

Report of the UEMS Section of Psychiatry

QUALITY ASSURANCE OF STANDARDS IN SPECIALIST PSYCHIATRIC CARE

Introduction

Good quality in terms of psychiatric practise means that every patient has the right to assessment, treatment and rehabilitation, according to the best knowledge available, in locally implemented treatment programmes.

The starting point can be the patient-flow (logistics) from the patient's point of view, covering the different phases in the course of their disease and the provision of services.

Five different phases can be recognised:

- Referral phase
- Assessment phase
- Treatment and stabilisation phase
- Transfer to other services and termination of treatment
- Rehabilitation phase.

For each phase, **indicators** (relevant points of investigation), **standards** (defined acceptable levels of quality) and **measures** (instruments or mechanisms of quantification) should be identified.

In quality assurance, measures traditionally concern **structure**, **process** and **outcome**. In this work, **outcome** will be the most recommended since it is of most interest from a patient's point of view, and least dependent upon local traditions.

Specific issues concerning coercion are not included in this report, since these belong to a defined Working Group.

Referral Phase

Accessibility and availability on optimal effective level of care.

Primary level: GPs must be competent to assess and treat psychiatric disorders. GPs must have access to and be able to consult psychiatric specialists/psychiatric teams, and to refer when needed. Social services must be competent in supporting psychiatric patients' needs in the community, in active collaboration with psychiatric specialists and GPs.

Secondary level: Psychiatric teams/specialists must be available for emergency assessment and treatment around the clock. For non-emergency cases, an assessment must be obtained within a week of referral.

Tertiary level: When needs for patient assessment, treatment and care cannot be met in the patient's home, temporary placement in hospital beds should be provided without delay until the services can be

provided on a home basis. The patient's dignity and integrity must be secured throughout the hospitalisation.

Indicators – examples

Primary level:

- GPs must have documented basic training in psychiatry
- GPs must have documented CME in psychiatry
- Time span from request to consultation or referral.

Secondary level:

- All patients referred by GPs should be assessed and treated around the clock in emergency cases, and within a week for referral cases.

Tertiary level:

- Facilities for extensive home treatment and care should be available
- When unavoidable, a sufficient number of hospital beds with physical standards corresponding to the culture of the patient's home should be available
- The number of patients treated at home compared to number of patients treated in hospital.

Others:

- Scheduled meetings between primary, secondary and tertiary services should take place to monitor individual cases, as well as general aspects of exchange between services.

Standards:

- To be discussed and decided upon locally.

Measures:

- Simple standard procedures as part of routine work, preferably computer-based, should be implemented.

Assessment Phase

Assessment is carried out as an interaction between the patient, the psychiatric specialist and the psychiatric team in collaboration with relatives and significant others. The psychiatrist makes the final decision concerning assessment. This should include details concerning psychopathology, personality traits (development, defence strategy, ego-strength), network (the needs of minors at home should also be assessed), social development, present life circumstances, somatic history past and present, level of social functioning and psychiatric history. Relevant available diagnostic tools, for example, psychometric tests, neuroradiology and laboratory tests should be used.

Indicators – examples

- The team must document competence in the above-mentioned areas
- Standard procedures for assessment should be documented
- Diagnostic tools should be available, either on a routine basis or in specific cases through referral to more specialised services
- Assessment of social functioning (GAF)
- Contact with family and/or significant others
- Assessment of needs of minors at home.

Standards:

- 90% of all patients must see the psychiatrist during the assessment procedure
- All staff working autonomously must be licensed or authorised by a national or professional board

- Local guidelines based on national guidelines for assessment for major diagnostic and problem groups (professionally accepted guidelines, “state of the art”) should be used
- Referral procedures to more specialised services
- 90% of all patients should be assessed with GAF
- 80% of family and/or significant others should be contacted
- 90% of needs of minors at home should be assessed.

Measures:

- Simple standard routine registrations, preferably computer-based, should be part of everyday work.

Treatment Phase

Based on assessment, the treatment plan should be established in collaboration with the patient, the psychiatrist and team, the family and/or significant others, where appropriate. The psychiatrist has overall responsibility for the implementation of the treatment plan and the assessment of outcome.

The treatment plan should actively consider the need for biological, psychotherapeutic and psychosocial treatment. For each treatment modality, purpose, goal and time for evaluation should be documented. The individual treatment plan should be based on local and national guidelines. Each service should be comprehensive and offer a diversity of treatment possibilities in the above-mentioned areas.

Indicators – examples

- Locally adapted guidelines based on national standards for treatment for major diagnostic and problem groups
- Documented individual treatment plan
- Documented patient involvement in establishing the treatment plan
- The team must document authorised competence in all treatment modalities
- Balance between treatment needs and capacity
- Measures for outcome should be defined – e.g. scales for psychopathology and social functioning (GAF), side effects of treatment, user’s satisfaction.

Standards:

- 98% of patients admitted either as in-patients or out-patients for seven days or more should have a documented treatment plan, and relevant treatment offered immediately or after a locally acceptable time span, according to assessment of needs
- For 90% of patients, the active involvement in the establishment of the treatment plan should be documented
- Within local services, documented competence in major and relevant biological psychotherapeutic and psychosocial methods should be available to all patients after proper assessment.

Transfer to other services and termination of treatment

Continuity of treatment should be secured when a patient is transferred from one level of treatment to another. Mutual agreements between the transferring and receiving level should be documented.

When treatment is terminated, in order to prevent relapse, there should be an agreement with the patient concerning how to recognise warning signs of possible relapse, and which specific service to contact.

Indicators – examples:

- Documented agreement between transferring and receiving level of treatment

- Documented agreement with the patient about recognising warning signs and which service to contact.

Standards:

- For 100% of patients who are being transferred to another service, there should be a documented agreement
- For 100% of patients there should be a documented agreement about how to recognise warning signs and which service to contact if needed.

Rehabilitation Phase/Re-socialisation Process

Rehabilitation is a re-socialisation process through which the patient, relatives or significant others are supported to regain as much psychological, and social autonomy and function as possible.

The patient should be supported to choose the relevant network among family, significant others, social, educational and vocational services, and psychiatry.

Lost abilities which cannot be regained should be compensated. Support should be provided to sustain function, when needed. Training measures should be applied to help regain function where possible.

Indicators – examples

- A documented rehabilitation plan to be worked out in collaboration with the patient and the network
- Documented patient involvement in network planning
- A professional responsible for securing co-ordination (for example, a case manager) should be appointed
- Measures for outcome should be defined – e.g. quality of life, satisfaction and level of functioning
- Procedures for evaluation and readjustment of plans should be defined
- A documented agreement with clarification of responsibility between social services and psychiatry should be established.

Standards:

- For 100% of patients, a documented rehabilitation plan should be worked out when required
- For 100% of patients, whenever social services are part of the rehabilitation plan, a documented agreement should be established
- For 100% of patients, a professional responsible for securing co-ordination should be appointed.

Conclusion

The overall purpose for the above-mentioned standards is to improve psychiatric services for patients in the most secure way possible. Furthermore, it is hoped they will contribute to the enhancement of patient autonomy and satisfaction. Finally, these standards may facilitate the provision of services in the most cost-effective manner possible.

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