Professional supporting materials for standards of care in Centres for Mental Health (CMH)

1. Preamble

Context

In the Czech Republic, care of mentally ill people is typical of the low share in the total health care expenses, concentration of care in psychiatric hospitals, and underdeveloped community-based care.

The issue that is referred to in numerous studies is the insufficient coordination of health care of mentally ill people. For instance, the report *Mapování stavu psychiatrické péče* (2012) states that one-fifth of admissions into residential treatment facilities takes care without any referral – thus, with no measures having been taken to prevent hospitalisation.

In the autumn of 2013, the Ministry of Health of the Czech Republic approved the strategy for reforming psychiatric care, in which it defined the need for a network of Centres for Mental Health (CMH) charged with providing and coordinating care in particular in respect of persons suffering from severe mental illnesses. Such Centres for Mental Health were described as facilities providing health and social services, working based on team work, specialised in outreach and outpatients' work, and well accessible in time and space.

The Czech Republic is bound by a number of documents defining the conditions of care of persons with disabilities, some of them specifically related to care of persons with mental illnesses. In January 2005, the Czech Republic bound itself to satisfy the conclusions of the Europe Conference of Health Ministers regarding the issues of mental health in Helsinki by virtue of the Mental Health Action Plan for Europe. In 2008, the European Pact for Mental Health and Wellbeing was approved, based on the Helsinki declaration. In 2009, the Czech Republic ratified the UN Convention on the Rights of Persons with Disabilities, which became a part of our laws as of February 2010.

The European Mental Health Action Plan adopted by the Members States in September 2013 sets forth as one of its objectives closing down of large institutions connected with neglect and abuse and developing of community-based services provided by multi-disciplinary teams.

Target group

In foreign literature and practice, the category of SMI, i.e., Serious/severe Mental Illness, is one commonly used. It is exactly the persons from this group who in the event of inadequate care are the ones most threatened by their illness becoming chronic, by repeated hospitalisation, and by social exclusion. In the standard submitted, for the sake of timely intervention, we specify the target group of CMH as persons suffering from SMI, including persons threatened with development of mental illnesses, and in the sector of services provided in emergency, the target group also includes persons in crisis in general.

Upon comparison with foreign models of regional centres (the Trieste model in Italy or FACT in the Netherlands), the target group may be quantified as 1,000 persons per 100,000 inhabitants per year, while most services will be provided to 200 persons with severe mental illnesses.

Ehler (2013) estimated the sum of direct (medical and non-medical) and indirect costs of mental illnesses in the Czech Republic in 2010 to have amounted to more than CZK 100 billion. Indirect costs are those incurred as a result of disability, incapacity to work, and shortening of the life expectancy of persons with mental illnesses. Over twenty-five percent of disability pensions of degree III are paid as a consequence of mental illnesses.

Seriousness of the issue of mental illnesses may be documented using the data provided by the Institute of Health Information and Statistics of the Czech Republic (2012). Schizophrenia (diagnostic group F20–F29) is identified as the most severe mental illness. According to the Institute's data, in 2012, psychiatrists in outpatients' clinics treated 46,893 patients with this diagnosis, of which 4,970 were new cases. 107,273 persons (of which 19,219 were persons newly diagnosed as suffering from the illness) were treated for affective disorders (F30–39). In 2012, 11,058 hospitalisations in psychiatric residential treatment facilities were terminated for the F2 diagnosis and 5,032 hospitalisations for the F3 diagnosis. The average treatment time was 115 days (23 days in psychiatric wards of hospitals, 153 days in psychiatric hospitals) in patients with the F2 diagnosis and 42 days (26 days in psychiatric wards of hospitals and 56 days in psychiatric hospitals) in patients with the F3 diagnosis. 431 patients with the F2 diagnosis and 20 patients with the F3 diagnosis were dismissed after hospitalisation lasting more than one year. After termination of hospitalisation for the F2 diagnosis, subsequent residential treatment or residential social services were recommended in 12% of patients, permanent or temporary outpatient care was recommended in 78% of cases, and another type of care was recommended in 8% of cases; in mere 2% of cases, no subsequent care was recommended. After termination of hospitalisation for the F3 diagnosis, no subsequent care was recommended in 3% of cases. Therefore, the total numbers show that 154,166 persons with the F2 or F3 diagnoses were treated in 2012. We can estimate that 90% of persons in outpatient treatment for the F2 diagnosis and 30% of persons treated for the F3 diagnosis need subsequent health or social care.

Health, psychological and social factors substantially affect the level of handicap resulting from mental illness. Pressing social situation may materially affect the degree of demonstration of the illness. That is why support and assistance need to be complex, of bio-psycho-social character.

This disability may put users at a disadvantage in many areas, such as employment, social relations, leisure time, etc. Thus, close team interrelation of various professions is necessary, including interconnecting of the existing or newly created social and health care services. With a view to the complexity of needs as well as to the significance of the working alliance (relationship) as an instrument, we need a system of long-term case management.

Centres for Mental Health

Each Centre for Mental Health is a connecting link between primary care, including outpatients' psychiatric care, and residential treatment, both emergency and specialized. Its function is to prevent hospitalisations or to reduce their number, and to assist persons going through long-term hospitalisations in reintegrating into the community. To that end, each Centre for Mental Health creates necessary programmes, and within the framework of its catchment area, it functions as an interconnecting link between outpatient and residential treatment. The team of each Centre for Mental Health carries out case management and provides flexible, individualised service to all users indigent of its services within its catchment area without waiting periods.

In order to accomplish its main objective, which is the maximum social integration and social and clinical recovery of patients, each Centre for Mental Health cooperates as needed with other entities and services within its region, both specialized and designated for common population, in the field of employment, education, housing, leisure activities, etc.

Components of complex multi-disciplinary care oriented at the natural environment of the Centres for Mental Health are classified as evidence based medicine. This includes emergency intervention with demonstrable improvement in clinical condition, greater satisfaction with treatment, reduction of family burden, reduction of repeated admissions in hospitals, and dropping out of treatment compared to standard treatment (Murphy et al., 2012). Then, it is assertive community-based treatment which demonstrably decreases the frequency of relapse of mental diseases and need for hospitalisation, which in turns results in stabilisation in the area of housing, employment, and increasing satisfaction of patients (Marshall et al., 2011). Supported employment is another system applied which has been proved to increase employment of persons suffering from mental illnesses (Kinoshita et al., 2013).

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2. Services provided by the Centre for Mental Health (CMH)

I. Target group

1) Patients suffering from severe mental illness (SMI – Serious/severe Mental Illness)
Characteristics of SMI:
a) diagnostic domains (F2, F3, or, as the case may be, F4 and F6)
b) duration of illness (more than two years)
c) functional impairment (GAF score $\leq$ 70, where GAF is a clinical instrument for overall assessment of the current degree of incapacitation) (adapted according to Ruggeri et al., 2000)

A CMH provides long-term care including psychiatric and social rehabilitation.

2) Patients with the need of early intervention, i.e., patients with the risk of development of SMI.
The objective of the CMH is early diagnostics of illnesses and prompt start of treatment.

3) Patients with acute mental problems and patients in crisis situations not requiring hospitalisation. Acute conditions or decompensation of chronic psychiatric illnesses, usually from diagnostic domains of F2, F3, F4, F5 and F6.

The objective of the CMH is short-term intervention and referral for further care/treatment.

II. Minimum scope of services provided by the multi-disciplinary team of the CMH

Multi-disciplinary team
Any and all services of the CMH are provided by multi-disciplinary teams. These consist of professionals of various expertise – please see Personnel Criteria for details – cooperating very closely with one another. All team members carry out outpatients' as well as outreach work, share users/patients, continuously share significant information, and carry out most of their interventions in the users/patients' natural environment.

Services provided:

A) Mobile services – for target groups 1 and 2
Services are provided through mobile multi-disciplinary teams in the patients' natural environment, but also in institutions where they are currently places, such as in psychiatric hospitals, prisons, and institutions, for the purpose of preparing them for discharge. These services have the character of long-term care in the form of psychiatric and social rehabilitation, and may

include provision of crisis intervention in the SMI patients' homes as well as scheduled early intervention in persons suffering from illnesses not yet diagnosed or currently not treated. The main objective of mobile services is the provision of care in users' natural environment and prevention of conditions requiring hospitalisation.

B) Day services – for target group 1

The CMH operates a centre of day activities for SMI patients aimed at their support and social rehabilitation. Day services are available for the minimum of 10 hours a day and include both structured activities and space for leisure activities. The CMH also operates or provides for services of a day centre with psychotherapeutic programme.

C) Emergency services

Emergency services are available 24/7, are organized as drop-in services, and are interconnected with other health and social services within the CMH's area.

The objective is to provide consulting services or short-term intervention and referral for further care. Emergency intervention is provided either within the CMH, or over the telephone. For critical conditions, the CMH disposes with 2 to 8 beds for short-term stabilisation placement lasting up to ten days.

D) Other services

Within the framework of the CMH, outpatients' treatment services in the field of psychiatry and clinical psychology are provided. These are determined in particular for patients from target groups 1 and 2. Patients from target group 3 are only provided outpatients' services temporarily, until further referral.

3. Personnel Criteria

The CMH is a health care and social service facility disposing with the personnel and technical resources adequate for the provision of services for the target group of the SMI persons within the catchment area of 60,000 through 140,000 inhabitants, which corresponds to 120 through 280 registered users/patients. The number of team members of the CMH depends on the number of users/patients to which the team provides its services. The size of the region and thus, the number of users/patients have both an upper and a lower limit in order to provide for optimum and efficient functioning of the CMH team. The outreach team member : registered users/patients ratio is expected to be 1 : 20[1].

A catchment area with 100,000 inhabitants and 200 registered users/patients is the reference value. The CMH personnel standard for a catchment area so defined is 9 general nurses and 9 social workers/workers in social services. For catchment areas with lower numbers of inhabitants or registered users/patients, or at the time of the very establishment of the CMH, the number of personnel (nurses and personnel providing social services) may not be less than 7/7. The number of psychiatrists and clinical psychologists as specified below is obligatory under all circumstances.

The fixed number of 6 nurses and 2 social workers/workers in social services is required for providing for the day-to-day operation of the crisis centre and the day activities centre, and 10 workers in the positions of nurses, social workers, and workers in social services are required for direct outreach work.

Personnel providing health services for a catchment area with 100,000 inhabitants:
Personnel providing health services ……total of 11.5 fulltime loads

Psychiatrist[2] 1.0 fulltime load

- employed by the CMH, member of the multi-disciplinary team
- satisfies the requirements pursuant to the provisions of Section 5 of Act No. 95/2004 Coll.

Psychiatrist 0.5 fulltime load

- need not be employed by the CMH, may be employed elsewhere, provides on call services outside working hours for the crisis centre
- satisfies the requirements pursuant to the provisions of Section 5 of Act No. 95/2004 Coll.

Clinical psychologist[2] 1.0 fulltime load

- employed by the CMH, member of the multi-disciplinary team
- satisfies the requirements pursuant to the provisions of Section 22 of Act No. 96/2004 Coll.

[1] Except for psychiatrists and clinical psychologists.
[2] At least one employee of the CMH with specialization in psychiatry or clinical psychology must satisfy the requirement for complete psychotherapeutic qualification (in systemic psychotherapy).

General nurse[3,4] 9.0 fulltime loads

- employed by the CMH, member of the multi-disciplinary team
- satisfies the requirements pursuant to the provisions of Section 5 of Act No. 96/2004 Coll.

Personnel providing social services for a catchment area with 100,000 inhabitants:
Personnel providing social services ……total of 9.0 fulltime loads

Of which:
Social worker[5,6,] minimum of 5.0 fulltime loads

- employed by the CMH, member of the multi-disciplinary team
- satisfies the requirements pursuant to the provisions of Section 110 of Act No. 108/2006 Coll.

Worker in social services[5,6] maximum of 4.0 fulltime loads

- employed by the CMH, member of the multi-disciplinary team
- satisfies the requirements pursuant to the provisions of Section 116 of Act No. 108/2006 Coll.

[3] Minimum of 6 fulltime loads of nurse with specialization of psychiatric nurse. A nurse without the specialization of a psychiatric nurse may supplement this specialization during three years after the execution of the employment agreement with the employer. A similar situation within social services may be referred to, as pursuant to the provisions of Act No. 108/2006, workers must supplement their qualification within 18 months following the commencement of their work in the social service.
[4] One of the workers qualified as general nurse or social worker specializes in working with persons with dual diagnosis.
[5] One of the workers qualified in compliance with the provisions of Act No. 108/2006 Coll. works as a peer consultant. This requires such worker's own experience with an illness from the SMI domain, their stabilized condition, and maintaining the uniqueness of their role – they may not conduct any other profession within the CMH team.
[6] One of the workers qualified in compliance with the provisions of Act No. 108/2006 Coll. specializes in the issue of employment of persons suffering from SMI.

4. Material and technical criteria

I. CMH structure and equipment of premises

a) Crisis centre

- admissions/ambulance department = nurses' room
- residential part – the minimum of two rooms equipped with beds, with the maximum of two beds per rooms
- day room – may be shared with the day activities centre
- *other facilities specified below*

b) outreach services

- the minimum of one office
- the minimum of one consulting room

c) day centre (DC) and day activities centre

- a room for group psychotherapy
- the minimum of one day room

d) a psychiatrist's office

e) a clinical psychologist and psychotherapist's office

f) a room for team meetings – *the day centre may be used*

g) other premises and facilities, pursuant to the provisions of Decree No. 92/2012 Coll., on requirement for minimum technical and material equipment of health care facilities and contact workplaces for home care and other valid standards – hereinafter referred to only as Decree No. 92/2012)

- for users – bathroom, kitchen, toilet, waiting room
- for personnel – bathroom, toilet, storeroom
- management office
- janitor room

II. Material and instrument equipment

a) rooms described under item I. above to be equipped with adequate furniture

b) instruments and other equipment – adequate equipment enabling provision of mobile outreach services, sharing of information, safety or workers and users

Notes

This standard only sets forth the minimum requirements for premises and material equipment. The actual equipment will differ according to the specific type of the CMH. Differences in types of CMH may be based on the following:

- size of the catchment area
- type of region (mountain area, urban conglomeration)

- organization of the CMH – for instance, a day centre may constitute a part of the CMH, or may be operated by another entity based on a contract

Typically, the CMH is operated based on teamwork – thus, the premises must be equipped correspondingly, for instance, sufficient space for meetings of the team and cooperation of workers must be available.

The minimum area of the rooms is governed by the provisions of Decree No. 92/2012.

Examples of instrument and material equipment and supply:

- a compact passenger vehicle, a larger vehicle – a van/microbus;
- computers + SW, mobile telephones, landlines, internet connection
- electronic security system, connection to a central protection counter, video surveillance system
- health care equipment – tonometer, stethoscope, thermometer, scale, bag valve mask, (defibrillator);
- cupboard/storeroom for pharmaceuticals …
- online system for information sharing
- medical material and pharmaceuticals; janitor material

5. Organisational criteria

The Centre for Mental Health is established by a legal entity.

The CMH has valid organization rules.

The CMH has defined and publically accessible written rules setting forth the following:

- the target group
- the CMH's catchment area
- the process of admissions and discharges
- processes for sharing and provision of information within the CMH
- powers and responsibilities of the individual workers of the CMH
- method of cooperation with all relevant entities within the CMH's catchment area

In the event the establishing entity conducts other activities outside the CMH, the CMH must be a separate centre as far as the accounting is concerned.

The spectrum of CMH's services is provided by employees employed by the CMH's establishing entity.

The specific managerial structure depends on the establishing entity's decision but needs to have sufficient capacity for strategic, financial, personnel, and operational proceedings in order to avoid overloading of workers working directly with the CMH's users with organization-related and administrative tasks.

The management is also liable for planning and assessment of activities, including inspecting of quality in compliance with the mission and objectives of the CMH.

The CMH approaches all relevant entities providing health care and social services within its region in order to establish systematic cooperation. It is desirable to enter into agreements on cooperation with such entities, while defining mutual competences, follow-up services, and coordination of services as well as methods of resolving disputable situations.

The CMH initiates establishment of a regional working group in cooperation with the regional or local administration in order to enhance systematic coordination of services for persons with mental illnesses.

The CMH is validly registered as a social rehabilitation service provider for the social field of its activities pursuant to the provisions of Section 70 of Act No. 108/2006 Coll., on social services, or, as the case may be, as a provider of other social services pursuant to the specified act.

6. Other criteria

The CMH is located within common residential areas, outside hospitals.

The CMH must:

- participate in pre-gradual and post-gradual education of practitioners, clinical psychologists, psychiatric nurses, and social workers;
- participate in education of workers of other social services cooperating with the CMH;
- create a program of continuing education for its doctors and health workers and social workers;
- participate in educational and information activities for the population;
- participate in researches of mental disorders;
- regularly send its data into the information database established for monitoring the care in the CMH;
- regularly inspect the quality of the CMH using quality assessment instruments within the framework of the individual activities of the CMH.

Required numbers of patients treated or of deliveries provided:

- The minimum of 150 patients per year in the continuous care of the multi-disciplinary team.
- The minimum share of direct work of specialized workers with users/patients at 50% in their overall engagement.
- The minimum share of direct work of specialized workers with users/patients conducted in their natural environment (not within the premises of the centre) at 50%.
- The data entered in the relevant information database are decisive for assessing the centre's performance.