establishing criteria for standards rather than with scores per se.

In order to resolve this difficulty, quality assessments should cover specific aspects of services. It should not be assumed that summary scores provide adequate assessments. Individual rating scale scores should be reviewed and should be supplemented by qualitative inspections of facilities or services and by consultation with a range of stakeholders, including people with mental disorders and their families.

Standards should be operationalized so that the quality of services can be rated.

Rating scales have several potential shortcomings.

Scores should be set at realistic levels and adjusted to countries' specific resources without compromising the rights and legal protection of people with mental disorders. Countries should set criteria for acceptable scores through negotiation with all the key stakeholders.

Key points: Step 2. Design a standards document

- Development of a set of standards against which services can be measured is an essential step towards improving the quality of mental health services.
- This requires the establishment of a working group, consultation with relevant stakeholders and the drafting of a standards document.
- The standards document should cover all aspects of the mental health service, identified by particular domains.
- Criteria for each standard have to be specified.
- These criteria can provide a means for rating existing services. WHO documentation is available which can assist with this process.
- The rating of services should be supplemented by observations on the quality of all aspects of mental health care.

Step 3. Establish accreditation procedures

Accreditation is the official authorization of a mental health service by a public body that is legally entitled to fulfil this role. In the context of quality, accreditation has come to mean the authorization of a service on condition that certain criteria of quality are demonstrably met.

Accreditation therefore presents an opportunity to assess the quality of care delivered by a particular service and to provide the service with the appropriate legal recognition. This protects people with mental disorders, mental health workers and funders by ensuring that care is of an acceptable standard. From the perspective of the organization, accreditation allows comparisons with established standards or similar organizations in various domains. Areas that need improvement can be identified and mechanisms can be developed to implement the required changes. For example, accreditation can result in improved staffing, improved conditions in institutional settings (e.g. improved bathing and recreational facilities), smaller wards and greater privacy.

Accreditation offers the following advantages to a mental health service.

- **Recognition.** Accreditation ensures that the organization meets criteria associated with quality and enhances consumer and community confidence.
- **Education and consultation.** Accreditation surveyors provide consultative expertise that is helpful in the self-improvement efforts of the service.
- **Monitoring and evaluation.** Deficiencies are identified which can be corrected. Moreover, the concern with accreditation results in ongoing self-monitoring by the service.
- **Staff recruitment.** The scrutiny implicit in accreditation creates a need for skilled, well-trained staff. Furthermore, talented staff are more likely to be attracted to work in an accredited organization than elsewhere. (Talbot, Halls & Keill, 1992).

Accreditation is essential because it makes quality a cornerstone of the official licensing of mental health services or facilities. Service providers that fail to meet the specified accreditation criteria are not entitled to render such services. This applies to mental health services in the public, private-for-profit, nongovernmental and informal sectors.

Accreditation has implications for the funding of services in some countries. For example, a managed care organization only reimburses service providers if accreditation procedures can demonstrate a certain quality of care.

The following tasks have to be performed by the mental health service planner in connection with the establishment of accreditation procedures.

Task 1. Identify relevant accreditation standards or procedures

Accreditation procedures may already exist in some countries. For example, there may be licensing procedures for psychiatric hospitals. Accreditation that is in place for general health services may be applicable to many mental health services. Thus the accreditation of primary care facilities may be possible through existing general health procedures.

The first task is therefore to identify the established accreditation procedures, if any, and how they can be used to assess existing mental health services. Some accreditation procedures may be outdated or no longer clinically relevant. For example, accreditation

Accreditation is the authorization of a service that meets specified standards.

Accreditation ensures that quality is not an optional extra for mental health services but an essential requirement for their legal functioning.

Mental health service managers should identify the available accreditation procedures in their countries in order to maintain and improve the quality of services.

may exist for psychiatric hospitals under outdated custodial or institutional forms of care. In such instances it is necessary to update the accreditation procedures in keeping with evidence concerning the most effective humane care, much of which is community-based.

It is not normally a task of local mental health service managers to develop accreditation standards for assessing local services. However, local managers or designated authorities may be required to use national accreditation procedures in order to assess and accredit local mental health services. It is therefore essential that local managers be aware of the available accreditation procedures in their countries in order to maintain and improve the quality of local services.

Task 2. Develop accreditation procedures where appropriate

If accreditation procedures are unavailable and general health procedures are inappropriate it may be necessary to develop accreditation procedures for mental health services. The standards that have been developed (step 2) provide a foundation for assessing the quality of services for accreditation purposes. The development of accreditation procedures requires the application of these assessment tools to the task of accrediting specific services, facilities or agencies.

Accreditation procedures should be consistent with established standards. The standards document developed in step 2 can be used as a structure to provide criteria and a rating system for assessing services and conferring the appropriate legal status. Combining these resources is essential in order to avoid duplication or inconsistencies in quality assessment.

As with the development of standards, the **participation of all relevant stakeholders** is essential when accreditation procedures are being developed, and the development of accreditation measures may be as much a political process as a technical one. Accreditation measures should balance the interests of the various parties involved in mental health care while maintaining acceptable standards of care.

More details on the application of accreditation procedures to the monitoring of services are provided in step 4. See also:

- Annex 3 on the accreditation of therapeutic communities for the rehabilitation of people with drug dependence in Chile;
- Joint Commission on Accreditation of Healthcare Organizations (<http://www.jcaho.org>);
- Joint Commission Resources International (<http://www.jcrinc.com>).

It is important to note that accreditation alone does not ensure that care is of good quality. Even if accreditation measures are in place a service may continue to neglect the human rights of the people served or may provide interventions that are not based on evidence. Thus accreditation is an important first step but it does not complete the quality improvement cycle.

The next steps for the mental health service manager are to ensure (1) that local services meet accreditation criteria, (2) that ongoing future reviews of services are conducted for accreditation purposes, (3) that once accreditation is established, services continue to improve the quality of the care they deliver. These tasks are discussed in more detail in steps 4 and 5.

Local mental health managers should be aware of national accreditation procedures.

It is essential that all relevant stakeholders participate in the development of accreditation procedures.

Key points: Step 3. Establish accreditation procedures

Accreditation provides the opportunity to assess the quality of care delivered by a mental health service and to provide the service with the appropriate legal recognition. Accreditation is essential because it makes quality a cornerstone of the official licensing of a mental health service or facility.

The following tasks are essential for the establishment of accreditation procedures.

- Service planners have to identify whether any existing accreditation procedures can be used to assess current services. Outdated procedures have to be reformed in keeping with the evidence for the most clinically effective and humane forms of mental health care.
- Accreditation procedures have to be developed if none exist. The standards document developed in step 2 can be used as a structure to provide criteria and a rating system for assessing services and conferring the appropriate legal status.

Step 4. Monitor the mental health service by using the quality mechanisms

Once the standards have been finalized and accreditation procedures have been identified the mental health services have to be monitored so that the quality of care can be assessed. Assessment can take several broad forms:

1. The **standards** can be used for annual assessment of the service.
2. The **accreditation procedures** can be used to assess and accredit new service developments and to review the ongoing functioning of services.
3. Routine information can be gathered through existing **information systems**, e.g. through the use of performance indicators employed by such systems.
4. Consultations can be held with **independent** organizations for people with mental disorders, carers and advocacy groups in order to obtain their assessments of services.

One of the purposes of having multiple assessment procedures for monitoring mental health services is to balance the needs of various stakeholders. Thus, for people with mental disorders, measures of user satisfaction may be an indicator of quality in mental health care, whereas for funders or purchasers, cost-effectiveness may be an indicator of quality. Multiple assessment procedures are also useful for separating service providers from bodies that monitor quality. There is always a danger, for example, that public sector services monitor themselves and therefore have no incentive to rectify problems that arise. Separating the provider and the monitor is essential for ensuring appropriate quality assessment.

An essential ingredient of monitoring the quality of mental health services is the use of **positive incentives** to improve quality. This is preferable to the use of critical or punitive methods. Capacity should be developed to reward people or units, give credit, allow for service bonuses and reflect improvement over time. This approach creates incentives for mental health workers to identify their own solutions to problems rather than waiting for management authorities to do so. In order to obtain the enthusiastic cooperation of staff the whole process of monitoring the quality of services should be framed in a positive collaborative manner.

A second crucial element is the inclusion of **outcome and other performance measures** in the assessment of mental health services. As an example, the ORYX initiative of the Joint Commission for Accreditation of Health Care Organizations in the USA has developed an approach to encouraging quality improvement initiatives by health organizations. Mental health organizations (or behavioural care organizations) are required to select 10 performance measures by which their service can be assessed, e.g. clinical measures and patient perception-of-care measures. The performance of services as assessed by the identified measures is used to measure the quality of care and in turn to inform the accreditation of a particular service.

Task 1. Use standards to assess services

Mental health services should be rated on a regular basis, preferably annually, in accordance with the standards that have been established. This should cover all aspects of the services.

The way in which this is organized depends on how the standards are organized and on the mental health services that are available in the country concerned. By means of the WHO quality assurance checklists and glossaries each domain of mental health service provision can be rated in accordance with the criteria laid down (e.g. outpatient or outpatient mental health facilities) (World Health Organization, 1994, 1997).

Services should be monitored and assessed on a regular basis in accordance with the agreed standards and accreditation procedures.

Multiple assessment procedures are required in order to balance the needs of varying stakeholders.

Positive incentives should be used to improve quality.

Outcome and other performance measures should be used to assess the quality of mental health care.

The precise mechanisms for assessing various aspects of a service in accordance with the established standards can be expected to vary significantly between countries and between local areas. In some settings the committee responsible for developing standards may be responsible for regular checks on services. In others it may be a responsibility of local managers to ensure that nationally developed standards are implemented at the local level. Alternatively, ratings may be done by the mental health workers or facilities themselves in self-improvement exercises.

Information on these aspects of service performance should be formalized in annual **reports** compiled by either standards committees or local managers. This information can be incorporated into subsequent planning and service delivery.

Box 9 illustrates the use of standards to evaluate psychiatric hospitals in Brazil.

Depending on countries' specific arrangements the rating of services may be a responsibility of a specific standards committee or of local service managers.

Box 9. Example: Evaluation of quality of care in psychiatric hospitals in Brazil (Caldas, personal communication, 2002)

Three levels of criteria

- Indispensable: legal requirements
- Necessary: conditions for improvement of care; compliance required with at least 80% of items
- Recommended: allowing evaluation of improvement

Examples of criteria

- Thirteen **indispensable** items, e.g. family meetings, referrals for outpatient care and absence of prison-like rooms
- Fifteen **necessary** items, e.g. socializing activities, out-of-hospital activities and access to telephone calls
- **Required**: characteristics of patients' records

Evaluation of criteria: interviews with patients

- Evaluation of 10 randomly chosen patients and their records

Other information for evaluation of quality of care

1. Listing of inpatients staying longer than six months in hospital
2. Average length of stay
3. Dynamics of beds turnover
4. Diagnostic profile provided by hospital
5. Number of patients with chronic neurological conditions
6. Clinical care - referrals
7. Patients in the general clinical care unit
8. Conditions for use of electroshock
9. Rate of patients with extrapyramidal symptoms (acceptable in under 5%)
10. Psychosurgery referrals
11. Deaths in the last 12 months
12. Number of patients with legal problems
13. Number of patients with retirement benefits
14. Sentinel events
15. General impression

Task 2. Use accreditation procedures to assess and accredit services

In addition to the rating of services they have to be assessed according to whether they meet accreditation criteria. Formal reviewing bodies such as **accreditation boards** may already exist in the mental health service or the general health service. If so, these bodies may be used to assess the quality of mental health services and to accredit services accordingly. This structure should be given adequate legal authority to license mental health services or to prevent services from continuing to function if the quality of care is considered unacceptable. Links with the funding of services should also be made so that decisions on funding can be based on accreditation assessments (Box 10).

An accreditation board should have:

- legal representation, including familiarity with the appropriate mental health legislation (see *Mental Health Legislation and Human Rights*);
- clinical representation providing assessment of the clinical functioning of a service or facility;
- representation of people with mental disorders in order to ensure that their rights and needs are a central consideration, this being important because such people should have recourse to independent review bodies if they are dissatisfied with the quality of care received;
- service management representation in order to provide an assessment of the organizational functioning of the service;
- financial representation, e.g. an accountant who can audit the financial affairs of the service or facility and assist with the assessment of cost-effectiveness.

Formal accreditation reviews should happen:

- when a new service is established (public, private or a nongovernmental organization);
- periodically thereafter, preferably at intervals not exceeding five years.

As a result of the accreditation process an accreditation board may publish a national list of services or organizations that have met its approval. For example, *Quality Check*TM provides a list of nearly 20 000 health care organizations and programmes accredited by the Joint Commission for Accreditation of Health Care Organizations in the USA. As with the monitoring of standards the precise mechanisms of accreditation vary between countries. For example, in Italy and other countries there is a clear separation between institutional accreditation and professional accreditation. The former is granted by central or local government whereas the latter proceeds from scientific institutions whose judgements are completely independent of government. In China there are three main mental health service providers: the health sector (mainly for treatment), the social security sector (mainly for shelter) and the public security sector (mainly for imprisonment). These sectors have various funding sources and administrative tracks.

It is a central unifying principle that all relevant stakeholders be consulted in the process of accreditation in order to ensure consistency and collaboration. They include mental health workers, people with mental disorders, family groups, service managers, universities, government institutions and nongovernmental organizations, together with the range of sectors that may be involved in the provision of mental health care.

A second essential function of the accreditation process is to monitor human rights, particularly in psychiatric hospitals. There may be convergent interests with organizations or committees that have been set up specifically to monitor human rights. If necessary, liaison between these groups may be a useful way of ensuring that human rights are monitored while service quality is assessed and accreditation is determined (see *Mental Health Legislation and Human Rights*).

An accreditation board should include appropriate representation.

An accreditation board may publish a list of services or organizations that have met the accreditation criteria.

The precise mechanisms of accreditation vary between countries.

Two unifying principles that should guide accreditation are those of consultation with all stakeholders and the monitoring of human rights.

Box 10. Examples of accreditation

Example 1: Accreditation of therapeutic communities for rehabilitation of people with drug dependence in Chile (see Annex 3 for legal accreditation document)

In 1993, approximately 10 therapeutic communities were functioning in Chile, most of them private (small nongovernmental organizations). However, they had no legal existence and were operating without authorization from the health authority. The following steps have been developed with the assistance of the Mental Health Unit of the Ministry of Health.

1. A working group was formed with people representing most of the therapeutic communities, public health professionals and clinicians. The group elaborated a draft document for the regulation of facilities.
2. The draft was distributed to all the therapeutic communities, all the health districts in Chile and some prominent mental health professionals. Suggestions were analysed by the working group and incorporated into a second draft.
3. The second draft went through a slow and difficult process of legalization and was finally approved with the signature of the Minister of Health and the President of the Republic.
4. A process of accreditation was begun through the health districts, involving the use of mechanisms similar to that used for the accreditation of health facilities.
5. A financial mechanism was established whereby social health insurance pays the accredited therapeutic communities for one month of treatment with three levels of intensity or complexity.

There are currently more than 50 therapeutic communities operating under this scheme in Chile.

Example 2: Accreditation of mental health institutions in Latvia

Since 1997 the health care institutions in Latvia have been evaluated by the Health Statistics and Medical Technology Agency of the Ministry of Welfare. This includes the evaluation of staff, equipment and premises. If an institution is found to meet the required standards it is subjected to confirmatory assessment. This accredits the institution with the necessary status to be contracted by sickness funds or commissioning companies for the delivery of the health service in question. All mental health institutions in Latvia have to undergo this evaluation. A minority of institutions have yet to undergo the process of evaluation. The Health Care and Quality Control Inspectorate of the Ministry of Welfare evaluates cases where legal claims are brought against these institutions (Veits, personal communication, 2002).

Task 3. Use information systems to routinely assess quality

The collection of reliable and detailed information is an essential component of the whole system of quality monitoring. Where information systems already exist they should be used to routinely assess the quality of all aspects of the mental health system. Where there are no information systems or minimal ones, such systems should be developed (see: Mental Health Information Systems, to be developed by WHO).

Existing information systems should be used to routinely assess the quality of all aspects of the mental health system.

A wide variety of information could be gathered for quality monitoring. Information can be obtained from diverse sources to assess the quality of care in various settings (including community care services, hospitals and prisons) for various stakeholders. Indicators are variables that summarize (or indicate) a given situation and thus can be used to measure change. Some indicators that can be used to measure quality for various stakeholders are presented in Table 1.

Table 1. Examples of mental health quality indicators by stakeholder group*

Stakeholders	Purpose of indicator	Indicator example
Funders	- Purchasing decisions - Monitoring performance specified in contracts	> Average cost per person served > Percentage of expenditure on administrative and support services
People with mental disorders	- Enrolment/re-enrolment decisions - Choosing providers - Monitoring quality and responsiveness of plans and providers	> Percentage of people with mental disorders whose functioning improved > Percentage of people with mental disorders who received care in a timely manner
Providers	- Quality management	> Percentage of adults with schizophrenia receiving appropriate antipsychotic medications
Accreditation agencies	- Monitoring regulations and standards	> Percentage of persons discharged from hospital who were followed up in the community within seven days
Government bodies	- Policy-making - Purchasing decisions - Accountability	> Per capita mental health expenditures by region > Percentage of persons with a history of mental illness who are in part-time or full-time employment

**The examples are not intended to suggest that indicators of importance for a particular stakeholder group have no relevance to other groups*

At the level of the service provider, more detailed information is necessary in order to monitor the quality of care. The information gathered should cover the following aspects of care:

- service resources, e.g. beds and staff (inputs);
 - the activities of the service, e.g. admissions, consultations and treatment (process);
 - the effect of service delivery on people with mental disorders (outcomes)
- (Thornicroft & Tansella, 1999).

Information on inputs, process and outcomes is routinely gathered to monitor the functioning of mental health services and these data can be used to assess the quality of care. For this purpose, specific indicators of quality may be adapted from the standards for inclusion in the regular gathering of information. In this connection it is important that the selection of indicators be guided by criteria developed in the standards document. As with accreditation procedures this is essential in order to avoid duplication or inconsistencies in the assessment of quality. It is also important that information-gathering is driven by the quality improvement agenda (e.g. the standards criteria) rather than by the limitations of the information system (e.g. the information that is available).

Inputs

Input indicators may be used to measure standards related to adequate staff numbers, adequate bed numbers and the availability of medications. For example:

- the ratio of staff to people with mental disorders;
- the ratio of beds to population;
- the availability of medications in primary care facilities.

Process

Process indicators may be used to measure standards related to the optimal utilization of inpatient facilities, for example:

- bed occupancy rates;
- length of consultation times in outpatient settings;
- numbers of critical incidents in secure wards;
- readmission rates;
- family involvement in care of the people with mental disorders;
- service support for families.

Outcomes

Outcome indicators can be used to measure standards related to the positive impact of interventions, for example:

- clinician assessments of outcome in outpatient settings;
- clinician assessments of outcome at discharge from inpatient settings;
- satisfaction of people with mental disorders;
- satisfaction of family members or other carers.

More broadly, outcome measures can be placed in four major categories (Rosenblatt et al., 1998):

- **Clinical status outcomes** focus on impairment in both psychological and physical status. Measures of clinical status are defined as processes that document and assess the physical, emotional, cognitive and behavioural signs and symptoms related to a disorder.

At the service level, information is needed about inputs, process and outcomes.

Information-gathering should not be driven by the limitations of the information system but by quality.

The purpose of a mental health service is to improve outcomes, which should therefore be monitored for quality improvement.

- **Functional status outcomes** are related to the ability to fulfil effective social and role-related functions. Examples of functional outcomes are the ability to work, attend school, live independently and maintain positive and life-enhancing relationships.
- **Life satisfaction and fulfilment outcomes** include quality of life and well-being measures and are related to self-esteem, hope, empowerment and recovery.
- **Welfare and safety outcomes** include suicide, substance abuse, involvement with the criminal justice system, victimization and homelessness.

Outcome measurement has multiple uses for different stakeholders and is relevant to individuals, programmes and mental health care systems. At the clinical level it can be used in the planning of treatment and for determining and adjusting assignments to levels of care. These data, gathered at the individual level, can be aggregated and incorporated into performance indicators at the system level. Not all outcomes at the system level are aggregations of consumer-level outcomes: some, related to resources, earnings, expenditures and administrative processes, are independent of consumer outcomes.

The choice of indicators (inputs, process and outcomes) depends on particular service priorities in local settings. During a deinstitutionalization programme, for example, readmission rates may be an important indicator of the adequacy of community-based care.

Measurement of performance

In addition to inputs, process and outcomes the performance of a mental health service should be measured in the interest of quality improvement.

The purposes of performance indicators are to evaluate and monitor how well a system responsible for providing mental health care is performing, to report the information obtained in quantitative terms and to direct the system's efforts and resources towards desirable goals. The fundamental problem with defining such indicators is the lack of consensus about these goals and the consequent lack of definition as to what constitutes good performance. The various stakeholders in a mental health system, i.e. people with mental disorders, family members, advocates, providers, funders and policy-makers, often have different performance requirements (Table 1).

The development of performance indicators therefore requires consideration of the needs of various stakeholders and consultation with them as to which indicators are the most appropriate. Countries have to balance these interests within budgetary constraints when designing appropriate information systems for the monitoring of quality. The selection of appropriate performance measures may also be informed by the aspect of quality which is being assessed and by the purpose of the assessment.

It is important to note that performance indicators are only one measure of quality. They do not summarize all quality. Measures of performance should be balanced by indicators that measure the availability of resources, outcomes and respect for the rights of people with mental disorders and their family carers.

Information infrastructure

The information infrastructure is critical in supporting efforts to monitor and improve the quality of mental health care. Many of the mechanisms described in this module depend on the availability of information. The application of quality management techniques is predicated on an ability to collect, analyse and report data. Similarly, the measurement of performance depends on the availability of timely data of high quality if it is to inform quality initiatives and change in structures and processes.

Performance indicators have different functions for different stakeholders.

While the potential is great the challenges in implementing information systems should not be underestimated. Clearly, resources are required in order to develop an automated infrastructure. Once the infrastructure is in place, behavioural adaptations are needed by managers, clinicians and other users.

In countries with minimal mental health resources it may be difficult to mobilize the finances and personnel to support all these monitoring measures. This means that important decisions have to be made about priorities in quality monitoring and about which indicators are affordable. Countries therefore have to identify which of the indicators described in this step would be most effective in their particular contexts and which are affordable.

These are important decisions because, in the short term, the development of quality improvement mechanisms is likely to require a financial outlay for mental health services. In the long term, however, information systems and quality monitoring are likely to be cost-saving as a result of the more efficient provision of more effective services. This is likely to have other positive outcomes, such as improved staff motivation, improved satisfaction among people with mental disorders and wider social and economic benefits. Building the quality of mental health care, even in circumstances of minimal services, provides a strong foundation for future service development.

In countries where mental health services are integrated into primary care or other general health services an established health information system can provide some of the initial infrastructure. In this case, mental health indicators and data collection can be incorporated into an already existing and functioning system.

Applications that are promising for the future of the quality of mental health care are available on the Internet, among them: consumer information enabling people with mental disorders to search for relevant information and participate in chat and support groups; clinical care; administrative and financial transactions; professional education; and clinical outcomes research.

As indicated in the next task, information systems are not the only mechanism for assessing the quality of services. Other mechanisms of quality assessment and feedback include focus groups, discussion panels and quality circles. A quality circle is a group of staff who meet regularly to discuss quality-related work problems with a view to examining and generating solutions. As well as allowing the review, analysis and interpretation of data, these mechanisms also contribute to problem identification and resolution that may be based on observations and experiences of stakeholders, particularly staff members.

Steps for establishing information systems

In countries where information systems are in the process of being established the following steps are recommended for initial development.

1. Establishment of **simple mental health data collection instruments** that are mandatory for front-line mental health workers. Initially, basic demographic and diagnostic information should be collected. The documentation of problems and needs that arise can prove useful for clinical and service planning. The data should preferably be automated but this may not be feasible. Simple forms can be designed in order to help with the monthly or quarterly aggregation and documentation of data.
2. Establishment of **regular routine data analysis** of the service at the field level, e.g. by the entire mental health team. For the aggregation of data at the local or field level, capacity is needed for basic data analysis. This includes the development of simple

In countries with minimal mental health resources, important decisions have to be made about priorities in quality monitoring and about what information can be gathered within budgetary constraints.

In the long term, information systems and quality monitoring are likely to save costs.

reports that allow for the monitoring of persons served (in accordance with their diagnostic and demographic characteristics). It also allows planners to document trends in local service delivery. Periodic reviews should be conducted by quality circles or front-line staff in order to improve their understanding and interpretation of the data. This allows solutions to be formulated for any problems that are identified. Initially, the focus should be on who receives services and on the services that are delivered. As capacity grows, data on who is receiving which services can be incorporated. As systems become even more sophisticated the next step can be to relate these data to outcomes and costs.

3. Establishment of a discrete mental health data collection and evaluation function centrally. This function is critical in several respects. Firstly, it supports the aggregation of data at the national level so that regional disparities in resources and services provided can be addressed. Such analysis is also the basis for feedback to the regional or local level. The second point is that direction, support and consistency are provided by national planners for activities at the local level. Each level requires inherent consistency even though the type of information needed at each level is different. Activities at the national level help to establish uniform mechanisms for data collection, analysis and reporting. Thirdly, data at the national level are the basis for documenting local needs and priorities and for planning the national mental health agenda and the allocation of resources. The establishment of a national data collection and evaluation function is fundamental to the activities covered in other modules, e.g. planning, advocacy and financing. Without this function it is difficult to support and implement a national agenda that emphasizes quality.

These three steps should enable the establishment of an information system that can be used to monitor the quality of mental health care.

Task 4. Consult with organizations of people with mental disorders, carers and independent organizations in order to receive their assessments of services

In addition to the monitoring of services by health sector managers or committees it may also be necessary for mental health services to have recourse to independent bodies, particularly ones monitoring human rights within the mental health service.

- **Human rights organizations** or other independent bodies can have access to mental health services in order to monitor the conditions of people with mental disorders. These bodies may be state-funded or independent nongovernmental organizations.
- **User, carer or family organizations** that support people with mental disorders and provide advocacy should be encouraged to report on the quality of mental health care received by people with such disorders. Research on user satisfaction, conducted by means of user satisfaction questionnaires or focus groups, can also provide valuable information. Furthermore, assessments can be made of how effectively services support the families of people with mental health difficulties.
- People with mental disorders, carers and mental health workers should have access to **ombudspersons** in order to ensure care of good quality. **Ombudspersons** also mediate in conflict situations. The provision of this function is essential so that people with mental disorders can have recourse to an independent review body if they are dissatisfied with the quality of their mental health service.

Independent organizations should be consulted regularly for their views on the quality of mental health care.

Key points: Step 4. Monitor services

Mental health services should be monitored so that the quality of care can be assessed. Assessment can take several forms:

- the use of standards to assess services annually;
- the use of accreditation procedures to assess and accredit new service developments and to review the ongoing functioning of services;
- the routine gathering of information by means of existing information systems, particularly through the use of performance and outcome indicators;
- consultation with independent organizations of people with mental disorders, carers and advocacy groups in order to receive their assessments of services.

Step 5. Integrate quality improvement into the ongoing management and delivery of services

Once mechanisms are in place for assessing the quality of local mental health care (through standards, accreditation procedures and monitoring systems), continuous quality improvement should be built into the management and delivery of services.

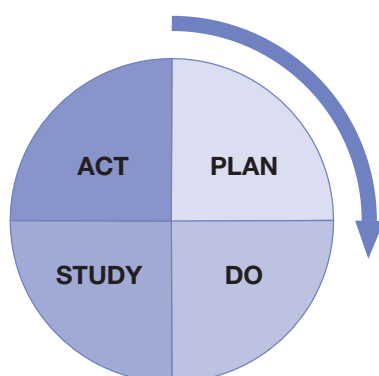
The incorporation of quality into the management of mental health services has also been termed quality management, i.e. a framework for assessing and improving clinical, operational and financial performance within a health care organization (Hermann et al., 2000). Much of this recent work is founded on the notion that a mental health service should continuously improve the quality of the care that it delivers (Pillay et al., 2002). In these terms, accreditation may be seen as a minimum norm in accordance with which services should function, and quality improvement as a process of continually striving for optimal norms, taking full advantage of the standards and criteria for accreditation which are already in place.

A quality improvement model has been developed by the Institute for Healthcare Improvement (<http://www.ihl.org/>). Intended for use in ongoing service management, it incorporates steps of setting aims, forming a team, establishing measures and testing changes. Changes are then tested by the plan-do-study-act cycle (Figure 3), involving:

- > planning a change;
- > trying it;
- > observing the results;
- > acting on what has been learnt.

Continuous quality improvement should be built into the management and delivery of services.

Figure 3: Institute for Healthcare Improvement model for quality improvement



The **advantages** of this cycle/model are as follows:

- > it builds quality improvement into the regular functioning of a service;
- > quality assessment is based on process and outcome indicators and not just on inputs (as in earlier models of quality assessment);
- > mental health workers and managers are encouraged to take responsibility for quality improvement, rather than it being imposed by management at a higher level;
- > clinical improvement is integrated with operational and financial performance (Hermann et al., 2000).

The development of this model requires several mechanisms or **structures** to be put in place in order to ensure implementation:

- > the establishment of a designated **post**, but not necessarily a full-time position, e.g. a quality improvement officer, in order to ensure ongoing quality improvement;
- > ensuring that the quality improvement officer has sufficient **support at an appropriately high level** within the health service so that proposals carry enough weight to be implemented;
- > ensuring that all relevant stakeholders among managers, mental health workers, carers and people with mental disorders are **consulted** in the design of quality measures;
- > ensuring that all relevant stakeholders among managers, mental health workers, carers and people with mental disorders **participate in the implementation** of quality measures;
- > ensuring that there is an adequate **budgetary allocation** for quality improvement.

Once these structures are in place, several tasks have to be performed for the ongoing improvement of the quality of mental health services.

Task 1. Manage annual service quality reviews

Quality improvement may be integrated into the ongoing management of mental health services by scheduling time for reviewing the quality of mental health care. This can be done by arranging annual meetings with managers in order to review progress in the improvement of particular aspects of the services.

Meetings should preferably be scheduled before the end of the financial year so that planning for annual budgets can be made on the basis of assessments of the quality of particular facilities. Financial incentives for quality improvement can then be built into the management consultation on quality (Table 2). Possible financial incentives are: the approval of budgets being contingent on the service meeting quality assessment criteria; reimbursement in line with specific performance indicators, depending on the reimbursement mechanisms.

Regular meetings should be scheduled with service managers in order to review the quality of particular services or facilities.

Table 2. Example: Scheduling the management of annual service quality reviews

Service / organization	Manager / contact person	Quality measure used	Month of review
- Psychiatric hospital	Superintendent	National standards	September
- Psychiatric inpatient unit in general hospital	Psychiatrist	National standards National standards	October October
- Primary care clinic	Nurse manager	National standards	November
- Rehabilitation service	Nurse manager	National standards	December
- Community-based residential service	Residence manager	National standards	January
- Professional body	Chair of professional council	Review of professional guidelines	February

Task 2. Include quality checks in service planning targets

In addition to conducting regular reviews of specific services, mental health service managers should incorporate quality checks into the targets set in planning and budgeting for services (see *Planning and Budgeting to Deliver Services for Mental Health*). For example, options for service development should be assessed not only for their financial viability and potential clinical efficacy but also for the quality of care they are likely to generate. Faced with two options of service delivery, such as institutionally based or community-based care, service planners should assess which is likely to deliver the better quality of care to people with mental disorders. Criteria for quality can be taken from the standards or accreditation procedures that have been developed.

Mental health service managers should incorporate quality checks into the targets set in planning and budgeting for services.

Task 3. Build quality improvement into clinical practice

Quality improvement has to be built into ongoing clinical practice. In the past, mental health workers took responsibility for clinical care without having responsibility for budgets, quality outcomes or service management. More recently, terms such as “clinical governance” and “quality management” have been used in attempts to increase mental health workers’ accountability and involvement in service management and quality improvement (Hermann et al., 2000).

Quality improvement should be built into routine clinical practice.

In their daily clinical practice, mental health workers should be encouraged to continually scrutinize and improve the quality of the care they deliver.

Evidence-based care

Mental health care should be consistent with the evidence on the most effective and efficient care available. This requires mental health workers to be familiar with the latest research related to the area in which they deliver care. Professional organizations and academic institutions should facilitate this process wherever possible.

Mental health care should be consistent with the latest evidence on the most effective and efficient care available.

The implementation of evidence-based services has become a means of achieving both quality and accountability. If evidence-based practices are implemented in strict conformity with the models that have proved them effective, positive outcomes automatically follow. It is inherent in the argument for resources for evidence-based practices, that value for money and accountability are assured (Goldman et al., 2001).

Not every problem has an evidence-based solution. Moreover, not every evidence-based practice is universally applicable to persons with similar symptoms: the need for clinical judgement and consumer choice remains critical.

Examples of evidence-based practice are given in Box 11.

Box 11. Examples of effective interventions for the management of mental disorders

Condition(s) / Prevention (primary and secondary) / Treatment / Rehabilitation

Schizophrenia

- Early detection to diminish the risk of a chronic course
- Public education to destigmatize the disorder
- Suicide prevention
- Relapse prevention through education and reduced social isolation
- Standard antipsychotic drugs, e.g. chlorpromazine and haloperidol, and second-generation antipsychotic drugs
- Psychosocial interventions, e.g. cognitive behaviour therapy
- Family support and education
- Community rehabilitation programmes for reintegration into the community and recovery of social and occupational skills
- Development of social and family networks

Depression

- Screening of depression in mothers in order to reduce depression and prevent adverse health outcomes for children
- Support networks for vulnerable groups
- Early identification and interventions that target vulnerable families and individuals
- Public education to destigmatize the disorder and create awareness of available treatments
- Tricyclic antidepressants and, where available, low-cost selective serotonin reuptake inhibitors (SSRIs)
- Adjunctive problem-solving, cognitive behaviour therapy and interpersonal psychotherapy
- Development of social and family support networks

Alcohol dependence

- Population-level preventive measures, e.g. restricted access, alcohol tax, public education on harmful effects
- Early recognition and early intervention
- Brief counselling and educational interventions (three to five sessions)
- For early drinking problems, brief primary care interventions
- For more severe alcohol dependence, cognitive behaviour therapy, motivational interviewing and twelve-step approaches, in conjunction with community and group interventions
- Detoxification, preferably within the community
- Inpatient care for serious comorbid medical or psychiatric conditions
- Community rehabilitation programmes to improve social and occupational skills

(Source: World Health Organization, 2001a)

The challenge for many countries, including the more developed countries, is to incorporate services and interventions into routine practice which have proved effective. There is increasing recognition of the knowledge gap between what research has shown to be effective and actual practice.

It can be argued that in many countries the challenge is more basic. Mental health services are often minimal and the expectations of providing cutting-edge services may seem unduly ambitious. However, efforts to provide evidence-based care should not be dismissed. They may allow for the development of enhanced community-based systems without the major outlays needed for institutional care. Evidence-based services should be consciously and explicitly considered as part of the planning and budgeting process for setting priorities and addressing issues of equity and access.

Clinical guidelines

Evidence-based care can be assisted by the development of clinical guidelines or clinical practice guidelines. Clinical practice guidelines are systematically developed statements intended to assist decision-making by practitioners and patients about appropriate health care in specific clinical circumstances (Institute of Medicine, 1990). Their purpose is to improve the quality and appropriateness of care, to guide clinical decision-making, to assist organizations in developing their clinical and risk management protocols, to guide funders in setting reimbursement policies and to help people with mental disorders to make informed choices about their care.

From a clinical perspective, guidelines can serve three primary functions: support for clinical decisions; tracking the treatment process; and tracking points where there is variance from the guidelines. Support for clinical decisions facilitates the selection of the most effective treatments and is useful to clinicians, people with mental disorders, family members and managers. Tracking the treatment process makes it possible to have a detailed and standardized record of clinical interventions. Tracking guideline variance evaluates the congruence or fit between treatment and guidelines.

There are significant barriers to the implementation of clinical guidelines for mental health treatment. Few clinicians are trained in the use of guidelines. There is a proliferation of guidelines and there is minimal agreement as to which guidelines are best. See Annex 2 for a list of available clinical guidelines.

Professional organizations are vital in connection with the development of clinical guidelines. In the USA, for example, the American Psychiatric Association and federal agencies developed practice guidelines recommending treatment approaches for depression and other conditions in the primary care setting (United States Department of Health and Human Services, 1993). Such guidelines are usually based on a review of the literature concerning treatment effectiveness and on the use of a process of expert consensus.

In other countries it may be necessary for health ministries to have primary responsibility for the development of clinical guidelines, particularly if professional organizations are not strongly developed. The guidelines may be developed for persons identified as a priority in national policies and plans by building alliances with, or delegating technical development to, professional organizations (see: *Mental Health Policy, Plans and Programmes*). The participation of consumers and family members can also contribute to this process.

Where resources are available, evidence-based health care research methods can be incorporated into the quality improvement process. For example, mental health workers can assess whether a particular service intervention improves patients' outcomes in

Clinical practice guidelines are systematically developed statements that are intended to assist decision-making by practitioners and patients about appropriate health care in specific clinical circumstances.

Clinical guidelines can support clinical decisions, track the treatment process and track variance from the guidelines.

In order to address barriers, ministries of health should have the primary responsibility for developing clinical guidelines.

comparison with no intervention or a different type of intervention (see *Research and Evaluation of Mental Health Policy and Services*, to be developed by WHO). Guidelines clearly have the potential to improve the quality and coordination of care and to facilitate the development of consensus about best practices among practitioners and funders.

Teamwork

In some quality management innovations, mental health workers are encouraged to work in teams so as to improve the efficiency and quality of care. The scrutiny of quality in mental health teams offers an opportunity to develop this aspect (Institute for Healthcare Improvement: <http://www.ihl.org/>). This can be done by devoting specific team meetings or continuing professional development programmes to quality improvement. Additionally, team members can provide mutual incentives to improve the quality of care during routine clinical work through joint work and peer supervision.

Continuing professional development

The importance of continuing professional development as a quality improvement tool cannot be overemphasized. Staff who receive regular training and supervision that keeps them informed of the latest evidence-based care are more likely to continually improve the quality of the care they deliver than other workers (see *Human Resources and Training for Mental Health*, to be developed by WHO). They are also more likely to remain stimulated by their work through a process of career-long development and therefore more motivated to deliver care. Continuing education can also be linked with accreditation in order to introduce incentives to mental health workers to continually improve their skills.

In Australia, innovations have linked quality mechanisms to general practitioners' continuing medical education programmes (Royal Australian College of General Practitioners, 1993). All practitioners are required to participate in both continuing medical education and quality assurance programmes in order to remain registered with the professional board. Credit points obtained from continuing medical education and quality assurance activities are added together and are required to reach a minimum total within three years. Financial incentives for these programmes can be introduced by making accredited training programmes tax-deductible.

Apart from offering ongoing training, continuing professional development is an essential quality improvement tool.

Task 4. Improve quality when services are being commissioned

Quality measures should be embedded in the contract specifications for countries in which mental health services are commissioned or contracted out. Commissioning can occur with internal organizations, e.g. inpatient units in the public health sector, or with external bodies, e.g. private-for-profit organizations that deliver specific services.

Commissioning offers the following advantages:

- by using market principles whereby various service providers compete for service contracts the purchaser can take advantage of improved efficiency;
- service targets can be carefully scrutinized in relation to the specific terms of contracts, emphasis being placed on outcomes (including quality indicators) rather than inputs.

In order to balance the risk of service contracting and optimize the above advantages it is essential that contract specifications include measures of the quality of mental health services. The precise mechanism for ensuring the implementation of quality measures depends on the type of contract, e.g. whether it is a block, spot, call-off or cost-and-volume contract (see *Mental Health Financing* for more details on commissioning).

Task 5. Audit

Auditing is an important tool that makes use of information systems and specific indicators in order to assess whether a particular aspect of service provision is measuring up to the established standard.

Audit differs from ongoing quality improvement as follows:

- > audit is usually undertaken for a specific aspect of service functioning, usually one to which some special concern or interest is attached;
- > in general it is conducted on an occasional basis rather than routinely;
- > it is more likely to involve outside consultants and experts;
- > it may involve the use of several methodologies.

Audit is an important complement to the overall quality improvement process because it can highlight specific areas that require improvement through providing more detail of problems and potential solutions. This may serve as an example for quality improvement in other areas.

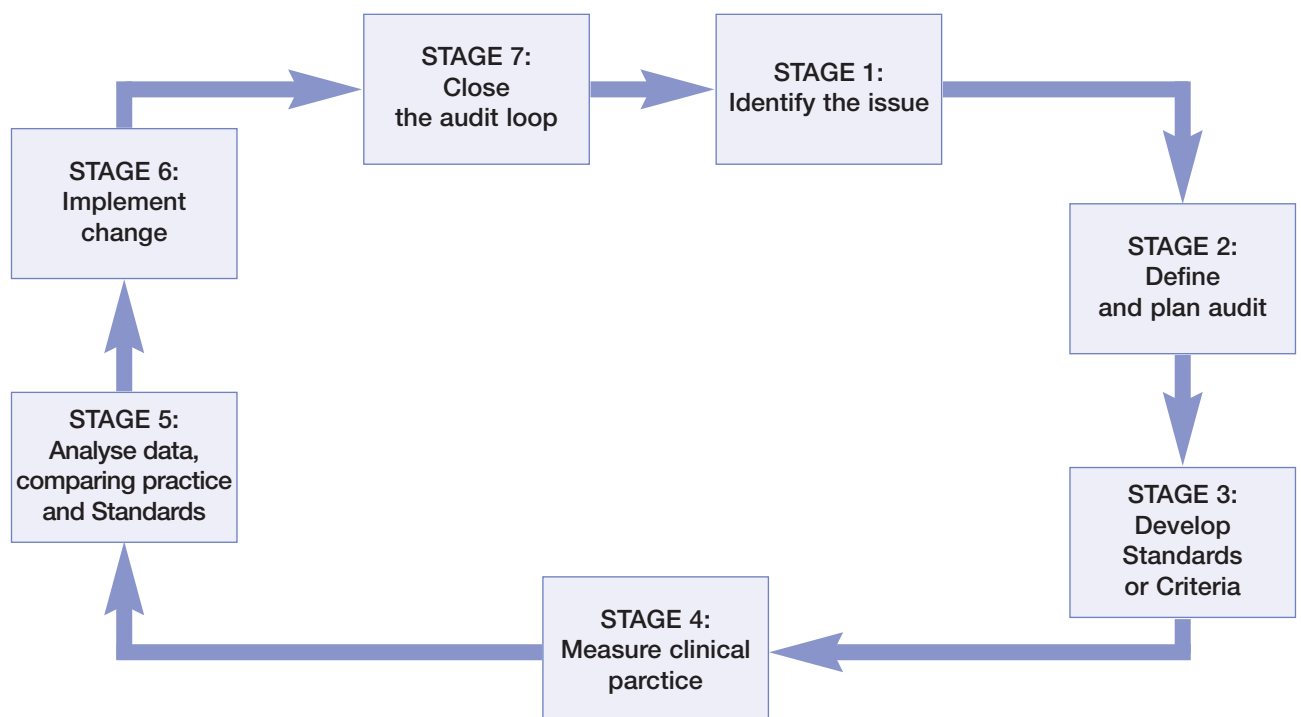
In situations where substantial demands are made on mental health services, audits may be perceived by staff as threatening or punitive (Louw, 2000). However, it has been observed that service staff are usually interested in improving their performance and establishing whether their activities make a difference. Framing audit and evaluation in this manner, and designing audits in collaboration with the staff concerned, can help to involve staff in implementing improvements and participating in future audits.

Several audit methods have been developed (Mark & Garet, 1997; Yeaman et al., 2000). The following method uses a seven-stage audit loop (Figure 4).

Several features distinguish audit from routine quality improvement.

Care should be taken to involve staff in the planning and implementation of service audits.

Figure 4: Stages in an audit cycle



Box 12. Example: Audit of supply of psychiatric medications in primary care settings

Stage 1: Identify the issue

Supply of psychiatric medications in primary care settings.

Stage 2: Define and plan the audit

1. Target the area of clinics to be audited, e.g. five clinics in a local area.
2. Specify the period, e.g. audit of clinical practice during one month.
3. Consult with the primary care workers concerned in order to check whether they would be prepared to participate in such an audit. This consultation may include receiving suggestions from the workers as to which areas of medication supply are worth investigating. This serves the dual purpose of increasing the likelihood of participation by the workers in the audit and providing the auditors with information about issues on the ground.
4. Design an anonymous questionnaire for distribution among primary care workers responsible for administering psychiatric medications to people with mental disorders.
5. Possible questions are as follows.
 - How many consultations have you had with people with mental disorders during the previous month?
 - How many times during this period have you not had the psychiatric medications required for these people?
 - What were the medications?
 - Why were the medications not available?
 - What did you do when the medications were not available?
 - In your clinical opinion, were acceptable solutions found?
6. Decide how many primary care workers will be given the questionnaire, e.g. all the workers in the five selected clinics or a representative (preferably random) selection of workers.
7. Plan who will take responsibility for the distribution and collection of the questionnaires and the analysis of the data.

Stage 3: Develop standards or criteria

In this instance the WHO quality assurance checklists (World Health Organization, 1994) could be used to set a standard for the supply of psychiatric medications. For example, the checklists specify that the primary health care facility should have an adequate supply of basic psychiatric drugs. A specification of these basic drugs may be obtained from the country's or local service's essential drugs list or the WHO essential drugs list (World Health Organization, 1993a).

Stage 4: Measure clinical practice

1. Distribute and collect the questionnaires.
2. Summarize the answers to the questions.

Stage 5: Analyse the data, comparing practice with standards

1. Add up the number of occasions when medications were not available and compare this with the standard (i.e. the number of occasions when medications should have been available).
2. Gather any other relevant data from the questionnaire which may be of use in improving the supply of medications.

Stage 6: Implement change

1. Approach the agency or sector of the health service responsible for the supply of medications and present the results of the audit.
2. Discuss strategies for improving the supply of medications in consultation with relevant sectors of the health service or agency. This may involve dealing with negative perceptions of change to the service and sensitivity to the audit process itself.

Stage 7: Close the audit loop

Repeat the audit six months after a plan has been made to improve the supply of medications in order to check whether an improvement in service delivery has occurred as a result of the initial audit.

Some topics that might be suitable for audit purposes are:

- the rate of readmission of people diagnosed with schizophrenia, following discharge from an acute psychiatry inpatient unit;
- referral pathways from primary to secondary care;
- critical incidents in medium-secure units.

Bottom-up versus top-down

In the management of quality improvement there is a danger that professionals may feel continually scrutinized, criticized and undervalued. In the stressful environment of mental health care this can contribute to reduced motivation and burnout. Wherever possible, therefore, a bottom-up approach to quality improvement should be adopted.

This means consulting with mental health workers, carers and people with mental disorders at the front line of care in order to make use of their suggestions as to how the quality of services might be improved. It also means explaining the rationale and the context of the quality improvement process and demonstrating that something valuable can come from it. The commitment of mental health workers to the process is essential for its success.

Increased participation in the quality improvement process is likely to yield the following benefits.

- Mental health workers are more likely to understand the real conditions of care and are therefore more likely to suggest realistic solutions to problems associated with care of poor quality.
- Mental health workers who have made contributions to the quality improvement process are more likely to comply with its implementation.

Consulting with mental health workers during the quality improvement process, rather than imposing quality measures from above, is likely to yield several benefits.

- The motivation of mental health workers may improve significantly if an audit arises because of a complaint from a mental health worker in direct contact with clients and if the complaint is investigated because of the audit. This can lead to an environment of blameless errors: employees are rewarded, not punished, for identifying problems; problems are not ignored and other people are not blamed for them (Hart, 1995).
- Mental health workers who are rewarded for quality improvement are more likely to continue improving the quality of services in future.

This implies that the development of quality should also focus on strengthening human resource management at all levels of mental health services. Satisfied mental health workers are likely to have satisfied customers, i.e. people with mental disorders. This requires the development of appropriate staff recruitment, training, retention, management, leadership and continuing professional development (see *Human Resources and Training for Mental Health*, to be developed by WHO).

The introduction of quality management, like any form of organizational change, is likely to take time to implement and may meet with resistance from service managers and mental health workers. Ongoing consultation with all relevant stakeholders and the construction of quality improvement as a learning process rather than a judgemental one, is likely to lead to long-term improvements (Hermann et al., 2000).

Key points: Step 5. Integrate quality improvement into management and service delivery

Apart from the use of standards and accreditation procedures for monitoring services it is essential that services continue to improve the quality of care. Continuous quality improvement is a process of striving perpetually for optimal quality. This can be achieved by the following means:

- managing annual service quality reviews;
- including quality checks in service planning targets;
- building quality improvement into clinical practice through evidence-based practice, clinical practice guidelines, teamwork and continuing professional development;
- improving quality when commissioning services;
- audit.

Step 6. Consider systematic reform for the improvement of services

In addition to the ongoing management and continuous improvement of the quality of services (step 5), the assessment of a mental health service may highlight a need for a systematic reform or improvement of services. This step may require concerted planning and coordination by various sectors.

The details of how reform may be achieved vary significantly between countries and are beyond the scope of this document. In broad terms, mental health service reform should be implemented through local consultation with all relevant stakeholders. More information on this matter is given in *The Mental Health Context, Mental Health Legislation and Human Rights, Mental Health Policy, Plans and Programmes, and Planning and Budgeting to Deliver Services for Mental Health*.

Examples of service reform or systemic improvement are:

- steps towards the attainment of particular service improvement goals, such as reductions in hospital services and the development of community-based services;
- improvement in the rights of people with mental disorders in psychiatric inpatient facilities.

In the case of large-scale reforms, such as the transformation from institutional care to community-based care, a system approach is most beneficial (Thornicroft & Tansella, 1999). This involves proceeding with organizational reform before institutional reform. Hospitals are integrated into the process of the reform and development of community services (Lesage, 1999). Reforms in the past have proceeded with little regard for the staff and people with mental disorders left behind in hospitals, and staff often feel disempowered by a lack of recognition, stigmatization by the community-based movement and a lack of training and information transfer. The need to include hospital staff in the process of reform is in keeping with the systemic approach rather than the segmental approach to planning. The advantages of this approach are as follows.

- It allows for planning of the population's needs as a whole rather than the needs of the institutionalized population of people with mental disorders.
- A thorough transformation of services is more likely to lead to real change that reduces the dependence of people with mental disorders on mental health services.
- In a more thorough, systemic approach, resources are more likely follow people with mental disorders from the institution to the community.

Models such as that of the learning organization have been useful for conceptualizing the continual change that mental health services undergo (Birleson, 1998). The model is appropriate for health services, which are staffed by educated professionals who are required to become more adaptive and concerned with improving user outcomes. In Box 13 some examples are provided of mental health service reform in specific countries.

On the basis of the previous steps, systematic reform of certain aspects of the service may be necessary.

In the case of large-scale reforms, such as the transformation from institutional to community-based care, a system approach is most beneficial.

Models such as that of the learning organization have been useful for conceptualizing the continual change that mental health services undergo.

Box 13. Country examples: Reforming mental health services

In Estonia, the reform of mental health services has required developments in various areas. These developments include: the formation of the Estonian Psychiatric Association in 1989; the establishment of the Mental Care Centre (aimed at evaluating psychiatric rehabilitation) in Tartu in 1993; the formation of the Estonian Psychosocial Rehabilitation Agency and the Estonian Psychiatric Patients Advocacy Agency in 1994; and the passing of the Mental Health Act in 1996. Activities aimed at obtaining international expertise for the training of clinicians and service planners have further assisted reform efforts. In 1998 a working group with representatives of various professional categories, agencies and institutions drew up a document outlining a mental health programme, which was approved by the Minister of Social Affairs. The principal aim of the programme was to improve the quality of life of people in need of mental health care services. Plans were drawn up for promoting the quality of social and rehabilitation services, optimizing and developing the network of service providers and making public services available to the target group. Reform continues and there are plans to gradually reintegrate into the community some 3000 persons in social welfare institutions who have long-term mental health problems, at a rate of around 10% per year. State budgets have been approved for the provision of suitable accommodation (Paavel & Sarjas, 1999).

In Romania, mental health professionals and non-professionals, facing government passivity in mental health planning, founded the Romanian League for Mental Health in 1990. This body has been involved in all steps that have led to mental health reform. In 1998 the National Mental Health Programme was formulated. In 1999, a majority of reformist psychiatrists were elected to the national board of the Romanian Psychiatric Association. In 2000 a mental health audit was conducted in Romania by WHO experts. In 2001 a new mental health law aligned with European norms was passed. WHO support was essential during this long process of legislative reform (B. Tudorache, personal communication, 2002).

Key points: Step 6. Systematic reform to improve services

- Assessment of the quality of mental health services may highlight a need for their systematic reform or improvement. This step may require concerted planning and coordination by various sectors.
- For large-scale reforms such as the transformation from institutional to community-based care a system approach has been shown to be most beneficial.

Step 7. Review the quality mechanisms

Once quality mechanisms are in place they have to be reviewed less frequently than services, which are reviewed annually. A review of quality mechanisms may occur at the same time as a review of service targets at the local level, i.e. approximately every five to eight years (see *Planning and Budgeting to Deliver Services for Mental Health*).

The review of quality mechanisms is necessary in order to update them with evidence on the most effective methods of quality improvement. Consequently, mental health service managers or quality improvement officers should keep themselves well informed about developments in quality assurance, quality improvement and quality management.

Those parts of the service organization that have been given responsibility for quality should undertake this review. They may include:

- the working group responsible for developing standards;
- committees or boards responsible for the accreditation of services or facilities;
- Individuals or bodies responsible for monitoring the quality of services, including independent organizations;
- service managers and mental health workers involved in continuous quality improvement or quality management.

Links with improvements in information systems should be maintained wherever possible in order to ensure that quality assessment makes full use of available information and that information systems gather data that are appropriate for ensuring care of satisfactory quality (see *Mental Health Information Systems, to be developed by WHO*).

The ongoing training of managers and mental health workers in mental health care of good quality is essential in order to sustain the momentum of early quality improvement initiatives. The development of quality improvement is a continual process, in which the mental health service perpetually strives to enhance its effectiveness and efficiency.

It is necessary to review quality mechanisms in order to update them with evidence on the most effective methods of quality improvement.

3. Barriers and solutions

There are numerous barriers to the improvement of quality in mental health services. However, solutions can be found for many of the problems (Table 3).

Table 3. Quality improvement: barriers and solutions

Barriers	Solutions
Lack of information and data systems for monitoring quality	- Gather available information - Conduct surveys, audits and focus groups on specific issues - Develop information systems within budgetary constraints, concentrating on essential data that can easily be collected
Insufficient dissemination or application of new clinical knowledge	- Develop and disseminate information on proven clinical knowledge - Support the implementation of innovations based on clinical knowledge - Reform training programmes and continuing professional development in keeping with clinical knowledge - Develop clinical guidelines
Lack of alignment of planning priorities and financial mechanisms with quality objectives	- Lobby for policy change in order to reform planning and financial mechanisms - Mobilize advocacy groups in support of reform - Identify areas where planning priorities and financial mechanisms could be aligned with quality objectives - Develop quality management initiatives in order to demonstrate the benefits of quality improvement
Inadequate workforce development and training	- Systematically review human resources and development needs - Provide continuing professional development for the current workforce - Reform training curricula, training institutions and enrolment criteria for trainees - Provide adequate recognition, compensation and support for staff

4. Recommendations and conclusions

This module has presented practical guidance for (1) the alignment of policy with the objectives of quality improvement and (2) the subsequent development of several quality improvement mechanisms. These mechanisms include standards, accreditation procedures, service monitoring, continuous quality improvement, the systematic reform of services and reviews of quality mechanisms.

Countries should adapt this guidance in accordance with their specific circumstances and needs. Specific recommendations can be made in relation to the level of quality development in countries' mental health services.

- For countries with few or no quality improvement mechanisms or policies, the first step is to align existing policy so as to facilitate quality improvement rather than obstructing it (step 1). With policy in place it becomes essential to develop a set of standards against which existing services can be evaluated (step 2).
- For countries whose policy is consistent with quality improvement objectives and which have a set of standards the next step is to develop procedures for accrediting services (step 3). The standards and accreditation procedures can then be used to monitor and assess services (step 4).
- For countries with policy, standards, accreditation procedures and monitoring in place the quality of mental health care can be further improved through continuous quality improvement methods (step 5).

By improving the quality of care, countries can increase the likelihood of outcomes reflecting the desires and aspirations of the populations served. The goal of quality improvement is ultimately to respect the rights of people with mental disorders, ensure that they are provided with the best available evidence-based care, increase self-reliance and improve the quality of life.

Countries should adapt this guidance in accordance with their specific circumstances and needs.

Annex 1. Glossary of terms

Indicators / Variables that indicate or summarize a given situation and can be used to measure change (Green, 1999; Thornicroft & Tansella, 1999).

Input / The resources that are put in to the mental health care system. The terms “inputs” and “resources” are used interchangeably in this document.

Integrated general health service / A general health service in which mental health care is one component within a comprehensive range of other health care services. In this sense, mental health care is integrated into the general health care infrastructure.

Outcomes / The changes in functioning, morbidity and mortality of people with mental disorders as a result of service intervention, possibly including measures of satisfaction with services.

Performance indicator / An indicator that measures some aspect of service performance. For example, the percentage of persons discharged from inpatient facilities who receive ambulatory services within seven days is a performance indicator reflecting continuity of care (an important aspect of quality).

Process / The way in which mental health services are delivered, or those activities that take place to deliver mental health services (Thornicroft & Tansella, 1999).

Quality / The degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (Institute of Medicine, 2001).

Quality assurance / Activities intended to ensure the quality of care in a defined setting or programme.

Quality assessment / The measurement of the method or practice used or its comparison with an accepted standard in order to determine the level or degree of excellence.

Quality improvement / A continuous process of striving for improved performance, involving problem identification, the testing of solutions and the monitoring of solutions on an ongoing basis.

Quality management / An ongoing and continuous effort to evaluate and improve the quality of services in order to achieve continuous improvement of the entire operations of the organization in question.

Resources / Elements put into the mental health service such as beds, facilities, staff (human resources), medications and vehicles.

Standards / Normative qualitative statements about what constitutes acceptable and adequate mental health care (Lund et al., 1998).

**Annex 2. Clinical guidelines that may be used as references
for countries' mental health service development**

- *Essential treatments in psychiatry* (World Health Organization, 1993b).
- Cochrane Database of Systematic Reviews (1996).
(<http://www.cochrane.org/cochrane/revabstr/mainindex.htm>).
- Scottish Intercollegiate Guidelines Network (SIGN) guidelines
(Scottish Office, 1999).
- Reviews of pharmacotherapies, medication practice and the evolution
of clinical guidelines for schizophrenia (Buckley et al., 1999).
- American Psychological Association guidelines
(<http://www.psychcentral.com/txmanul.htm>).
- Centre for evidence-based mental health (<http://www.cebmh.com/>).
- Canadian Psychiatric Association (<http://www.cpa-apc.org>).
- Clinical practice guidelines supported by the United States Agency for Health
Care Policy and Research (now the Agency for Health Research and Quality)
(<http://www.ahcpr.gov/clinic/cpgsix.htm>).

Annex 3. Country example: accreditation of therapeutic communities in Chile

Translated from Spanish

*Approval of the regulations applicable
to establishments providing rehabilitation
in therapeutic communities for persons
dependent on psychoactive substances*

No. 2298

Santiago, 10 October 1995

Considering the provisions of articles 129 and 130 of the Health Code, Ministry of Health Decree No. 725 of 1968, having force of law and;

Having regard to the faculties vested in me by article 32.8 of the Constitution, I hereby issue the following

DECREE

approving the following regulations applicable to establishments providing rehabilitation in therapeutic communities for persons dependent on psychoactive substances.

Paragraph I

SCOPE OF APPLICATION

Article 1: For the purposes of this article, a therapeutic community shall be an institution providing rehabilitation services for persons dependent on psychoactive substances through a long-term residential regime or outpatient treatment.

The basis for their method of treatment shall be the provision by relatives, former dependants and specialists of a wide variety of activities combining individual rehabilitation, self-help and psychosocial activities designed to achieve rehabilitation and reincorporation into society.

Article 2: The therapeutic community shall accept persons who use and/or are dependent on psychoactive substances and voluntarily decide to join a rehabilitation programme.

The method of rehabilitation shall comply with the following requirements.

- An up-to-date record shall be kept of the treatment and progress of the drug abuser or drug-dependent person.
- The rehabilitation programme shall be sufficiently flexible to adapt to the circumstances of abuse and/or dependence of the person desiring to use the programme's services, taking into consideration:
 - a) the type of substance concerned;
 - b) the nature and severity of the mental and physical disturbances caused;
 - c) the provision of a permanent system of evaluation of the rehabilitation programme, based on the views of the programme's staff and of the dependent person;

d) the existence of specific norms for treatment, depending on the needs of the dependent person;

e) the existence of a rapid system of referral to specialist and emergency medical services.

Paragraph II

PREMISES AND FACILITIES

Article 3: The facilities where the activities of the rehabilitation programme are conducted shall comply with the hygiene and security requirements of all persons participating in the programme and of the staff responsible for rehabilitation.

Depending on whether residential or outpatient treatment is being provided the premises shall contain:

- toilet and washing facilities;
- lounges;
- areas for storing solid waste;
- areas for group work;
- living areas;
- reception areas;
- passageways.

The premises of a therapeutic community providing residential rehabilitation services shall provide patients with bedrooms, a dining room and kitchen facilities, as well as a private area for the storage of their personal belongings.

Paragraph III

AUTHORIZATION TO ESTABLISH AND OPERATE THERAPEUTIC COMMUNITIES

Article 4: Authorization to establish therapeutic communities subject to these regulations shall be granted by the Director of the Health Services in whose area they are located, who shall also be responsible for inspecting them.

The authorization shall be valid for three years, at the end of which it shall be automatically renewed for equal and successive periods, unless there are substantiated reasons for cancellation, by a decision of the health service management.

Any changes to the physical facilities or the objectives and fields of action of the establishments or decisions to transfer them to other premises shall require authorization from the appropriate health service.

Article 5: Therapeutic communities shall be established only on independent and suitable premises. In order to apply for approval, applicants shall submit a request together with the following information and documents:

- a) location and name of the establishment;
- b) identity of its legal representative;
- c) documents testifying to ownership of the premises or to the right to use them;
- d) the objectives, fields of action and description of the rehabilitation programme on the basis of which the establishment intends to operate;
- e) a drawing showing the location and use of each part of the premises;
- f) copies of plans showing the layout of the electricity, drinking-water, gas and security installations;
- g) details of the capacity of the rehabilitation programme to admit persons suffering from alcoholism or dependence on any other psychoactive substance.

Article 6: Applications made to the health authority for authorization shall be examined by professionals specialized in the field from the office or department of the Health Service and appointed by the Director who shall submit their report, after visiting the premises and examining the components of the programme, within 30 working days of the applicant having completed the necessary formalities.

On the basis of their report, the Director of the Service shall decide either to approve the establishment of the therapeutic community or to reject the application, in which case, the Director shall explain the grounds for rejection.

If, on expiry of the period specified in the first paragraph of this article, the Service has failed to take a decision, the establishment shall be considered to have been approved.

Scheduled temporary closure of the establishment's premises or definitive closure for voluntary reasons or because of unavoidable circumstances shall be reported to the Health Service management.

Paragraph IV

ORGANIZATION AND TECHNICAL MANAGEMENT

Article 7: Each establishment shall be free to decide its internal organization without restriction, subject to the adoption of a registration and statistical information system that includes at least:

- a) a register of admittance and discharge;
- b) individual files containing up-to-date information on each person's rehabilitation;
- c) follow-up files on persons who have completed treatment or been referred;
- d) a final evaluation report.

Article 8: Technical management of each establishment shall be the responsibility of a professional with at least three years' experience of rehabilitation, who shall be a permanent appointee and shall be immediately replaced by another professional, specialist or expert with similar experience in case of absence or inability to perform his or her functions.

The manager shall be responsible for all technical and administrative aspects of the establishment, and shall ensure the proper operation of the equipment, programmes of work and installations necessary to ensure that patients receive proper treatment. He/she shall also ensure compliance with the relevant norms and procedures by the establishment's staff.

The manager's responsibilities shall include:

- a) relations with the health authorities;
- b) performance of the rehabilitation programmes;
- c) recording of data and statistical information;
- d) supervision of the hygiene of staff and of the establishment;
- e) monitoring food;
- f) sanitation and waste disposal;
- g) security measures.

Article 9: Any statistical or clinical information relating to residents or persons treated in the therapeutic community shall be confidential and subject to the provisions on professional secrecy.

The technical manager of the establishment shall alone be authorized to provide or authorize the disclosure of any such information to the courts and other institutions authorized by law to request it.

Where any other institutions are concerned, information may only be provided at the request of the person concerned or as global statistics that do not allow the identification of individuals.

Paragraph V

PERSONNEL

Article 10: The establishment shall employ suitable and sufficient personnel in order to carry out its programmes of treatment and rehabilitation properly and permanently.

Article 11: Anyone directly working with persons undergoing rehabilitation in order to contribute towards their treatment, as described in article 1, and to help them carry out the activities planned for them by the programme of treatment shall be considered as an assistant in treatment for drug addiction.

Such personnel must provide proof of having completed at least the second year of intermediate education and of at least three years' experience of similar activities in the same or a similar establishment, certified by the Director and approved by a health service.

Paragraph VI

PATIENTS' RIGHTS

Article 12: On admission to the establishment, persons undergoing treatment shall be entitled to agree to an individual programme of rehabilitation that sets goals, objectives and deadlines, and which may also include paid or other work, even when not initially agreed to by the patient, provided that he or she accepts it.

Any such programme shall not prevent the continuation of necessary medical treatment, whether or not it is related to drug dependence and whether or not it is provided within or outside the therapeutic community.

Patients and their relatives shall be entitled to information on the nature and content of the rehabilitation programme and of its expected risks and benefits, as well as reasons for the patient's continued attendance, if this is required.

Article 13: Patients undergoing treatment shall be entitled to respect for their privacy. Accordingly, no sound, video or photographic recording shall be made of them without their consent; if any such recording is made with their consent its use for teaching, research, publicity or other ends must receive their prior agreement.

Any correspondence and personal effects of persons undergoing treatment shall be private.

Article 14: All residential patients shall be entitled to leisure activities and facilities.

They shall also be entitled to have access to premises where their privacy is ensured, if they so wish, depending on the circumstances and resources of the rehabilitation programme.

Article 15: The right of patients freely to decide whether or not to continue to participate in the programme of treatment must be respected.

Persons shall not be forced to remain in the residential regime against their will unless ordered by the courts or specified by a medical certificate, in which case they shall not be held for more than 24 hours.

Article 16: Persons receiving treatment shall be entitled to express disagreement with the rehabilitation programme or its methods to the establishment's authorities or to the ordinary courts as appropriate,.

A formal written procedure shall be adopted for this purpose, and shall be available to patients and their families.

FOR REGISTRATION, REVIEW, PUBLICATION IN THE OFFICIAL JOURNAL
AND INCLUSION IN THE COMPILATION OF REGULATIONS OF THE OFFICE
OF THE CONTROLLER-GENERAL OF THE REPUBLIC

(signed)
EDUARDO FREI RUIZ-TAGLE
PRESIDENT OF THE REPUBLIC

(signed)
CARLOS MASSAD A.
Minister of Health

*Amending Ministry of Health
Supreme Decree No. 2298 of 1995,
approving the regulations applicable to establishments
providing rehabilitation in therapeutic communities
for persons dependent on psychoactive substances*

No. 225

Santiago, 27 April 1998

Considering the provisions of articles 129, 130 and 112, paragraph two of the Health Code, Ministry of Health Decree No. 725 of 1968, having force of law and;

Having regard to the faculties vested in me by article 32.8 of the Constitution, I hereby issue the following

DECREE

approving the following amendments to Ministry of Health Supreme Decree No. 2298 of 1995, published in the Official Journal of 5 February 1996:

1. The title of the decree is hereby amended to:

Regulations on establishments providing rehabilitation for persons dependent on psychoactive substances in therapeutic communities and regulating the profession of rehabilitation specialist for persons suffering from drug dependence.

2. The following third paragraph shall be added to article 4, the existing third paragraph becoming the fourth:

However, three months before the expiry of each three-year period the health authorities shall inspect the establishment for the purpose of ascertaining that it still meets the operational requirements for such establishments and shall set any necessary conditions, determining also a reasonable deadline within which they are to be met.

3. In article 5, subparagraph f), after the word “plans”, insert the words “or drawings”.
4. In article 7, subparagraph d), the final full stop shall be replaced by a comma, and the words “at the time of release or discharge” shall be added.

5. Article 8 shall be amended as follows:

- a) The first paragraph shall be replaced by the following:

Article 8: The technical management of each establishment shall be the responsibility of a health or other professional or of a specialist in psychosocial rehabilitation for persons suffering from drug dependence, with a minimum of three years' experience of rehabilitation of drug-dependent persons; the person shall perform this function on a full-time basis and shall be immediately replaced by another specialist, technician or expert with similar experience whenever he or she is absent or unable to perform his or her functions. The appropriate health service shall be informed of any changes in the technical management within 30 days.

- b) In subparagraph d) of the third paragraph, “supervision of” shall be deleted.
6. In article 10, the final full stop shall be replaced by a comma and the following words shall be added:

“who shall include at least one specialist in rehabilitation for persons suffering from drug dependence.”

7. Article 11 shall be replaced by the following article, and articles 12 and 13 (below) shall be added:

Article 11: A specialist in rehabilitation for persons suffering from drug dependence, subsequently referred to as a rehabilitation specialist, shall be a person directly involved in the rehabilitation of persons dependent on psychoactive substances for the purpose of contributing to the relevant treatment, by means of community therapy and, in an appropriate and permanent manner, helping them to carry out the activities planned as part of the rehabilitation programme.

Article 12: A rehabilitation specialist practising in public and private care institutions shall have the following functions.

a) Induction, individual interviews and leadership of groups, as part of the rehabilitation process for persons suffering from drug dependence or with severe problems caused by drug use, under the supervision of the technical director of the therapeutic community;

b) Helping persons suffering from drug dependence or with severe problems caused by drug use to carry out the activities planned under the individual rehabilitation programme, as indicated by:

- a specialized psychiatrist, or
- a health professional practising in a health facility or as a member of a recognized multidisciplinary team treating persons suffering from drug dependence, or
- the therapeutic community’s treatment team, including the technical director.

When the individual rehabilitation programme begins, during the evaluation and preparation stage a medical consultation must be carried out in order to assess the patient’s state of health.

If the patient is suffering from other general medical or mental disorders the manner and desirability of treating them shall be determined in consultation with the attending physician or another physician and decided by the patient or his or her relatives.

c) Informing the person suffering from drug dependence and his or her relatives of the nature and content of the rehabilitation programme and of its expected risks and benefits, as well as of the reasons for its discontinuation if this occurs.

d) Requesting the consent of the person suffering from drug dependence for a record to be made by either sound or video recording or photographs of the different stages of his or her treatment in the establishment, and for permission for it to be used for teaching, research, publicity or other purposes.

e) Organizing educational activities for healthy persons or persons at risk from drug dependence, and especially for the relatives of persons undergoing rehabilitation, for the purpose of preventing drug consumption and promoting mental health.

Article 13: In order to practise as a rehabilitation specialist it shall be necessary to obtain the qualification of specialist in rehabilitation, awarded by a state-recognized higher education establishment.

Persons lacking this qualification may perform the said function provided that they have obtained prior authorization from the Health Service.

To this end the applicant shall submit the following to the Health Service's Bureau of Medical and Paramedical Professions:

- a) a certificate of completion of the fourth year of intermediate education;.
- b) an employer's certificate from an establishment approved by the Health Service for the rehabilitation of drug addicts, testifying to his or her aptness.

The minimum skills required by a rehabilitation specialist include basic knowledge of the following subjects: the characteristics of and effects on human beings of the most common psychoactive substances consumed by the national population; the consequences of their withdrawal and overdose in persons dependent on them; the physical and mental disorders most commonly associated with the consumption of and dependence on each of these substances and the most common and obvious manifestations for a non-specialist; the factors specific to psychological development or associated with living conditions in the family, at school and in a person's immediate social and cultural environment which are most frequently associated with drug consumption and dependence in the Chilean population; the existence of local medical and specialized health facilities for persons with substance dependence; and basic knowledge of medicaments that could be used to treat such persons. In addition, the skills that rehabilitation specialists should possess or acquire include the following: skills that facilitate and permit interpersonal communication based on truth, mutual trust, recognition and the expression of feelings; the ability to provide emotional support; the ability to develop a sense of responsibility and the work ethic; the ability to develop a sense of responsibility for one's own health and a sense of solidarity with those who suffer; the ability to show firmness with people who go back on their word and to use techniques for working in small groups. All of these skills and abilities are more easily demonstrated in practice than in an abstract or theoretical manner.

The competent health service may add to these requirements in order to ensure that the specialists improve the performance of their duties.

If the competent health service is not satisfied that the applicant can provide evidence that he or she is able to meet or comply with the standards required of a rehabilitation specialist it may require him or her to take a skills test before a committee made up of professionals in the field with experience of working in therapeutic communities with persons suffering from drug dependence. The committee shall include a physician and surgeon with training in psychiatry and mental health. To this end, the health service shall set the date, time and place for the test, which shall be held within 180 days of the submission of the request.

8. The existing numbering of articles 12, 13, 14, 15 and 16 shall be replaced by 14, 15, 16, 17 and 18 respectively, and the second paragraph of new paragraph 14 shall be replaced by the following:

The programme shall not prevent the administration or continuation of any medical treatment considered necessary for other conditions, whether or not they are associated with drug dependence and diagnosed either within or outside the therapeutic community.

9. The following article shall be added:

Article 19: Any infringement of the provisions of these regulations shall be punished in accordance with Volume Ten of the Health Code.

10. The following transitional article shall be inserted.

Transitional article: Persons currently performing the tasks described in article 12 to whom the present regulations may apply and who lack the accreditation referred to in article 13 shall regularize their status within six months of the publication of these regulations in the Official Journal.

FOR REGISTRATION, REVIEW, PUBLICATION IN THE OFFICIAL JOURNAL
AND INCLUSION IN THE COMPILATION OF REGULATIONS OF THE OFFICE
OF THE CONTROLLER-GENERAL OF THE REPUBLIC

(signed)
Eduardo Frei Ruiz-Tagle
President of the Republic

(signed)
Fernando Muñoz Porras
Deputy Minister of Health

*Office of the Controller-General
of the Republic Legal Division*

*Clarification of Ministry of Health
Decree No. 225 of 1998, in annex*

Santiago, 22 May 1998

No. 018051

The Office of the Controller-General has examined the document referred to above, amending Ministry of Health Supreme Decree No. 2298 of 1995 on establishments providing rehabilitation for persons dependent on psychoactive substances and regulating the profession of rehabilitation specialist for persons suffering from drug dependence, in order to ascertain that it conforms to the law.

Notwithstanding the above, the Office wishes to clarify that the provisions of the said administrative instrument regulating the profession in question do not apply to persons who have been awarded the qualification of rehabilitation specialist on completion of a course of study at a professional college or at a technical training centre or other officially recognized higher educational establishment, given that, as has been established on numerous occasions by this Office, and in particular in decisions 35.688 of 1994 and 26.758 of 1996, persons who have been awarded a qualification by the said establishments are entitled by law to practise their profession without having to meet any other requirements as to knowledge or skill.

Subject to this clarification, the annexed Decree is approved.

God be with you.

To: the Minister of Health

Further reading

Australian Health Minister's Advisory Committee National Mental Health Working Group (1996). *National Standards for Mental Health Services* Canberra, Australia: Mental Health Branch, Department of Health and Family Services.

World Health Organization (WHO) (1994). *Quality assurance in mental health care: check-lists and glossaries*. (Vol. 1) Geneva: WHO.

World Health Organization (WHO) (1997). *Quality assurance in mental health care: check-lists and glossaries*. (Vol. 2) Geneva: WHO.

References

1. Anderson CA, Daigh RD. (1991) Quality mind-set overcomes barriers to success. *Healthcare Financial Management* 45:20-32.
2. Australian Health Minister's Advisory Committee National Mental Health Working Group. (1996) *National standards for mental health services*. Canberra: Department of Health and Family Services, Mental Health Branch.
3. Birlleson P. (1998) Building a learning organisation in a child and adolescent mental health service. *Australian Health Review* 21:223-40.
4. Buckley PF, et al. (1999) Implementing effectiveness research and improving care for schizophrenia in real-world settings. *The American Journal of Managed Care* 5(Spec No.):SP47-56.
5. Department of Health. (1999) *A national service framework for mental health*. London: Department of Health.
6. Donabedian A. (1980) *Explorations in quality assessment and monitoring*. Ann Arbor: Health Administration Press.
7. Flisher AJ, et al. (1998) *Norms and standards for psychiatric care in South Africa: A report submitted to the Department of Health, Republic of South Africa (Tender No. GES 105/96-97)* Cape Town: Department of Psychiatry, University of Cape Town.
8. Freeman M. (2000) Using all opportunities for improving mental health-examples from South Africa. *Bulletin of the World Health Organization* 78:508-10.
9. Goldman HH, et al. (2001) Policy implications for implementing evidence-based practices. *Psychiatric Services* 52:1591-7.
10. Green A. (1999) *An introduction to health planning in developing countries*. (Second edition.) Oxford: Oxford University Press.
11. Hart CWL. (1995) *The power of internal guarantees*. Cambridge, Massachusetts: Harvard Business School.
12. Hermann RC, et al. (2000) Developing a quality management system for behavioural healthcare: the Cambridge Health Alliance experience. *Harvard Review of Psychiatry* 8:251-60.

13. Institute of Medicine. (1990) *Clinical practice guidelines: direction for a new program*. Washington DC: National Academy Press.
14. Institute of Medicine. (2001) *Crossing the quality chasm: a new health system for the 21st century*. Washington DC: National Academy Press.
15. Juran J. (1988) *Juran on planning for quality*. Glencoe: The Free Press.
16. Juran J. (1992) *Juran on quality by design: the new steps for planning quality into goods and services*. Glencoe: The Free Press.
17. Kaplan R, Norton D. (1996) *The balanced scorecard: translating strategy into action*. Cambridge, Massachusetts: Harvard Business School Press.
18. Lesage AD. (1999) Canada. In: Thornicroft G, Tansella M, editors. *The mental health matrix: A manual to improve services*. Cambridge: Cambridge University Press. p. 201-15.
19. Louw J. (2000) Improving practice through evaluation. In: Donald D, Dawes A, Louw J, editors. *Addressing childhood adversity*. Cape Town: David Philip. p. 60-73.
20. Lund C, et al. (1998) Facing the absolute need: norms and standards for severe psychiatric conditions in South Africa. *South African Medical Journal* 88:1480-1.
21. Mark H, Garet DE. (1997) Interpreting profiling data in behavioral health care for a continuous quality improvement cycle. *The Joint Commission Journal on Quality Improvement* 23:521-8.
22. Paavel V, Sarjas A. (1999) Estonian mental health care reform: 30 years in 10 years. *Mental health reforms* 4:2-5.
23. Pillay YG, et al. (2002) *Rethinking the delivery of quality public health care: an integrated approach using lessons from the private sector*. Pretoria: Department of Health.
24. Rosen A. (1999) Australia. From colonial rivalries to a national mental health strategy. In: Thornicroft G, Tansella M, editors. *The mental health matrix: a manual to improve services*. Cambridge: Cambridge University Press. p. 177-200.
25. Rosenblatt A, et al. (1998) Managing what you measure: creating outcome-driven systems of care for youth with serious emotional disturbances. *Journal of Behavioral Health Services Research* 25:177-93.
26. Royal Australian College of General Practitioners. (1993) *Quality assurance and continuing education programme*. Rozelle, New South Wales: Royal Australian College of General Practitioners.
27. Talbott J, Halls RE, Keill SL. (1992) *Textbook of administrative psychiatry*. Washington DC: American Psychiatric Press.
28. The Scottish Office. (1997) *A framework for mental health services in Scotland*. Edinburgh: Scottish Office.
29. Thornicroft G, Tansella M. (1999) *The mental health matrix: a manual to improve services*. Cambridge: Cambridge University Press.

30. Tobin M, Yeo F, Chen L. (2000) The beginning of a structural reform: reorganizing the front line of a mental health system. *Australian Health Review* 23:64-76.
31. United States Department of Health and Human Services. (1993) *Clinical guidelines for depression in primary care*. Washington DC: Agency for Health Care Policy and Research.
32. United States Department of Health and Human Services. (2000) *Mental health: a report of the Surgeon General*. Rockville, Maryland: United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.
33. World Health Organization. (1993a) *Essential drugs in psychiatry*. Geneva: World Health Organization.
34. World Health Organization. (1993b) *Essential treatments in psychiatry*. Geneva: World Health Organization.
35. World Health Organization. (1994) *Quality assurance in mental health care: check-lists and glossaries (Volume 1)*. Geneva: World Health Organization.
36. World Health Organization. (1996) *Mental health care law: ten basic principles*. Geneva: World Health Organization.
37. World Health Organization. (1997) *Quality assurance in mental health care: check-lists and glossaries (Volume 2)*. Geneva: World Health Organization.
38. World Health Organization. (2001a) *World Health Report 2001. Mental health: new understanding, new hope*. Geneva: World Health Organization.
39. World Health Organization. (2001b) *Atlas: mental health resources in the world*. Geneva: World Health Organization.
40. Yeaman C, et al. (2000) Performance improvement teams for better psychiatric rehabilitation. *Administration and Policy in Mental Health* 27:113-27.

