Community-based Mental Healthcare

Community-based Mental Healthcare: A Case Study in a Cross-border Region of Germany and the Netherlands

Gemeindebasierte psychiatrische Versorgung in der Grenzregion Deutschlands und den Niederlanden

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ABSTRACT

Background Community-based mental healthcare (CBMH) aims at supplying psychiatric patients with rehabilitative care outside the hospital. The aim of this study was to compare the organization of CBMH in a cross-border region of Germany and the Netherlands.

Method Semi-structured interviews gave insight into characteristics of CBMH approaches applied in the German region of Aachen (IHP) and the Dutch Province of Limburg (FACT). We applied a Delphi technique to select a performance indicator (PI) set for CBMH, which served as a conceptual model to allow comparison.

Results Both approaches are flexible, patient-centred and include the evaluation of quality. Both provide financial and administrative support for the access.

Conclusion CBMH approaches appear to be equally valid from several perspectives even if they revealed, at the same time, important differences related to scope, integration with non-CBMH care resources and geographic coverage. Secondarily, the study provides a contribution to the development of a PI set to compare and evaluate CBMH approaches.

ZUSAMMENFASSUNG

Hintergrund Gemeindebasierende psychiatrische Versorgung (GPV) zielt darauf ab, Patienten außerhalb des Krankenhauses mit Rehabilitationsmaßnahmen zu versorgen. Ziel dieser Studie war es, die Organisation von GPV-Ansätzen im Grenzgebiet Aachen zur Provinz Limburg zu vergleichen.

Methode Interviews gaben Einblicke in die Merkmale der beiden GPV Ansätze. Wir verwendeten Delphi-Verfahren, um ein Leistungsindikatorenset auszuwählen, das als Konzeptmodell diente. Wir verglichen 1) Stärkefallmanagement mit seinem individuellen Hilfeplan in der deutschen Region mit 2) funktioneller konsequenter Gemeinschaftsbehandlung mit seinem intensiven Fallmanagement in der niederländischen Region.

Ergebnisse Beide Ansätze sind flexibel, patientenorientiert und beinhalten die Bewertung von Qualität. Beide Ansätze bieten finanzielle und administrative Unterstützung für den Versorgungszugang.

Fazit GPV-Ansätze scheinen aus vielerlei Hinsicht gleichermaßen gültig zu sein, auch wenn sie gleichzeitig wichtige Unterschiede in Bezug auf Umfang, Integration mit Nicht-GPV-Betreuungsressourcen und der geografischen Abdeckung aufzeigen. Sekundär liefert die Studie einen Beitrag zur Entwicklung eines Leistungsindikatorensets, um GPV-Ansätze zu bewerten und zu vergleichen.

Introduction

Community-based mental healthcare (CBMH) was initiated in the 1960s with the aim of preventing secondary effects of institutionalization [1]. The CBMH approach focuses on employment, recreation and housing over and above outpatient mental health treatment [2]. Services can include activities from professional team-building to improving communication systems and from intensive supervision with a structured day concept to a loosely organized living context. Our study focused on tertiary prevention, which is the therapeutic stage of prevention. This stage is primarily based on rehabilitation, medical care and the improvement of quality of life at community level [3].

Performance or quality indicators (PI) in healthcare are essential tools for improving health system functioning. As such, PIs can be used for the comparison of CMBH services in cross-border care to support quality improvement and equality in health care. Border regions provide a valuable laboratory to compare different approaches to CMBH.

We explored CBMH for individuals with depression as a Case Study in the German administrative district of Cologne and Aachen and the Dutch Province of Limburg (Netherlands) using a single set of PIs for comparison. The Netherlands applies a well-described approach to CBMH called Functional Assertive Community Treatment (FACT). The German region applies a CBMH approach, which includes an Individual Help Plan (IHP) and a case manager.

The main objective of this study was to describe and compare the two CBMH approaches in the 2 border regions. A secondary aim was to define a conceptual model from a set of PIs for CBMH in order to allow such a comparison.

Methods

Performance indicator selection

We built upon the international literature on performance and quality indicators for healthcare (systems) and the conceptual model of Donabedian [4]. We attempted to establish a balanced PI set for CBMH consisting of appropriate areas, dimensions and indicators by using Delphi-technique in 'Rounds', which were held until group consensus had been achieved [5]. The PI set was adapted for CBMH in the two border regions under study [6]. Five independent and unbiased experts, an economist, occupational therapist, psychologist and 2 public health professionals, all experts in the field of performance/quality of care indicators and/or community-based care, validated the proposed set of indicators [7]. The following Steps were completed in this modified Delphi process:

1) An initial face-to-face meeting aligning experts, agreeing upon a set of principles to guide the development of the indicator list;
2) A working group scanned available international literature for performance, quality indicators and for CBMH practices;
3) A draft document was created based on Step 1 and 2;
4) Experts met to discuss and confirm issues addressed in the draft;
5) Two rounds of an on-line survey were completed to reach anonymous consensus; The first Delphi round sought to extract performance and quality indicators from a draft (Step 4) considered as relevant for the evaluation of CBMH in border regions with a questionnaire (▶ **Table 1**). Indicators were categorized in structure, process, and outcome according to the conceptual model of A. Donabedian [4] (▶ **Table 2**).Responses were collected into a series of suggested indicators. Only suggested PIs applicable and relevant for CBMH were considered. The suggested indicators with proposed definition and classifications were returned to the experts who express their lever of agreement.
6) All investigators participated in a final focus groups to validate the proposed PI set [5].

Two relevant areas of mental health selected by a panel of the OECD [7] with corresponding dimensions were included [7–11]. ▶ **Table 3** depicts all three categories, areas, dimensions and indicators redefined based on a mental health and community-based care perspective established in Step 5 and 6 [3, 6, 7, 12–15]. PIs for CBMH were selected from four international sources on system quality and performance [8–11] resulting in the inclusion of 6 indicators (▶ **Table 4**).

Patient case to ensure comparability

A theoretical patient case was created as heuristic tool to explore a typical clinical course used to address mental disorders in a real-life setting (**Supplement 1, online**). The case was developed by one of the authors who has worked in the field of community-based care with depressed patients. We decided to use a case of moderate-severe Unipolar Depression for the analysis because depression has a high prevalence with substantial public health and economic impact [16]. We did not employ fabricated cases from the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) because of their focus on psychiatric testing and clinical intervention [17, 18]. To insure a structured and holistic narrative of the cases the "functional model on mental health" by Lahtinen [19] was used to formulate a detailed, accurate and comparable case in order to answer the objectives. The living circumstances of the patient were provided in as much detail as possible while allowing the cases to be realistic for the 2 regions. The case was pre-tested among respondents before the interview to optimize typicality of the case.

Expert interviews

Starting from a comprehensive database of psychiatric organizations, contact points and institutions of the regions, we networked to find qualified professionals involved in the development of CBMH in the corresponding regions. Two experts, one for the German region and one for the Dutch region, were identified. The final draft of the case and the PI set with questions (▶ **Table 2**) were sent to the professionals. The semi-structured face-to-face interviews took place in a one and a half hour meetings and relevant information was paraphrased, transcribed and included in the results [20].

Results[1]

A number of authors see case management from the angle of coordinating and connecting healthcare services; others see case

[1] The qualitative data presented in this section was derived from the semi-structured interviews. Only a selection of data is depicted. Additional references in this section confirm authors statements. Some information was added to give additional information.

▶ **Table 2** Interview guide based on performance indicators for community-based mental healthcare with the categories of the conceptual model of A. Donabedian.

Areas	Dimension name	Indicators	Corresponding Question	Donabedian [4]
Continuity of care [7, 10]	*Timely ambulatory follow-up after mental health hospitalization* [7]	Access	Which kind of ambulatory follow-up care or community-based mental healthcare is provided?	structure
			How do patients get informed about this care possibility?	structure, process
			How to get access for the follow-up care?	structure, process
			How support professionals clients with the admission process in case they are not able to do it by themselves?	structure, process
		Equity	How is the access of community-based mental healthcare for patients organized? – with regard to financials (requirements for access) – with regard to cross-border issues (nationality, special cases, insurance contracts)	structure, process
		Timelines	How to insure a timely ambulatory follow-up care?	structure, process
			How is cooperative work with professionals of the hospital set up?	structure, process
Coordination of care [7]	*Case management for severe psychiatric disorders* [7]	Responsiveness	How is the set up for care time hours (previously fixed amount/flexible)?	structure
			How long is an individual help plan valid?	structure
		Patient-centeredness	Does the patient have a voice in decision-making process? – Within the application for care – Extent/amount of care – Content of care	structure, process
			Which mechanisms and approaches are in place to support and ensure patient-centred care?	structure, process
		Quality of care	How to insure quality in follow-up ambulatory/community-based mental healthcare? – EBP – Evaluation – Norms/Quality management	Outcome (for EBP) outcome, process, structure

management as coherent and holistic healthcare service supervised by networks. Such differences were recognizable between the Aachen Region and the Dutch Province of Limburg, where case managers have different tasks and operating principles. Two models of case management are relevant for this research (▶ **Table 5**). The Strength (IHP) Model is applied in the Region of Aachen, which emphasizes support of individuals based on resources. The Province of Limburg offers Intensive Case Management provided by a team using holistic care plans [21].

Continuity of care – Access

According to German expert, in the German region the CBMH is embedded in an IHP, which is administered by a case manager and supported through ambulant assisted living depending of the need of the individual [22]. The IHP is available in eight languages (including a German version). An IHP conference involving all key stakeholders identifies the individual support needs based upon the International Classification of Functioning, Disability and Health (ICF) areas (living, working and leisure activities) [23]. The IHP conference evaluates objectives and their results on a regular basis and is typically attended by the case manager, representative of local social and health department, provider of inpatient and outpatient services, representatives of the social psychiatric centres and/or coordination, contact and counselling services for people with intellectual disabilities, plus the applicant. Any kind of involved stakeholder can support the individual in the admission process for an IHP.

FACT is a 24-h multi-professional treatment and rehabilitation approach employed in the Netherlands. FACT was evolved from ACT [24], an Evidence-Based Practice Model, which increases positive outcomes for persons with severe mental problems who are at risk for psychiatric crisis, or for becoming hospitalized or homeless. Depending on the status of the individual, the team can intensify or reduce the support (up- and downgrading of care). The psychiatrist meets regularly with the team and individual in non-crisis appointments, where all parties evaluate the current status and work on medication management. The psychologist can provide different kinds of specialist treatments, such as psychotherapy, individual counseling or cognitive behavior therapyin the FACT centre. Intervention within the family and assistance in work life may be added to the treatment plan. The person with mental disorder, the police, neighbours, relatives or family-members may request FACT. FACT teams are also assigned to neighbourhoods in which they identify new cases [25].

Continuity of care – Equity

The German expert explained that health insurance is needed to gain access to services in Germany. The LVR provides proportional subsidies to allow for coverage for individuals without health insurance.

The Dutch expert noted that the acute health insurance system in the Netherlands covers only specific portions of mental health care. Long-term mental healthcare is covered by a combination of long-term health insurance (AWBZ) and municipal programs (under the WMO) depending on what type of care and curative services

▶ **Table 3** Performance indicator set and definitions.

Areas	Dimension name	Indicators
Continuity of Care [7, 10] Continuity of care is a dimension where the scope of the integration and interrelation between the health system and the service delivery to a patient can be measured over various settings and time [15]. Continuity of care is an essential aspect in mental health service delivery where the individual needs to be connected to the healthcare system [12, 13].	*Timely ambulatory follow-up after hospitalization* [7] This dimension is a part of the previous mentioned area. The arrangement of appointments with patients back in their community in a narrow time frame is primarily for advice on care and treatment of mental disorders important. It ensures continuation of a treatment course, maintains compliance and prevents a stop of intake of medication. In order for a more accurate exploration of this main dimension, 3 sub-divisions, namely access (accessibility), equity and timeliness, have been added.	Access "Accessibility to health care services refers to the degree to which the system inhibits or facilitates the ability of an individual to gain entry and to receive services" [15]. Geographical aspects like the provision of community-based care within the country and the region-wide coverage within the separate parts of the 2 compared regions is one aspect of this sub-dimension.
		Equity It is a concept that assumes fair and neutral prospects to reach fullest health potential possible for the patient. Equal chances for health should be developed to lower differences in health outcomes amongst patients and patient-groups [3]. Mental health equity focuses on the issue that equal chances to mental health community-based care should be provided. Individuals with depression and a lower income, a certain health insurance, different culture or patients living in a certain geographical area may have the same opportunity to access care.
		Timelines Timelines is defined as "happening at a good or proper time" or as "being timely" [15]. For the follow-up care after a psychiatric hospital treatment for mental ill and depressed individuals, the timing is of a great importance in order to prevent relapse and promote recovery as already elaborated above.
Coordination of care [7] Coordination of care is a process where activities of healthcare providers are synchronized or assembled in order to ensure an effective procedure [15].	*Case management for severe psychiatric disorders* [7] The care provision in the community of chronically or severe mentally ill individuals often go beyond drug provision or support for body hygiene. It includes the management of a variety of services per case to ensure an independent live of clients with depression in the community. Case management has its own challenges, which can be grouped into 3 sub-dimensions: responsiveness, client-centeredness and quality of care [7].	Responsiveness The Oxford Dictionary explains responsiveness as "reacting quickly and positively: a flexible service that is responsive to changing social patterns" and further "responding readily and with interest". Individuals with mental disorder pass continuously through different phases or severity grades of their disorder. In these phases, their behaviour connected with daily activities and social patterns change. The task is here to react individually and fast on these changes to prevent from worsening of the situation.
		Patient-centeredness Patient-centeredness expresses the needs, values and preferences of an individual and focuses on respecting them in the care taking process. This view achieves shared decision-making and responsibility, empowers the client burdened by depression to stay reactive, and prevents release of duty. Moreover, patient-centeredness supports the coordination of different care settings and integrates the patient in the care process [14].
		Quality of care The assessment of the quality of care provided is based on the training and certification of the provider [15]. It is the "degree of excellence or conformation to standards that the various components of the health care system adhere to" [15]. Quality in care shall insure that almost equal and satisfactory outcomes are delivered in a care setting regardless of the caretaker or the care-setting [6, 15].

▶ **Table 4** Indicator set selected from four sources about health system performance/healthcare Quality.

Indicator set	Sources about Health System Performance/ Healthcare Quality			
	OECD 2006	**WHO**	**IOM**	**JCAHO**
Access/Accessibility	x	x		
Equity	x	x	x	
Timeliness	x	x	x	x
Responsiveness	x			
Patient-centeredness	x	x	x	
Quality of care	x			

x indicates the characteristic present in a respective indicator set
OECD: Organisation for Economic Co-operation and Development, WHO: World health Organisation, IOM: Institute of Medicine (U.S.), JCAHO: Joint Commission on Accreditation of Healthcare Organizations

▶ **Table 5** Application models of Case management.

	Strength Case management (GER)	**Intensive Case management (NL)**
Patient empowerment	Self-monitoring and Self-management	Self-monitoring and Self-management
Aspects of care	Medical and psychosocial care	Medical and psychosocial care
Integration and treatment concept	Patient-centred, individual plan	Holistic care plans
Personnel	Professional Case manager	Team
Based on concepts of Gensichen [21]		

are needed. Admission to the FACT care trajectory requires a down payment of 500 euros. In some cases, it is possible for the individual to obtain or be reimbursed for this down payment by the municipality of residence.

Continuity of care – Timelines

In the German Region, the caretaker can visit individuals during hospitalization 2 hours per week under paid conditions. The hospital-based psychiatrist writes prescriptions for medications and treatment while the individual is in hospital. After discharge, prescribed drugs are administered by an ambulatory nursing team under the supervision of the community-based psychiatrist.

In Limburg a close alliance exists between FACT teams and emergency rooms. In weekly meetings, FACT teams and wards identify individuals in need of support [26]. "Continuity of care is assured by a shared vision and organization, by the use of transmural treatment plans, and on a personal level by the case managers, who visit their clients in the hospital and make arrangements for their discharge"[25].

Coordination of care – Responsiveness

In Germany, the number of hours for various types of support are detailed in the IHP. The IHP is valid for 3 months to 2 years and can be adjusted after one year. Amending an IHP requires a compelling reason for change. The case manager has the final decision on the amount of hours and the duration.

In the Netherlands, an individual care/treatment plan is set up with the individual during 2to 4 home visits per week by the case manager. The care plan has to be updated each year, but a time limit does not exist [25].

Coordination of care – Patient-centeredness

IHP comprises several parts including personal data, interview, goal, activities to reach the goals, and time needed. The interview questionnaire contains questions about life aims, barriers and social integration. Out of these statements, the caretaker formulates the final goals on behalf of the individual taking into account professional and therapeutic considerations. The caretakers' aim is to empower the patient to meet the formulated goals.

FACT teams are intended to allow individuals to live within the community to promote social inclusion and normal functioning. Daily multidisciplinary team meetings ensure a close exchange and evaluation of the patient's situation thus increasing a controlled and elaborated strategy. FACT provides care for people who are not able to answer life goal questions or are involuntarily treated [25]. The case manager plans supportive daily life activities with the individual.

Coordination of care – Quality of care

Weber & Pfeiffer [26] evaluated the applicability and effectiveness of the German IHP. IHP 3.1 was developed with the main associations of voluntary welfare, together with patients, the LVR and different providers [22]. The German expert stated that the instrument is now well established. Several social acts (SGB's) indicate the quality aspects of the different care and cure services summarized and listed in the IHP [27]. Care providers have to meet this quality criterion to supply their services [22].

As noted earlier, the development of the Dutch FACT is based on ACT, which is a recognized evidence-based intervention. The Dutch expert stated that the certification process is carried out by the Certification Centre for ACT and Flexible ACT". FACT is assessed on a 60-item scale. It includes the evaluation of human composition of the team, the organization and content of care, cooperation with the environment quality and training of the team [28].

Discussion

Differences of the two approaches

The IHP goes beyond access for mental disorders and includes services for mental deficiency and physical disabilities. In contrast, FACT is specifically designed to address severe mental disorders. Differently from FACT, the IHP and related material is available in simplified German and several other languages. In the IHP the psychiatric or psychotherapeutic visits are not planned by the case manager. This is largely explained by the fact that the IHP is not only for mental disorders. However, this can be also seen as an asset when it comes to the decentralization of service provision. During times in which the patient is stable, visits with the psychiatrist and psychologist can be separated from CBMH and IHP planning. The IHP has only been implemented in few federal states of Germany, whereas FACT and ACT are available in all areas of high population density in the Netherlands. That could mean that equality of CMBH provision is higher in the Netherlands than in Germany. In a German context, this may lead to underprovision of services for mental disorders. With respect to timelines, the professional team around the individual never changes in the FACT approach and 24 h availability is in place (part of responsiveness). The communication channels are thus simplified. Individuals might experience more companionship. This could save time, money and can reduce stress for individuals, but could lead to overprovision and a situation similar to hospital treatment.

Similarities of the two approaches

In both the German and Dutch border regions, administrative and financial support are provided for accessing CBMH. Approaches in both countries are also subject to quality assurance processes, some of which are statutory. Both approaches assign the individual to a hospital-based team: CMBH and hospital teams work together. Regarding the dimension responsiveness, the German and Dutch approaches react flexibly to the conditions of the individual including planning for the amount and duration of care time, which can be seen as part of patient-centeredness.

From an international perspective the 2 approaches described are most likely only affordable in high- income countries with high levels of public expenditure on mental health compared to low-/middle-income countries covering mainly inpatient mental hospital care. This can be from relevance for the WHO Mental Health Action Plan 2013–2030 seeking to increase service coverage for severe mental disorders by 20 % to offer comprehensive, integrated and responsive mental health and social care services in community-based settings [29]. In order to achieve this aim it is advisable to deeper investigate on pros and cons of diverse CBMH approaches applying suggested quality PIs in combination with an economical evaluation in order to identify the most efficient approach.

Limitations

Using Delphi-technique comes with methodological limitations. Variances in knowledge level of CBMHC and familiarity with PIs could have introduced bias. Therefore, Step 1 was introduced to align experts, giving instructions on the topic. Moreover, expert selection depended on subjectivity of the researcher and on expert availability for the research period. Regarding the accountability of experts for decision-making, Step 6 and 7 were introduced after two anonymous Delphi rounds.

The selection of expert interview partners was limited to a very small group familiar with CBMH approaches in the 2 border regions thus results are not easily generalizable due to particular geographic and socioeconomic characteristics.

Conclusion

CBMH approaches applied in the German region of Aachen (IHP) and Dutch Province of Limburg (FACT) appear to be equally valid from several prospective such as access, patient centeredness, administrative and financially support as well as flexibility even if, at the same time, they revealed important differences related to scope, integration with non-CBMH care resources and geographic coverage. Indeed one aspect of the IHP that appears to be less holistic from a multidisciplinary team perspective is that psychiatric or psychotherapeutic visits are not part of the approach, which can be also seen from benefit regarding decentralization and power abuse. This case study provides, as a secondary outcome, a contribution to the development of a PI set for CBMH. CBMH PIs are relevant to develop and monitor responsive mental health and social care services in community-based settings and this original work gives first suggestion on PIs quantitative assessment.

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Conflict of Interest

The authors declare no conflict of interest.

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