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Supervision of Mental Health Care in the Netherlands

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Summary. In the Netherlands the Inspectorate of Mental Health has to supervise the quality of mental health care that is given to its citizens. A shortage of inspectors hampers effective accomplishment of this task, and government budget cuts have increased this problem. Another obstacle is the absence of standarized methods of supervision and clear norms for medical practice. This paper describes the efforts of the Inspectorate to develop a new technique of supervision to solve this problem, the so-called frames of reference.

Key words: Inspectorate of Mental Health – Supervision – Quality of care – Frames of reference – Cycles of repeated evaluation

Introduction

In the Netherlands as a result of the increasing costs of mental health care, politicians, society, and sickness funds are beginning to demand accounting and justification of the care given to its citizens [7, 13, 16]. In relation to the growing concern of quality assurance the Inspectorate of Mental Health (IMH) is placing emphasis on activities associated with assessing and assuring the quality of mental health care [5]. The term "quality assurance" is misleading to the extent that it implies that the quality of mental health care in general can be assured. A more meaningful definition of the term would be: quality assurance is any activity aimed at or resulting in maintaining or improving the quality of care of mental health services.

Quality of care of mental health services can be defined as the degree to which the system fulfills a number of quality standards [7]. Quality assurance activities can be divided into two categories, external and internal. External quality assurance efforts usually involve monitoring standards of the IMH, health legislation, or government directives based on legislation. Examples are the topics or criteria in the frames of reference of the IMH and the legal conditions under which inpatient services may function as formulated in the Hospitals Facilities Act.

Although ideally the standards used in the external monitoring process have been developed in consultation with the care provider being supervised, the final assessment and actual application of the standards is by an outside party like the IMH rather than the service provider himself. This can be defined as "external supervision".

Internal quality assurance activities are those conducted by a mental health care facility itself in attempting to evaluate and improve the quality of care. Program evaluation and peer review efforts are examples of these activities which can be defined as "internal supervision".

In Table 1 the term accountability refers to the legal and moral obligations of mental health professionals to assure the correct fulfilling of professional duties. To date internal and external quality assurance activities have not been coordinated and do not complement each other in assessing and assuring the quality of mental health care.

In this paper the development of so-called frames of reference is described, a monitoring system of the IMH which takes into account both internal and external standards of quality of care.

External Supervision

As Table 1 shows supervision takes place at different levels. At each level supervision is done in different ways. At the micro-level examples of supervision activities are peer reviews and the functioning of a medical disciplinary law. At the meso-level supervision takes the form of hospital audits and interinstitutional reviews. At the macro-level quality assurance activities are carried out by the Department of Welfare, Health and Culture Affairs, the Dutch Sickness Fund Council, and the IMH.

The Dutch government fulfills its tasks by means of:

1. Regulations that are formulated in several Health Acts. Examples are the Hospital Facilities Act which encompasses the conditions for planning and building institutions for intramural mental health care and the Health Care Tariffs Act
2. The coordination and regulation of mental health education
3. Taking into account the results and recommendations of mental health care studies in political decisions
4. Taking into account the recommendations of the IMH
5. Using data from mental health enquiries, from two psychiatric case registers, and from the national inpatient register.

The Sickness Fund Council sees to it that patients and clients receive the treatment and care to which they have a legal right according to the Sickness Fund Act and the General Act on Exceptional Medical Expenses. It is important to note that government and sickness funds limit their quality assurance activities to the structural and organizational conditions under which mental health care is given. They do not focus on the quality of care actually given to the patient. This

Table 1. Supervision and accountability in mental health quality assurance. To date an internal program usually sets its own standards and priorities for review and therefore does not have to correspond with external standards. The parties involved in internal and external quality assurance activities are listed [2]

Supervision	Accountability			
	Micro	Meso		Macro
Structure	– Professional worker – Health Care Service – Association of professional workers – Sickness Fund Council – Inspectorate of Mental Health	– Professional worker – Health Care Service – Association of professional workers – Sickness Fund Council – Inspectorate of Mental Health	– Government – Inspectorate of Mental Health	– Government – Third pay parties
Process	– Professional worker – Association of professional workers – Sickness Fund Council – Inspectorate of Mental Health	– Professional worker – Association of professional workers – Sickness Fund Council – Inspectorate of Mental Health		– Professional worker
Outcome	– Professional worker – Inspectorate of Mental Health	– Professional worker – Inspectorate of Mental Health	– Sickness Fund Council – Inspectorate of Mental Health	– Professional worker

Table 2. Mental health care facilities 1984

	Admissions	Discharges	Patients present at census day (31st of Dec)	Manpower (full-time)	Capacity			Costs (in million guilders[c])
					Number of services	Number of beds	Number of days in care (× 1000)	
Intramural mental health services								
General psychiatric hospitals	25,751	25,941	21,511	23,941	44	22,907	7,293	1,670
Special psychiatric hospitals[a]	7,361	7,329	1,874	2,843	34	1,958	623	228
Psychiatric departments of general hospitals	*15,250*	*15,200*	*1,700*	*2,100*	81	1,899	*623*	*350*
Psychiatric university clinics	*3,700*	*3,700*	*410*	*710*	64	. 479	150	82
Psychogeriatric nursing homes[d]	10,021	9,770	20,842	20,800	182	21,022	7,648	1,459
Semi-residentional mental health services								
Psychiatric day treatment[d]	5,035	4,801	2,769		64	1,853	426	71
Psychogeriatric day treatment[d]	2,809	2,493	2,015		84	1,047	233	30
Sheltered homes[d]	*830*	*780*	*2,770*	*940*	121	2,906	*1,010*	*88*
Non-residentional mental health services								
RIAGG[b d]	*126,000*	*113,000*	*120,000*	*3,644*	*59*			*378*
Consultation bureaus for alcohol and drugs	21,361	14,845	27,891	894	64			68
Outpatient clinics of psychiatric hospitals and of psychiatric units of general hospitals[d]				*300*	*134*			*57*
Private psychiatrists[d]				*200*				*60*

[a] Including clinics for the addicted, child and youth institutions, detention and treatment centers for mentally disturbed offenders
[b] Regional Institutes for Ambulatory Mental Health Care, including social psychiatric services, child guidance
[c] 1 $ ≈ 2.80 guilder
[d] The figures in italic are estimations

is done by the IMH which gives directives and formulates quality standards in order to keep the operational freedom of mental health services and professional workers within bounds. In a sense the quality assurance activities of the government and sickness funds can be defined as preventive and passive, the supervisional activities of the IMH as repressive and active [1].

The Inspectorate of Mental Health

Tasks, competence, and powers of the IMH have been defined and layed down in three acts: namely the Insanity Act, the Health Organization Act, and the Health Facilities Act. The tasks of the IMH can be divided into five categories:

1. Supervision of mental health care
2. Upholding health regulations including the tracing of penal offences
3. Advising the Minister of Welfare, Health and Cultural Affairs, and the Director-General of Health. It is important to note that the IMH has considerable autonomy in that it is not subordinated to the Minister. The IMH functions as an independent body but has to observe the government directives
4. The hearing of complaints
5. Initiating and stimulating new developments in the field of mental health and mental health care.

Usually all these tasks and activities of the IMH are described with one term: supervision. The term supervision often refers to only one of these activities, depending on the context.

According to the IMH itself, the first activity, supervision used in the narrow meaning, has a high priority [14].

The IMH has to monitor and supervise:

1. The legal position of the individual patient
2. The psychiatric treatment and care of each patient
3. The quality of the mental health care services
4. The education of mental health nurses.

At the present time the IMH is confronted with two serious problems in fulfilling its supervisory task in an effective and efficient way. Firstly the IMH does not have enough manpower to accomplish its monitoring and supervisory tasks.

Supervision of the quality of care is carried out by five regional inspectors (psychiatrists). Each of them covers a certain region and is assisted by two adjunct-inspectors. The Chief Inspectorate supports and advises the Regional Inspectorates and coordinates the supervisory activities. It may be clear that in relation to the figures in Table 2 it is physically impossible to control the quality of care given to each patient. The Inspectorate tries to solve this problem by stimulating the services to develop computer-based information and registration systems containing data which indicate the level of the quality of care. These data enable the services themselves to evaluate their programs and enable the IMH to supervise the services at a meso-level. Divergent data may function as a warning and will lead to a visit by the Inspectorate. Examples of such systems are the National Inpatient Case Register, the register of complaints, the register of measures of constraint, and the register of suicides.

Secondly the monitoring procedures do not take place in a systematic way and are not based upon explicit, uniform standards. As a consequence each inspector often estimates the quality of care according to his own implicit standards. This hampers a comparison between the various mental health care services and creates confusion among the institutions supervised.

Recently the Chief Inspectorate started with the development of two important monitoring systems that will help the Regional Inspectorates to supervise in a more efficient and effective way, namely the development of a regional information system of mental health care services and the development of frames of reference.

The regional information system will give an indication of the quality i.E. the effects, of mental health care at a meso-level in a certain region. The system covers all existing mental health care services so that it will be possible to examine the treatment career of patients rather than monitor the use of the facilities. This regional information system will be based on computer-based quality assurance systems, the frames of reference. These frames of reference are to be used in case a mental health care facility is checked by the IMH.

Frames of Reference

A frame of reference contains a set of topics, i.e. criteria, and standards that indicate the quality of care of the facility and of the care given to the patient. Topics or criteria can usually be divided into three independent types [6]:

1. Structural aspects – these data enable the IMH to evaluate facilities and resources necessary for service provision
2. Process of care – these data give a review of actual provided care by explicit standards
3. Outcome topics – these data make an evaluation of the effects of treatments possible.

By "structure" is meant the relatively stable characteristics of the mental health care services, the tools and resources they have at their disposal, and the physical and organizational settings in which they operate.

The use of structure as an indirect measure of the quality of care depends on the nature of its influence on care. In the frames of reference it is presumed that when they are present, features of structure that are known or believed to have a salutary effect on the quality of care, are taken to be indirect evidence of quality. Other features, known or believed to have a negative effect, are taken as evidence of poor quality. It is important to emphasize that structure, therefore, is believed to be relevant as an indicator of quality in that it increases or decreases the probability of good performance.

Elements of process have a number of advantages as indicators of the quality of care. Psychiatrists claim to have no great difficulty in specifying the criteria and standards of good care, at least for technical management. These may serve as interim measures of acceptable practice.

Because the frames of reference are to be used at one point in time and due to the restricted manpower of the IMH, the criteria in the frames of reference refer mainly to the structure of the care services and to the process of care. Besides these pragmatical reasons, outcome measures often do not possess the face validity attributed to them. They reflect more than just the effects of care and often do not include many relevant effects of care [9, 12].

The purpose of the regional information system of mental health care services is to give an indication of the effects of care. In a sense the two systems complement each other.

In developing an instrument as the frame of reference the following problems have to be solved: (1) what is meant with "the quality of mental health care"; and (2) how can quality be assessed?

Quality of Care

As professional, public, and political interest in measuring and assuring quality of care mounts, the need for a clear definition of the term "quality of care" becomes very important. Many discussions are due to different, often implicit, connotations of the term [4]. Quality of care refers to a body of values, ideas, and interests that change in time and differ from culture to culture. As a consequence the standards of quality of care differ in time and from place to place. Hence, the term is dynamic and contains an implicit apraisal.

What the quality of care is or should be is influenced by political, scientific, technical, economical, and ethical factors. This makes it necessary to evaluate the criteria and standards that are formulated in the frames of reference regularly. The Inspectorate is well aware of the different focus of quality activities of the people involved in the process: the government who create structural conditions, psychiatrists who produce disease-specific, provider– and procedure-oriented assessments of quality, whereas patients examine the caring function through patient-centered, nontechnical assessments dealing with compliance, relief of symptoms and satisfaction. All these conflicting "paradigms" are taken into account in the frames of reference. Information is given by managers, psychiatrists, nurses, and the patients themselves.

Assessment

Another problem to be solved is how to assess quality. Should we measure process criteria or outcome criteria, predetermined and explicit criteria or judgemental and implicit criteria, maximal or optimal quality [11, 15]? As with the term quality, confusion exists regarding the definitions of criterion, standard, and norm [3]. In this stage of development of the frames of reference it is important to clarify these terms. In the frames of reference "criterion" is interpreted as the name of a variable. A variable must be identified and named before a method of measurement can be developed and before a standard can be established for it. "Criterion" can be defined as the name of a variable believed or known to be a relevant indicator of the quality of patient care. "Standard" can be defined as the desired and achievable level or range of performance corresponding with a criterion, with which the actual performance is compared. "Norm" refers to the empirically established current state and can therefore be defined as the current level or range or performance corresponding with a criterion.

The naming and listing of criteria is easier than standard setting since criteria are value-free. In contrast, the setting of standards is problematic. As mentioned earlier standards are subject to change and have to be reevaluated continuously. Ideally, standards are based on scientific evidence but in practice they will often have to be set on the basis of value judgement and professional experience. The standards in the frames of reference will be set not only on the basis of information given by service providers, funders, and patient representatives but also in close consultation with them. The final standardization however is made by the IMH. Feedback to the parties involved is an important part in this process. This is especially important because the implementation and the acceptance of the frames of reference depends on careful planning involving the participation and compliance of all relevant interest groups. A monitoring system which is composed and imposed from above is likely to generate criticism and resistance from below. Consultation, feedback, and setting of standards are elements of IMH quality assurance system. The system will become more valid and reliable with repeated evaluation. Hence, the frames of references can be considered as cycles of repeated evaluation consisting of the following phases [2]:

Phase 1: observation the observation and assessment of the actual situation
Phase 2: description of parameters the formulation and listing of criteria
Phase 3: standardization the setting of standards corresponding with the criteria
Phase 4: supervision controlling the quality of care by judging the actual situation according to the standards
Phase 5: evaluation in this phase the shortcomings in psychiatric care can be corrected, criteria can be changed, and standards made more valid.

Phases 4 and 5 of each cycle coincide with phases 1 and 2 of the next one. In this way the quality of care will approach the quality standards as set by the IMH.

In the following two examples out of the frame of reference of psychogeriatric nursing homes are presented:

Example 1

Criterion: the psychogeriatric nursing home is free of danger from fire.
Standard: the psychogeriatric nursing home has a declaration and confirmation from the local authorities that it is free of danger from fire.
IMH: does the nursing home satisfy this criterion?
1. yes
2. no in case no: a. explanation...
b. suggestions to improve the situations...

Example 2

Criterion: the patient and his relatives have been prepared for admision.
Standard: some patients and relatives are asked whether the nursing home had prepared them for the admission and what they thought about these activities. They are also asked what was the time between their being informed and the actual admission. This should be 3 to 10 days.
IMH: does the nursing home satisfy this criterion?
1. yes
2. unclear
3. no in case no: a. what are the shortcommings...
b. suggestions to improve the situation...

Conclusion

Lembcke stressed 30 years ago that the purpose of quality assurance systems is to insure that the full benefits of medical knowledge are applied effectively to meet patients needs [10]. In the Netherlands the Chief Inspector of the IMH, Van Borssum Waalkes, also stressed the importance of an internal and external computer-based quality assurance system [8]. Internal because the responsibility of the care that is given belongs to the service provider, external because the IMH cannot visit and supervise all mental health care services because of its limited manpower. This is especially important because, by means of the frames of reference, shortcomings in the quality of care can be detected and corrected by trying to change the behavior of psychiatrists, other professionals, or institutions through feedback about the shortcomings.

References

1. Bangma SP (1983) Tasks and functions of the Inspectorate of Mental Health. Maandblad Geestelijke Volksgezondheid 6/7: 637–650
2. Beenackers AAJM (1984) The development of a quality assurance system. Unpublished paper Inspectorate of Mental Health, Leidschendam
3. Bloch R (1977) Criteria, standards, norms – crucial terms in quality assurance. J Nurs Adm 9:20–29
4. Boelen JLA (1985) Quality of care. Med Contact 12:361–363
5. Brook OH (1986) Budgets and quality of care. Het Ziekenhuis 6: 198–201
6. Donabedian A (1985) Explorations in quality assessment and monitoring. Ann Arbor, Michigan
7. Inspectorate of Mental Health (1985) Annual report. Ministery of Welfare, Health and Cultural Affaires, Leidschendam
8. Heerma van Voss AJ, Schrameijer F (1983) Chief Inspector of Mental Health Van Borssum Waalkes: Who says that we don't control? Maandblad Geestelijke Volksgezondheid 6/7:685–702
9. Keppler-Seid H, Windle C, Woy JR (1980) Performance measures for mental health programs. Community Ment Health J 16:217–234
10. Lembcke PJ (1956) Medical audit by scientific method. J Am Med Assoc 162:646–650
11. Mattson MR (1984) Quality assurance: a literature review of a changing field. Hosp Community Psychiatry 35:605–616
12. McAucliffe W (1979) Measuring the quality of medical care: process versus outcome. Health Soc 57:118–152
13. Ministery of Welfare, Health and Cultural Affaires (1984) Report mental health. Governmental Press, The Hague
14. Dutch centre mental health (1986) Mental health in figures. NcGv, Utrecht
15. Stricker G, Sechrest L (1982) The role of research in criteria construction. Professional Psychology 13:19–22
16. Council of Sickfunds (1986) The quality of health care. ZFR, Amstelveen

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