QUALITY ASSURANCE AND PSYCHIATRY

IN

THE NETHERLANDS

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ABSTRACT

Psychiatric Quality Assurance (QA) in The Netherlands has been and remains the focus of interest at both local and national levels. The achievements of the State Inspectorate for Health, the health care professions, the National Hospital Association (NZR) and the National Organization for Quality Assurance in Hospitals (CBO) are impressive. In Ziekenhuis 'De Grote Beek' (Eindhoven) and the Psychiatrisch Instituut Stichting Het Hooghugs (Etten-Leur) may be found impressive examples of where QA has been seriously addressed at the local level. QA is a significant feature of the psychiatric hospital landscape of The Netherlands. However, its development has not been without trauma. Nor is there any guarantee that it will survive. Not all Dutch mental health workers regard QA as an issue. The successes of those agencies operating at national level are often fragile. QA in psychiatry is faced with considerable methodological and practical obstacles. The lack of a common intellectual framework threatens to prejudice irretrievably the future evolution of QA in The Netherlands. Moreover, the material benefits of QA to the patient have yet to be made manifest. Nevertheless, despite the considerable differences between the health service in The Netherlands and the NHS the Dutch experience can provide valuable lessons for those seeking to introduce QA into psychiatry in Britain.

I INTRODUCTION

The following notes are the fruit of a fortnight's sojourn in The Netherlands during September 1987 as a Kings Fund Travelling Fellow.

My purpose in undertaking the trip was to observe psychiatric QA programmes in action with a view to 'pirating' their blueprints for possible use within Gloucester Health Authority or, should such programmes be only in the research/development stage, assess progress to date and feed my findings into the UK debate.

Although I was able to spend time with community psychiatric services in Breda, the chosen theme of this report is QA in psychiatric hospitals. This is partly a reflection of the severe time constraints within which I was working and partly a reflection of the current swing back towards institutional care in the Dutch mental health services.

Apart from limited time, my task was complicated by a lamentable lack of Dutch and the paucity of relevant literature. Doubtless this has led to factual errors. I am confident, however, that such errors do not prejudice the overall worth of the project.

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II QUALITY ASSURANCE AND PSYCHIATRY IN THE NETHERLANDS

A) The National Framework

Unlike the U.K., in The Netherlands QA in hospitals has been and remains the focus of interest, debate and action at not only a local but also a national level. Four principal actors may be identified on the nati onal stage

- The State Inspectorate for Health
- The health care professions
- The National Hospital Association (NZR)
- The National Organization for Quality Assurance in Hospitals (CBO)

The State Inspectorate for Health

The Dutch State has opted for indirect regulation and control of the quality of hospital care, creating a structural and procedural framework within which hospitals are required to operate.

On the one hand, in 1985 it became a legal requirement for health care professionals to participate in the development of QA programmes. On the other hand, those hospitals seeking funding from the government's Health Insurance Scheme undertake to meet certain minimum standards with regard to

- administrative procedures
- financial procedures
- cooperation with other health agencies
- health and safety
- peer review mechanisms
- support services etc.

Compliance is monitored by the State Inspectorate for Health. Sanctions include the withdrawal of the hospital's operating licence and reductions in the amount of funding (and thus profit) made available.

The Professions

(i) Medical Staff: between 1974 and 1976, the Dutch Medical Association (LSV), inspired by the example of the American Professional Standards Review Organizations, produced a report which committed its members to the development of QA in medicine and called for the creation of an independant body to provide methodological support. As a result of this report, the National Organization for Quality Assurance In Hospitals (the CBO) was established in 1979. The work to date of the CBO is detailed below.

At least one medical school has established a chair in health care QA, charged with the education of medical students in QA methods and the development of research programmes.

In 1986 the Dutch Psychiatrists Association began a continuing dialogue with the CBO over the development of a psychiatric QA model.

(ii) Nurses: Dutch nurses have given an undertaking to implement QA across the profession within five years and are currently working with the CBO to achieve this (details of the project are given below). Schools of Nursing have also included QA in their curricula.

(iii) Occupational Therapists: In 1985 the Dutch Association of Occupational Therapists produced a 'professional profile' detailing standards in referral procedures, patient evaluation, goal setting, treatment techniques etc. The Association has also held work-shops on protocol development and peer review but a formal QA programme has yet to be devised.

(iv) Physiotherapists: In 1986 the Dutch National Society of Physical Therapy established the Science and Education In Physical Therapy Organization charged with the development of high standards in psysiotherapy. This body, which has experimented on a local basis with peer review systems, is currently working with the CBO to produce a QA model for the profession.

Similar initiatives - with or without the assistance of the CBO - have been launched by the speech therapists and pharmacists.

The National Hospital Association (NZR)

The NZR represents all health care institutions. It acts as their mouthpiece on policy matters. It negotiates with hospital employees over terms and conditions of employment. It acts as a health care think tank and possesses in the National Hospital Research Institute (NZI) a research and development wing.
The involvement of the NZR in QA is the child of the demand made by member institutions for assistance in devising frameworks.

The NZR has responded to the needs of the institutions through the development of a hospital wide QA package. In 1984 the NZR commissioned the NZI and the CBO to develop a hospital wide QA package over a three year period. The DGH's at Deventer, Tilburg and Haarlem were chosen as pilot sites. The so called Hospital Audit Project has now been running for two years. A formal assessment is awaited.

In addition, psychiatric hospitals are the subject of HAS type inspections. A visiting team of nine or ten people (three of whom are from the NZR, the rest being clinicians from other hospitals), who cannot be denied access to any facility they wish to inspect, will spend four days analysing the service provided and produce a series of recommendations. No specific sanctions exist to ensure compliance with these recommendations but in extreme cases the institution concerned can be called upon to account for its inaction by the Council of the NZR.

The NZR is currently reviewing its approach to QA. Two options have come to the fore:

- option 1: To continue with the Hospital Audit Project and the development of a hospital wide QA package, ensuring, however, that it can be adapted to local needs.

- option 2: To join with the State Inspectorate for Health in developing minimum standards for hospitals, enshrined in quality check-lists.

Debate upon which option to pursue continues.

The National Organization for QA in Hospitals (CBO)

The terms of reference of the CBO (which is a WHO QA collaborating centre) include

- the development and implementation of QA methods in DGH's and teaching hospitals

- the education of health care providers in QA techniques and the operation of QA programmes

- the evaluation of developments in QA .

The CBO invests a considerable amount of time in discussions with professional associations on the theory and practice of QA. Such discussions then lead on to the development of training packages and the on-site education - on an experimental basis - of a limited number of health care providers in QA methods, QA priority setting and review techniques. After a formal review of the pilot scheme, a decision is made how best to proceed further. Mention has already been made of CBO involvement with those disciplines contributing to psychiatric care. Additions to the list are G.P.'s, dieticians and dentists. The CBO also trains the officers of the State Inspectorate for Health. Increasingly it is involved in the current restructuring of the curricula of Dutch medical schools to reflect more accurately the skills and knowledge required by the physician in daily clinical practice. The CBO also organises Consensus Development conferences which develop national guidelines on contentious health care issues.

Of particular interest from the psychiatric point of view are the CBO's involvement in the Hospital Audit Project and discussions with the Dutch Psychiatric Association (both of which are referred to above) on the one hand, and on the other its role in assisting the nursing profession to develop a structured approach to QA and its desire to develop a hospital wide QA programme specifically for psychiatric institutions:

- In 1985 a two year project was launched to compare the Phaneuf Nursing Audit System (which uses 'imported' standards) with the Unit Based Approach of Lang, Schroeder and Maybush

(where locally developed standards are employed). 900 nurses in 30 wards in 7 hospitals were involved. The project ended in May 1987. On the basis of user satisfaction, resource utilization and improvement in the quality of care, the Unit Based Approach was deemed the better method.

- Negotiations are currently in progress between the CBO and a chain of six protestant psychiatric hospitals over the development and implementation of hospital wide QA programmes.

B) The Local Scene: Two Examples

Ziekenhuis 'De Grote Beek' (Eindhoven)

QA in De Grote Beek has been explicitly formularized.

On the one hand, responsibility for peer review amongst psychologists and psychiatrists - who provide leadership to each ward and between whom no distinction is made - is invested in the Treatment Evaluation Committee, a sub group of the Scientific Staff Committee (whose membership comprises all the psychiatrists and psychologists working in the hospital). Every three years each clinician is obliged to open up his/her ward to the scrutiny of his/her colleagues. A five stage process is gone through:

(i) The psychologist/psychiatrist concerned prepares a ward profile specifying the model of care adopted, the theraputic goals set, the methods of treatment applied and the means to evaluate outcome employed which is circulated to members of the Treatment Evaluation Committee.

(ii) The clinician under review presents to the Treatment Evaluation Committee a case history designed to exemplify the working of his/her ward. Typically a video of the patient concerned is shown and a paper detailing background, diagnosis, treatment plan and progress to date is produced. It is common for ward staff - nurses, O.T.s etc. - to assist in the presentation and make their own views known.

(iii) The clinician concerned is called upon to defend his/her practices before a Review Panel of eight fellow clinicians (who have digested both ward profile and case history), under the chairmanship of a member of the Treatment Evaluation Committee.

(iv) The criticisms of the Review Panel are discussed in open forum by the individual under review, ward staff (who may have attended the Review Panel session as observers) and other interested parties, together with members of the Panel and Treatment Evaluation Committee.

(v) A report is prepared by a member of the Treatment Evaluation Committee for for general circulation and for filing prior to being fed into stage (iii) when the clinician concerned is reviewed again.

On the other hand, the General Principles of Treatment Working Party is charged with drafting therapeutic policies for the whole hospital and establishing a framework within which clinicians of all disciplines are obliged to operate. Issues dealt with by the working party include admission criteria and procedures, diagnostic criteria, links with community and social services, drug policies and consent to treatment. The working party's modus operandi involves the commissioning of sub groups to produce draft guidelines for consultation. After suitable amendments are made, an Editing Group chosen from the membership of the Working Party produces a final document which is sent to the Hospital Management Team for ratification.

There are no separate professional QA systems for nursing, O.T. etc. in De Grote Beek.

Psychiatrisch Instituut Stichting Het Hooghuys (Etten-Leur)

Peer review is no longer carried out in the Psychiatrisch Instituut Stichting Het Hooghuys on the grounds that it stimulates interest in quality but cannot act as a permanent QA mechanism. Instead, two QA co-ordinators - one for acute psychiatry and one for continuing care - have been appointed. It is my understanding that both are from nursing backgrounds. Their role is to stimulate and encourage quality initiatives on a local (individual patient, ward or department) level in an informal manner.

In addition, the post of 'Professional Satisfaction Counsellor' (my translation) has been created with the remit of assessing the level of professional satisfaction of professional members of staff, bringing together both clinicians who have similar ideas for service development and those whose differences of opinion are causing professional frustration. The present occupant of the post is also, I believe, a nurse by training.

Permanent, hospital wide, QA structures and mechanisms have been avoided. At the most, ad hoc working parties of limited life-span

to produce guidelines on such issues as patient rights and consent to treatment are occasionally established.

The absence of the sort of formal QA mechanism existing at De Grote Beek is the corollary of a belief that any sort of skilled professional work in a rapidly changing field is best organized in an 'adhocracy'. Indeed, the managerial culture of Hooghuys may be described as Maoist in its desire to "let a thousand flowers bloom". On the basis of the twin premises that clinicians actually want to deliver high quality health care and that the approach of an individual clinician to his/her craft is intensely personal the formulaic has been avoided. A freewheeling open atmosphere of cheerful anarchy has been fostered. Clinicians - of all disciplines and grades - are encouraged to voice their opinions and experiment. Responsibility for ensuring quality care has been definitively invested in the individual clinician.

C) A CRITIQUE OF THE DUTCH EXPERIENCE

1. The foregoing would suggest that QA forms a significant feature of the hospital landscape of The Netherlands. It should be recognised, however, that its development has not been without trauma. Nor is there any guarantee that it will survive.

2. (i) For instance, while De Grote Beek and Hooghuys provide impressive examples of where QA has been seriously addressed at local level, in the Lucia Stichting Clinic, a psycho-geriatric unit in Breda, QA is not regarded as an issue. There is no evidence to suggest that the attitude of the managers and clinicians at the Clinic is not the more typical amongst mental health care workers in The Netherlands. Moreover, on the one hand it should be noted that the De Grote Beek's QA system has only been relatively recently established: the first review cycle has yet to come to a close and it is of interest that the Chairman of the Scientific Staff Committee bemoaned the absence of sanctions and admitted that peer review proved a fruitless exercise when the individual under review was at all dogmatic or obstinate. On the other hand, it should be recognised that the approach to QA adopted at Hooghuys depends crucially on continued presence of the current Medical Director, whose commitment to putting into practice the management philosophy of Henry Mintzberg is not shared by his colleagues with equal enthusiasm.

2. (ii) The achievements of those agencies operating at the national level are often no less fragile. The Dutch hospital licensing system should not be imagined as a Cisatlantic version of the American. Regular analysis of to what extent individual hospitals meet accreditation norms and standards is unknown and sanctions are rarely applied. Rather, the State Inspectorate operates on a 'fire engine' basis, investigating scandals and effecting remedial action. The Medical Director of Hooghuys who has had experience of the Inspectorate operating in this fashion, rated the Inspectors highly for their understanding of psychiatry and their appreciation of the disparate models of psychiatric care. On the other hand, a consultant psychogeriatrician at the Lucia Stitchting Clinic, which has admittedly yet to play host to the Inspectorate, suggested that the Health Inspectors understanding of E.P.D. care was limited and that their recommendations, which are irrelevant to quality clinical care, can

be ignored. Given the NZR's current deliberations over whether or not to join with the State Inspectorate in the development of quality checklists, it is interesting to note that the NZR's member institutions are, at the time of writing, refusing to co-operate with Inspectors over accreditation. They have done so on the grounds that the norms and standards employed by the Inspectorate to assess hospitals' eligibility for remuneration under the State's Health Insurance Scheme were not drawn up in liaison with either clinicians or health care institutions.

2. (iii) The work of the professions on QA is laudable, but given that their enthusiasm became apparant only after the legislation of 1985, one may reasonably question the depth of their commitment. It should also be remembered that in The Netherlands clinical practice dictates legislation rather than vice-versa, as the current controversy over euthanasia exemplifies. Paramedical staff in particular have complained of a lack of unanimity amongst clinicians about what to assess and of insufficient methodological support on how to assess quality. Of particular concern is the lack of progress made in negotiations between the CBO and the Dutch Psychiatrists Association resulting from antagonism between the biological psychiatrists and those who support the 'psycho-social' model. Indeed, the CBO would appear to have considerable doubts about the wisdom of continued investment of scarce manpower resources in what might prove to be the chimera of a universally accepted psychiatric QA model.

2. (iv) The Chairman of the Scientific Staff Committee of De Grote Beek was very positive about the initiatives of the NZR in the field of QA. He found the HAS type visits extremely helpful and indicated that both he and his colloeagues took the visiting Team's report seriously. Research suggests that between 60% and 70% of recommendations are actioned and certainly an NZR visit can both facilitate and initiate radical change: two hospital management teams have been peremptorily dismissed as a result of NZR visiting Teams' reports. On the other hand, the NZI - CBO Hospital Audit Project has run into serious difficulties. One particular problem has been that the various professions within each hospital came to the Project with varying degrees of familiarity with QA methods and techniques. It is felt by the CBO that the NZI has no long term commitment to the Project and relations would appear strained. The managers of those hospitals chosen as second generation sites for the Hospital Audit Project have all

stipulated that they wish to deal with the CBO alone. Such inauspicious beginnings do not augur well for the successful development of a viable hospital wide QA package.

2. (v) Critics of the CBO argue that any hospital QA programme developed by the child of the LSV is bound to fail. They dub the CBO a 'doctors'club' whose medico-centric bias means that it is in reality reluctant to assist other health care professions to create and implement QA systems. In the development of service or hospital wide QA packages it lacks the necessary fundamental belief in multidisciplinary care to produce a model to which non-medical staff could feel commitment.

Certainly it is questionable how real the CBO's current interest in psychiatry is. Reference has already been made to its doubts concerning the worth of continued dialogue with the Dutch Psychiatrists Association. None of the literature I have read indicates that even a single Consensus Development conference has been devoted to a psychiatric topic. There are no qualified psychiatrists on the staff of the CBO. In the early 1980's the Organization made a concious decision to avoid being drawn into mental health, partly on the grounds that measuring quality in psychiatry is exeptionally difficult (particularly for those trained as somatic physicians), and partly because of despair at getting biological and psycho-social psychiatrists to agree on even the parameters of QA in mental illness. A further reason was that Dutch psychiatric hospitals were at the time going through a series of fundamental re-organizations which denied QA the stability required for successful development. In fact, Evert Reerink, a senior figure within the CBO, suggested at the time in a paper delivered to the World Psychiatric Association that QA in psychiatry might prove 'unattainable'.

3. Reerink's reasons for this suggestion are worth dwelling upon. He defines the obstacles confronting QA in the treatment of mental illness as being on the one hand methodological and on the other bound up in the very nature of psychiatric care. Methodological problems include

- poor documentation of care provided

- the lack of objective criteria in evaluating behavioural problems

- the number of care variables (e.g. what happens to a patient on leave) over which the psychiatrist can have no control, which increase the difficulties of evaluation

- the highly individual nature of psychiatric care (most QA methods focus on groups of patients)

Problems inherent in psychiatry include

- a lack of uniformity in how care is documented

- the influence of ever changing social values, of which psychiatry has to take cognizance

- the absence of a universal standard for the classification of psychiatric problems and the lack of uniformity in diagnosis and the classification of behavioural problems

- the conflict between the different schools of psychiatry which hamper the development of uniform guidelines for diagnosis and treatment

- the multi-disciplinary nature of mental health care and the consequent plethora of perspectives from the professions about what constitutes quality psychiatric care which increases the difficulties of evaluation

- the fact that care outcomes are strongly influenced by the family of the patient and his environment

4. (i) This list forms a useful though by no means exhaustive outline of those obstacles facing the development of QA in psychiatry which on the one hand perhaps lie behind the limited success so far achieved by Dutch mental health care workers and on the other should be taken into account by those on this side of the Channel who would introduce QA into British institutions. More importantly,

it also underscores the lack of a common intellectual framework which threatens to prejudice irretrievably the future evolution of QA in the Netherlands.
The dangers inherent in disparate and on occasion antagonistic groups developing separate QA programmes are obvious: scarce skills are spread too thin (the argument that limiting support staff in hospitals forces clinicians into developing QA systems for themselves, so securing the necessary commitment to the concept, remains unproven); institutions and clinicians opt for those programmes which occasion the least trauma, thus frustrating the raison d'etre of QA; as increasing numbers of professions establish their own packages, the potential for a major interdisciplinary clash over quality leading to the discrediting of QA also increases. However, the plethora of agencies involved is but the natural corollary of the confused and even incompatible strands of thought in the Dutch approach to QA.

4. (ii) First, it is clear that in attempting to define how QA fits into the health care production-line model of input, process and output/outcome, the Dutch have either worked on the premise that quality can be determined by specifying inputs or concentrated their attention upon process and output/outcome and their inter-relationship. The 'input' model of QA is embodied in the check-lists of the National Inspectorate for Health. In contrast with this, the CBO, for instance, has regarded quality care as being determined by what is done to a patient (process), and how this affects his/her health (output/outcome). The State has looked to the development of universal structural and procedural frame-works within which health care is to be delivered as a means of ensuring quality. The professions, generally, have regarded QA as a problem solving mechanism, utilizing the twin tools of peer review and consensus development.

In fairness, it has been recognised that these two approaches are not theoretically irreconcilable, a view shared in the UK by advocates of "Bowden's Balls", the model whereby clinical audit and utilization review first overlap and then become indistinguishable. The problem solving approach recognises quite rightly that to gain and retain the interest of clinicians in QA it has to extend the possibility of avoiding health care "nightmares". However, debate on therapies and their efficacy cannot ignore the impact made upon them by resource availability. Moreover, meaningful discussion of

inputs depends crucially on a clear appreciation of how they are used and what results are achieved.

It is possible to conceive of a model in which clinicians develop mechanisms for assessing outcomes and how they relate to process and how inputs impact on both process and outcome; in which it would then become possible to define quality care for any given condition, specifying necessary input, appropriate process and expected outcome; in which such specifications could be enshrined in protocols in accordance with which clinicians would be expected to operate to ensure quality health care.

Attractive, however, as such a model may be conceptually, it should be recognised that in psychiatry at least, given the current total sum of knowledge of the human mind and its ills, any attempted reconciliation of the input and process/outcome models would do little for either the future of QA in mental health care or the treatment of the mentally ill. At present in mental health care it is almost impossible to detail therapeutic goals and progress towards them in a systematic fashion. How any patient reacts to a given therapy depends largely on social, psychological, biological and historical factors which vary between individual patients. The relationship between a clinician and a patient cannot be standardised: human interaction cannot be dictated. The validity of research conclusions is limited to the therapist, patient(s) and environment studied. Universally applicable detailed methodologies - the raw material of the clinical protocol - defy development.

4. (iii) Second, noting that some clinicians in The Netherlands, once confronted with an operational QA package, have subordinated themselves to the system and denied the worth of their own intellectual inputs, the Dutch would appear to be uncertain whether QA is to do exclusively with structure and its relation to the input - process - output/outcome model or whether it is also a cultural phenomenon, impacting on understanding, attitude and expectation.

Undue empahasis on the structural side of QA is dangerous - particularly in psychiatric care. As indicated above, the

human mind is still largely terra incognita. Psychiatry is a young science.

Those working in mental health are obliged to admit many areas of ignorance. Such ignorance equals powerlessness. It may be said without exageration that coming to terms with that powerlessness forms one of the greatest personal and professional hurdles for those working with the mentally ill. The quality of their work is determined largely by how they cope with this powerlessness. It is arguable that too rigid and formal a QA mechanism would tend to increase rather than reduce the mental health care worker's feelings of impotence and thus de facto lead to a reduction in the quality of the care provided.

It is of course a commonplace that structures in an organization cannot exist in a vaccuum but survive by both reflecting and promoting the aims and values - the culture - of that organization. It would appear that in The Netherlands greatest emphasis has been given to the creation and development of structures, not creating the necessary pre-existing culture. The limited success to date of QA in the Dutch Health service perhaps reflects the failure of its champions to capture the "hearts and minds" of their fellow clinicians. The CBO's involvement in medical schools and the deliberations of the professional organizations are not enough. The required internalization of quality assurance, of a desire for clinical excellence, has yet to take place amongst Dutch clinicians en masse.

4. (iv) In sum, the absence of a common intellectual framework, the problems, methodological and otherwise, confronting its development, and the fragility of the achievements of it proponents notwithstanding, it would nevertheless be possible to predict QA a future place in the sun were it actually improving the quality of care received by Dutch patients. However, the recommentdations of the NZR teams aside, there is little evidence to suggest that this is in fact the case. A recent article on peer review noted that: "action for improvement is always reported but seldom executed". Change, a full decade after QA first appeared on the Dutch health care scene, remains the 'orphan' of QA. The material benefits to the patient have yet to be made manifest.

III CONSLUSION : SOME LESSONS FOR THE NHS

Despite the considerable differences (cultural, structural and financial) between the Dutch health service and the NHS, the above critique would indicate that those who would undertake the development of QA in psychiatry in Britain should note the following:

(i) QA must be actioned centred. If it does not confer immediate and continuing benefit upon the patient it should cease.

(ii) There must be clear and general agreement amongst mental health care workers as to what QA is (who is responsible for it, what its purpose is, how it is organised and structured), whether it is an independant phenomenon or a manifestation of cultural values, and how it relates to both the input - process - output/outcome model and the overall management of the organization.

(iii) QA programmes can be developed and implemented at a local level. They are not the exclusive preserve of the centre.

(iv) If central control of QA development is considered desirable, that control should be invested in a single body. Consistency of approach is guaranteed. Resources (human and financial) are harnessed in the most productive fashion. The potential for interdisciplinary clashes is minimised.

(v) The successful development and continued functioning of a QA package in any given psychiatric hospital/unit depends crucially on agreement amongst clinicians, managers and the local public on the psychiatric model in accordance with which the service is to run. Only then can those problems identified by Reerink (see above) be addressed and resolved.

(vi) QA reqires commitment from its participants and stability to succeed. It may well take a decade to establish QA as an integral part of an hospital's life. A generation may be required to create a quality orientated culture.

(vii) The format which QA takes must be sufficiently flexible to take account of advances in clinical psychiatric care, the personalities of those participating in it and the social framework within which treatment for mental illness is given.