Quality in Primary Mental Health Care

Introduction

This Primary Mental Health Care (PMHC) Toolkit is intended to help organizations and professionals consider the most effective ways to deliver quality care and achieve quality outcomes. Quality in PMHC is challenging to measure and assess although it is possible to determine some of the elements of a ‘quality’ service. With this in mind, all the content of the Toolkit could be described within a quality framework. In this essay we define aspects of quality as they relate to PMHC and encourage you to develop activities within your organization or role which will evaluate the quality of care provided to those who use PMHC. We build on the Primary Mental Health Initiatives Evaluation and use our recent refinement of our ‘Optimal Model’ for PMHI (Dowell, Garrett, Collings et al, 2009) to develop a quality framework to support New Zealand PMHC development into the future.

Quality in health care

The Institute of Medicine in the USA defines Quality in Health Care as “The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge”. ¹

There is an extensive literature both internationally and locally on this important topic and while definitions may vary in different settings, some themes, mainly relating to the clinical domain, such as safety, effectiveness and patient experience, are common to most quality frameworks.

Other themes such as efficiency, capacity and value for money are less common in quality frameworks but are all associated with the economic or resource allocation aspects of services. As such they are linked to service integrity and sustainability, and are also important elements to consider from a DHB and PHO perspective.

The processes and activities involved in establishing and maintaining quality in health care fall into two broad and overlapping groups: Quality Assurance (QA) and Continuous Quality Improvement (CQI) (Berwick 1989). The first Quality Assurance (QA) developed out of time and motion and efficiency study and has at its heart monitoring and the measure of performance. The second, Continuous Quality Improvement (CQI) had its origins in production line industries and the belief that quality can be improved if all those involved in an activity look at ways of improving the overall quality of the system they are working in.

The most enduring model or framework for understanding quality in health care was developed by Donabedian (1998), who divided quality processes, activities and measurement into structure, process and outcome domains with each component having an effect on the next. We will use this framework for our discussion of PMHC quality. Structure refers to provider attributes (e.g. therapist/patient ratio, Number of clinics in a given locality), process refers to the care given to the patient (e.g. the type of psychological or drug therapy), and outcome is what happens to the patient (e.g. improvement in psychological rating scale). These three types of measures have their unique strengths, but each is also associated with conceptual, methodological and practical problems. The choice often falls between process and outcome measures.

**Quality in Primary Mental Health Care**

While the central role played by primary care in the recognition and delivery of care for people with mental health problems is now widely acknowledged, ensuring the quality of primary mental health care remains a challenge in both developed and developing countries (Shield 2003). There has thus far been little formal assessment of service quality in PMHC settings. Within the UK Quality and Outcomes framework (QOF) there are a number of measures relating to mental health care, though as will be discussed later some aspects measuring performance and outcome in this area are challenging. Valid indicators of mental health care are important in assessing and improving quality of care as they can show variations in care, including suboptimal care (Seddon 2001). However, there are few indicators available for quality
assessment of primary mental health care, and few that can be applied at the system level—for example, practice or primary care organisation—rather than at the level of the diagnostic group (such as depression or anxiety) or that reflect the views of key stakeholders in the primary mental health setting, particularly patients and carers (Shield 2003).

General Practice and primary care inherently include service attributes that would usually be considered as indicators of high quality health care provision. The personal contact and continuity of care offered in primary care means that there are many opportunities for mental health issues to be addressed and many opportunities for a bio-psychosocial approach that supports good clinical outcomes. Moreover the family oriented perspective of primary care is enabling as far as mental health care is concerned.

In practice however a number of factors potentially compromise quality. In many countries including New Zealand the time allocation for individual consultations is brief and the competing demands in each consultation mean that mental health issues may not be prioritized. While the MaGPle study demonstrated that GP’s were more likely to recognise mental disorder if they knew their patients well, recognition and management were less likely to be optimal if the patient was seen in an acute care setting (MaGPle 2004). There has also been much debate about disparities in recognition and outcome with some evidence that the mental health care needs of Maori and Pacific people are less well addressed (MaGPle 2005). In addition there are widely acknowledged quality issues to be addressed at the primary-secondary care interface including appropriate communication and referral pathways.

As has been discussed elsewhere in the Toolkit, there are major gaps in PMHC service provision for some groups such as children and adolescents, and people over usual working age (Dowell et al. 2009). While those with problems of extreme severity may be able to access some services at times, an underlying lack of service provision means that there are very likely to be important quality issues when
services are provided, as there is essentially no infrastructure in terms of organizational or professional capacity to support the work.

In the last few years the introduction of targeted funding for PMHC through the Primary Mental Health Initiatives has provided new imperatives to assess the quality of the care being provided.

**Different perspectives on Quality**

In any organization quality improvement can be seen from a variety of different perspectives, and activity on a number of different scales or levels. At DHB or PHO level the planning, implementation and assessment of mental health quality could potentially be focused on systems efficiency within the DHB, efficacy of PHO initiatives, the training needs of primary care teams and so on. There are many aspects of care and service delivery that contribute to overall quality and hence a ‘mixed economy’ of different quality initiatives will be appropriate. In theory, quality measures can drive improvement in a number of ways. One model described by Don Berwick is the ‘change’ ‘selection’ and ‘reputation’ pathways (Berwick 2003). In the change pathway, quality measures act on the intrinsic professional motivation of clinicians and organisations to improve in areas where they see potential for improvement. In the reputation pathway, the publication of quality measures that compare performance between individuals, teams and organisations drives change through a desire to protect or improve reputations relative to others. Particularly in a North American context the selection pathway suggests that patients drive improvements by using measures to make choices between providers, incentivising providers to improve quality.

There are key quality issues in primary care, which can be explored within a mental health service context. These will include issues of access to care, workforce development and training and the use or otherwise of indicators of quality in a mental health care context.
In terms of the primary health sector engaging in quality initiatives the first and most important measures of quality are generic and challenging.

**Time:** There is no protected time in General Practice and much of primary care for anything other than patient care and contact. The single biggest improvement that organizations could make to further quality work is to fund time for quality activities.

**Teamwork:** There is a strong evidence base for the presence of good teamwork being linked to improved quality across a wide range of aspects of primary care clinical activity (Crampton et al. 2004). In addition there are effective means of measuring teamwork such as the Team Climate Inventory. We suggest that at DHB and Primary Care Organisation level, consideration is given to the measurement of teamwork effectiveness and promotion of effective teamwork in mental health care.

**Information technology:** Present primary care information systems were developed through small vertical markets with a focus on billing and prescribing functions. There were not designed for audit, evaluation or population health assessment. Moreover secondary care IT systems in many DHBs are idiosyncratic and isolated from other DHBs or primary care.

**Primary/secondary care integration:** Many quality issues present across the primary care interface including problems in communication and referral pathways. An important function of DHBs is to assess the effectiveness of work across the interface and support quality initiatives in this area.

We realize that working on these issues carries resource implications and that any quality indicators in this area are aspirational. The success or otherwise of other more specific indicators is dependent on them.

In addition there are other quality themes that apply to the primary mental health field.
As a starting point we suggest the DHB should have considered the following:

- Overall access to primary mental health care and to what extent there are disparities within local areas.
- The local working arrangements for primary mental health teamwork, together with training needs.
- The patient journey and some assessment of the patient experience.

As will be discussed below, for quality to be appropriately built into the work of the DHB and PHO there must be measurement of quality activity. How formal or incentivized this measurement becomes is a trade-off between trying to get accurate measures of quality activity and the compliance costs of data collection and follow up.

**Use of Performance indicators and measures of quality**

There is ongoing debate about the appropriateness or otherwise of performance indicators in primary mental health care (Crampton et al. 2004). Considerable work has been undertaken internationally on the development of mental health indicators, particularly in the United States. However this work is focused on addressing issues related to discrete disorders. In primary care the focus is appropriately centred on the concept of a group of less well defined Common Mental Disorders (CMD). For indicators of quality to be successful and accepted they must be able to reflect the complexity of the primary care environment, and avoid creating perverse incentives.

As those working in DHBs and PHOs are aware the current performance indicators in primary care stem from the PHO performance management programme (PPP). Until now mental health indicators have been absent from this programme, and it has been difficult to see how relevant indicators could fit into the current incentivized framework.

Some of the challenges in indicator development include a lack of agreement over illness terminology, lack of consistency of data collection and uncertainty over the
meaning of any outcome measure trends. Antidepressant prescribing rates provides a good example of the difficulties in developing an indicator in this area. A low rate of prescribing might mean a prudent use of pharmacotherapy and access to psychological therapies. Conversely it might mean under recognition and under treatment for patients who would benefit. The local and regional variation in prescribing added to the lack of a gold standard for appropriate prescribing rates mean that while this indicator would be excellent for stimulating debate it should not be used for benchmarked target setting.

Despite these challenges there is the potential to utilize indicators of primary care quality and performance which could have significant educational value in peer group discussions to raise quality of care.

We emphasise again the need for a strong element of ‘aspiration’ in any mental health quality indicator development. There has been a great deal of enthusiasm in the last few years to promote primary mental health care, and it is important to retain the positive commitment of the sector. Many quality initiatives fail in their potential because the bureaucratic demands of monitoring overtake the initial professional desire to improve quality in a particular area.

The indicators described below are examples of potential quality themes for primary mental health care identified as a result of discussions between the College of General Practitioners and the Ministry of Health (Perera et al. 2010).

a) Measurement of the Prevalence of common mental disorders in (i) adults and (ii) children.

This indicator is frequently suggested in the international literature. The overall aim is to capture the extent of practice level activity in relation to mental health. Exploring this issue with practice teams brings up the question of avoiding recording a diagnosis of CMD (as a result of a patient request or health professional choice), and the fact that current coding systems do not capture well the complexity of mental health presentations in primary care.
b) Referral to other primary care providers for the management of common mental disorders.

One of the challenges in primary care practice is enabling access psychological therapies for patients at a cost they can afford. Exploring referral pathways for psychological therapies is a good high level systems indicator of quality.

c) Prescription of selective serotonin re-uptake inhibitors for the management of common mental disorders.

As described above exploring patterns of prescribing is a useful marker of quality because there are no gold standards of prescribing rates.

These indicator themes and others would fit well within an educational framework of peer review. They do not lend themselves well to benchmarked target setting.

As well as the important generic indicators of quality and the more technical potential indicators above, we believe that organizations should support and promote the identification of quality initiatives and indicators that are important to primary care teams and practices. Getting practice teams to identify the aspects of quality that ‘make the heart sing’ from the provider perspective is likely to be both empowering and helpful in creating constructive relationships between practice teams and DHB/PHO.

**Evaluation of the New Zealand primary mental health initiatives: a step towards quality**

In this section we consider the main outcomes from the primary mental health initiatives evaluation in relation to service quality. The evaluation of the first wave of 41 initiatives identified a number of major themes which provide ‘lenses’ through which we can consider and debate the quality of PMHC (Dowell et al. 2009).

Most notably, there were nine different models of care, each deemed to be appropriate for the local context and each of which had features often associated with quality health services. The evaluation team defined an ‘optimal model of care’ (which we refer to here as ‘Optimal Model I’) based on all the observed facets of
care and service provision. No single model or organization contained all the elements of optimal care or service provision, although the majority included access to a wide range of mild to moderate mental health problems, a focus on mental health workforce development and the use of both psychological and pharmacological therapies.

Other issues relating to the ‘typical’ conception of service quality were:

- targeting of services to high-needs populations
- having both Kāupapa Māori and mainstream options available
- the use of clinical outcome measures was encouraged as a clinical tool

While there were many examples of effective interdisciplinary teamwork, the involvement of practice nurses was not always facilitated. In addition, there was no structured training or education programme for PMHC that included all disciplines.

Observations relevant to a broader conception of service quality included: the observation that no service delivery model offered inherently superior value for money, or an inherently more cost-effective service compared to others; up to 80% of service users benefited from the variety of interventions offered; and well-defined criteria for determining clinical eligibility for care are important.

In relation to access for the whole population, the initiatives provided access to Māori in excess of their proportion in the enrolled population. Although, given the higher prevalence of some common mental health conditions among Māori, it is likely there was still some under-utilisation of services by Māori. There was under-utilisation by Pacific peoples and significant under-utilisation by Asian people. The mental health needs of children and young people overall were not sufficiently met, and over half did not offer services to this group; and few PMHIs offered services to service users over 65 years of age.

Based on these observations figure 1 summarises the main structural elements that could potentially be markers of quality at DHB or PHO level. It might be an advantage
for example that there is congruence between DHB and PHO mental health initiatives and that there are clearly identified markers of integration between primary and secondary services.

Figure 2: Optimal model for Primary Mental Health Initiative (PMHI) Source: Evaluation of the Primary Mental Health Initiatives; Summary Report (Dowell et al. 2009).

Further markers of quality can be identified by looking at process components of primary mental health illustrated by patient pathways through the health system (figure 2). Quality issues might be identified for example in identifying the rationale for the use of particular psychological therapies and the deployment of particular types of staff.
Figure 2: Service user pathway (in the context of figure 1) Source: Evaluation of the Primary Mental Health Initiatives; Summary Report (Dowell et al. 2009).

****** A task for you ******

Looking at the diagrams above – write down which elements of quality you think are most prominent in your service.

What elements are missing from the diagrams?
The evolution of Quality frameworks

It is important that quality evolves. As a result of our work on this Toolkit project we have reviewed and revised some of our previous perspectives on what would constitute the optimal delivery of quality within a primary mental health care service. We have refined our thinking from the original optimal model and created a new version – Optimal model II.

One significant omission, for example, from the previous optimal model was absence of specific services for children and young people. This is particularly important if a service is taking a long term perspective on quality.

Further discussion about this evolution of quality is found in the perspective essay titled ‘Towards the future Primary Mental Health Care: Optimal Model II’.
References


