Standards for the mental health care of people with severe psychiatric disorders in South Africa:
Part 1. Conceptual issues

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ABSTRACT

Part one describes conceptual issues underlying the development of South African standards for people with severe psychiatric disorders. Mental health care standards seek to describe what is an acceptable and adequate quality of mental health care for service users. A focus on service quality is especially crucial in resource constraint contexts. Standards are essential tools for quality assurance, advocacy and rights protection, capacity and management development and dialogue. They should be appropriate, useful and patient-centred, and operationalise local policy and legislation. Mental health standards are a challenge to define, and need to combine both a consumer and rights based approach. International and local standards and views were adapted and included in order to develop these standards which should be applicable, measurable and gradable across all South African contexts.

Keywords: Standards; Mental health care; South Africa; Conceptual

National and provincial departments must publish standards for the level and quality of services they will provide, including the introduction of new services to those who have previously been denied access to them.
(Batho Pele)[1]

Introduction

This two-part series developed out of a tender awarded by the national Department of Health to develop norms and standards for mental health care for people with severe psychiatric conditions (SPC's) in South Africa.[2,3]

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This series addresses only the standards aspect of the tender. Several papers in which the norms aspect were reported have already appeared.[4,5,6,7,8,9]

This first part of this series explores some general conceptual issues that informed the development of the standards. The second part[10] focuses more specifically on the process and results of developing standards for people with severe psychiatric disorders in South Africa.

Mental health care standards seek to describe what is an acceptable and adequate quality of mental health care for service users. Standards therefore aim to improve quality of care, while guiding and facilitating the movement towards service reform and transformation objectives.[11]

The functions of standards

Standards can have a range of functions. First, they can serve as a quality assurance tool. The development of standards, and the consultation process involved in doing this, may encourage a process of negotiation and

discussion on what constitutes essential aspects of treatment and rehabilitation of South Africans with SPC's.

Second, they can function as an advocacy tool. Standards may be used to highlight practices that are currently unacceptable due to limited resources or apathy, and hence may function as an advocacy tool to motivate for greater funding allocation, performance and increased service equity.

Third, they can function as a statement of rights and responsibilities. Standards can emphasise the inherent rights of SPC users, and their need for assertive protection from abuse and neglect. Standards can also outline users' responsibilities towards the health services. Clear standards, based in a culture of rights and greater democratisation within the health service, can be an empowering tool for users, their caregivers, communities and consumer groups.

Fourth, they can serve as a training and human management tool. Although primarily user centred, it is recognised that user care also depends upon a sufficiently humane, supported and adequately skilled health service provider. Standards also serve to acknowledge the efforts of service providers who have managed to sustain acceptable quality of care, despite limited resources. Standards therefore may be used both for health provider training and human management planning.

Finally, they can be used as a tool for dialogue and awareness. A standards development process can begin to open up dialogue touching upon powerful unarticulated rules and beliefs within the health service. Dialogue, innovative thinking and greater awareness of quality, rights issues, and services, may be seen as a powerful mechanism for change and greater coordination and mutual vision.

Background

Historically health standards development has its roots in quality assurance processes. These emerged out of accreditation mechanisms developed since the 1960's by the Joint Commission for Accreditation of Health Care Organisations (JCAHO) in the United States.[12] Standards have therefore been linked to the evaluation and assessment of service quality, as a component of a boarder quality assurance strategy.[13]

Currently quality assurance, including standards development, is increasingly being used in the control and evaluation of services for managed care.[14] There has also been a shift or evolution from quality assurance to more "dynamic" quality improvement or performance improvement models.[15] Standards are therefore increasingly embedded in ongoing managerial processes. Standards development can create a heightened awareness about components and quality of care. The emphasis here is not evaluation of services or performance as an end point in itself, but the development of local standards and criteria as a quality improvement process.

Although quality assurance processes have their origins in first world market driven economies, it has

been emphasised that service quality is applicable, and indeed essential, for less resourced, developing countries.[16] The World Health Organisation began to endorse this approach as internationally applicable, and since the 1990's, have been developing practical guidelines and tools for quality assurance.[17]

> *At first glance high quality services appear to be a luxury beyond budgetary limits at most LDC [less developed countries] health systems. However, improving quality often does not cost, it pays…a fact that health managers with restricted budgets cannot afford to ignore.[16]*

The JCAHO historically viewed standards for psychiatric hospitals as distinct from medical/surgical health care establishments.[18] Standards of care for mental health and psychiatry are potentially difficult to describe and quantify. This related to the "soft" nature of some of its key domains, for instance interpersonal relationships and empathy. There has also been little research to evaluate different types and models of mental health care, and thereby develop a strong database of empirical best-evidence or practice research.[19]

With a greater emphasis upon the process of standards development, value has also been placed on the consultative, as well as the empirical nature of standards development.[18] The proposed standards presented in Part 2 of this series have been the product of research as well as a broad national consultative process. We hope that the standards may be "owned" by various stakeholders, and therefore function as both a quality assurance and health charter or advocacy tool.

Vision and ideology

The international development of standards of health care, as used in this project, can be linked to two global social trends and ideologies. The first is the development of practical tools associated with the growth of consumer demands for quality and choice in a competitive free market economy, and the second is the development of charters associated with various democratic citizen rights.

The development of rights charters to empower South African citizens is enshrined in the constitution (Section 234, Constitution of the Republic of South Africa), and has a long political history in guiding political action in this country. A health charter, and therefore mental health charter, assists the public health sector to listen to the views and needs expressed by local health users; develop a set of norms and standards; improve the quality of relationship between users and providers; increase the levels of acceptability and transparency; decrease corruption and malpractice; and transform and democratise.

Although these two ideological forces, that is consumer and rights-orientated approaches, have at times been regarded as diametrically opposed to each other, the current state and public service policy supports an

uneasy co-existence. Few people with severe psychiatric conditions have the finances to purchase mental health care, and the majority of South Africans rely on subsidised or free state services. A consumer or customer-based model of social empowerment therefore does not reflect the reality of the majority of service users with SPC's, who are economically and socially vulnerable. It is therefore important to emphasise users' basic rights to adequate care, and means of advocacy and social or political action to achieve this (e.g. lobbying and public education and awareness).

A clear rights-based approach has been adopted by both the new Mental Health Care Act (Act 17 of 2002)[20] and the recently released National Health Act (Act 61 of 2003).[21] Furthermore, both pieces of legilslation make provision for regulations to develop service standards, while the National Health Act (2004) proposes an "Office of Standards Compliance" (Section 78) to enforce or facilitate these within the public and private sector.

The Batho Pele or White Paper on Transforming Public Service Delivery[1] has replaced a rights-based focus with a market-orientated framing of the "customer" within the public service. This "customer ethic" stresses that the public service must listen to their views and take account of them when making decisions about what services should be provided; treat them with consideration and respect; make sure the promised level and quality of service is always of the highest standards; and respond swiftly and sympathetically when standards of service fall below the promised standard.

The proposed standards[2] therefore seek to address both quality assurance and charter aspects. It has also highlighted the role and impact of power and local politics to achieve the best possible quality of care. Thus, the standards are policy and context specific. To be effective they must address the specific political and social context in which care is delivered, such as provincial and district health management structures. The proposed standards seek also to reflect an ethic of care in our services which recognises the need for user participation and empowerment; is based on principles of equity and human rights; is caring, just and humane; recognises the desire of all South Africans to live in a dignified manner; and recognises the resource limitations of the public services.

Evaluating standards and criteria

How do we measure the "standard of the standards", and what are good standards and criteria? Good or adequate standards of care are those which are useful, and which may be instrumental in establishing better quality of care and greater protection for users against rights abuses. International guidelines for establishing standards specify that they should be patient/user centred; be desirable and measurable; be related to the quality of care patients/users receive and the environment in which it is delivered; represent an efficient and effective use of resources; reflect current professional thinking and practice; and be specific, measurable and achievable. However, in all standards development, there

is little empirical evidence to link the desired outcome with the standards developed.[18] Standards therefore require ongoing review and re-development, including greater fine-tuning of levels and goals of quality.

How much detail should there be in a standards document? There is surprisingly little literature and research to address this question. Our proposed standards include a fair degree of detail in some areas. The degree of detail developed in such a standards document is not, however, simply a matter of editorial preference. Detail is used strategically here to articulate and describe current practice goals or performance benchmarks. The level of detail will need to be directly proportional, therefore, to the level of development and quality of service delivery.

The degree of detail required in standards document development should be directly proportional to the risk that either poor care is likely to be delivered in this area, or the outcome or implication of poor care in this area (e.g. poor medication management). Many aspects of care which are most at risk of being undertaken poorly, or in manner which abuses user's rights occur in areas subject to little scrutiny or open public or professional discussion or discourse. Detail must address these areas of risk or vulnerability and items of strategic importance. Detail in these proposed standards is therefore related to the following: basic historical rights and ethical violations (e.g. Constitutional rights); degree of clarity for policy operationalisation (e.g. community participation); degree of authorised expectations in terms of quality expectations (e.g. integrated PHC care and language interpreting); the skills and knowledge base of providers in this area (e.g. assessments undertaken by generalist PHC providers); and scope for small, but significant, breaches in service quality and user rights (e.g. basic physical care for institutionalised users).

Defining quality of care

The search for quality in medicine is like searching for the perfect mother: approximates are found, the search continues, and hope endures. Realistically, the defining characteristics of medical quality change continuously.[12]

The project has set standard goals as the level of "adequate" care. Within the international literature on health quality, the comments and criteria for quality mental health care have been debated and problematised. There are three aspects by which quality can be judged: the science of health care that determines efficiency; individual values and expectations that determine acceptability; and social values and expectations that determine legitimacy.[11] It was our experience within the consultation process described in Part 2 of this series, that health care users and providers have little difficulty identifying what mental health care they want or would like to offer. Porteus[11] calls this "folk" knowledge of what constitutes good or adequate care

quality.

Beattie[22] argues that the definition of quality is therefore less important than "identifying the components of quality to be assessed and the objective of the assessment". In order to identify the scope of the standards developed, one may be guided by the international literature on indicator (qualitative and quantitative) development and components of care. Input, process, output and outcome indicators are most commonly developed categories for conceptualising and assessing quality of care. It terms of the conceptual developments of this study, standards need to be seen as addressing all these aspects care.

Outcome indicators have been proposed the most effective means of determining quality of care, although these are the most difficult to measure and evaluate.[23] Outcome variables include: patient and caregiver satisfaction[23]; alleviation of family burden[23]; social integration[23]; social adaptation[24]; quality of life[23]; general functioning[25]; and improved symptoms.[26]

Research has shown that in studies in patient satisfaction, the aspects of care that are most highly valued include empathy, collaborative treatment planning, match of provider skill to tasks performed, duration of care, and access and co-ordination.[27] Other dimensions of quality which need to be included in standards development are:[16] technical competence; access to services; effectiveness; interpersonal relationships; efficiency; continuity; safety; and amenities.

The American Medical Association describes elements of quality care, as the following:[16] emphasis on health promotion, disease and disability prevention, early detection and treatment; care provided in a timely manner, without inappropriate delays, interruption, premature termination or prolonging of treatment; seeking patient's co-operation and participation in decisions and the process of his/her treatment; base foundation of acceptable principles of medical science, and the skilful and appropriate use of other health professionals and technology; provide care which is sensitive to the anxiety and stress that illness can cause with concern for the patients and family overall welfare; use technology and other resources efficiency to achieve the treatment goal; and sufficiently document the patient's medical record to allow continuity of care and peer evaluation.

It is therefore important to include these internationally accepted domains and benchmarks of quality into local standards developments. International standards models must of course be adapted for the South African context. Issues that may inform the adaptations include: general economic and social development and infrastructure of South Africa (e.g., developing nation status, annual growth rate and poverty); resources and skills of the health and welfare sectors, and mental health care specifically (e.g., health budgets and skill pools); regional and social distribution of resources, including geographic and historic inequities; local health governance and service models (e.g., district health service); general political goals and targets (e.g., democratisation,

decentralisation and political economy); national and local values, attitudes and knowledge relevant to mental health care; general health and public sector policy and goals (e.g., policy documents for transformation of health, and the public services); and provincial and other local health and mental health policy, goals and programmes.

Setting level for quality of care

> *Service standards must be set at a level which is demanding, but realistic.* (**Batho Pele[1]**)

The question of the level at which to set the service standards is complex and contested. There are few precedents for the development of national standards. Existing studies focus on the development of institutional and organisational standards.[18] The key problem to be addressed in the development of national South African standards is the uneven spread of resources across the country. Different provinces and regions are therefore offering care in specific historical and economic contexts.

This dilemma may be addressed through two mechanisms, namely setting graded standards and criteria, and graded evaluations of service delivery. Each will be discussed below.

Setting graded standards and criteria
Batho Pele[1] suggests that:

> *..certain services, such as health or education, national departments, in consultation with provincial departments, may set standards which will service as national baseline standards. Individual provinces may then set their own standards, providing these meet or exceed the national baseline.*

Porteus[11] suggests the setting of two tiers of standards, "safety net, the level below which constitutes inhumane care", and "service transformation" or "target" standards. The notion of two standard levels requires, however, a process of evaluation and grading. The strength of this structure is the highlighting and prioritization of the most fundamental aspects of care. This links standards to rights based issues, and sets more realistic goalposts for areas with fewer resources.

Although there was substantial support for a grading system emerged during the process of developing the standards, it is clear that this cannot be simply implemented within the current document. The levels of standards proposed by different provinces were often informed by strategic considerations as opposed to objective or practical realities. For instance, poorly resourced provinces tended to set high standards in the hope that they would function more effectively as a lobbying tool for increased resources. It is clear that in order to grade standards meaningfully, it would be

necessary to apply a systematic and standardised process to the set of proposed standards for each province individually.

Graded evaluations of service delivery

Grading can occur in the rating and evaluation of the performance levels achieved on a specific criteria. Thus, the grading is part of the broader quality assurance process, rather than an integral component of the standards per se. For instance, a quality assurance checklist developed by the World Health Organisation[17] and piloted across ten countries contains a single set of criteria. An example of such a criterion is "Staff speak to patients in a friendly, positive and courteous manner". In order to evaluate a service, the performance on each criteria is rated: 0 = absent, 1 = partially present, 2 = fully present (or at times only 0 and 1 are scored). Composite and sectional scores can then be aggregated and turned into percentages, so that 80% is good quality care, fair quality falls between 60 and 79%, barely acceptable, between 40% and 59%, and unacceptable, below 40%. It may be said that "adequate" care, as defined by this project, may be said to fall within the "fair" range of care.

The Australian "National Standards for Mental Health Services" use this graded evaluation.[28] The performance level on each criterion is graded and recorded on specially developed checklists. Ratings are:

A.   Attained
AP.   Attained Partially
AI.   Attainment Initiated
UA.   Unattained
NA.   Not Applicable

Uys et al.[29], in the only local example of psychiatric service quality assurance evaluation, uses a similar approach. The standards and criteria they developed emerged from existing literature as well as active review by representative consumers in KwaZulu-Natal. The instrument developed from this process was used in a sample of ten clinics over a four-month period. Consumers rated the service. It is worth noting that the overall weighted average quality of care for the province was 46%, The highest figure was 74% for staff attitudes, and funding research and development were lowest at 14%. The average standards of direct service provision was 58%. The study appears to have scored services according to whether they are found within a setting or not. It does not however stipulate what levels are "acceptable", but uses an overall scoring across standard and substandard to develop a comprehensive picture of the weaknesses and strengths of a service. For example, under Substandard B, "Every patient receives optimal bio-psycho-social treatment based on a comprehensive assessment and accurate diagnosis", the scored criteria ask, "Assessment, diagnosis and treatment are provided at the nearest clinic (etc)"

These international and local examples have been included here to demonstrate the manner in which a service's ability to achieve a particular standard or criteria can be built into the evaluation process, rather than the actual standards themselves. However, it is not quite as clear cut. A careful balance is still required between the level at which a standard is pitched and the expectation that it should be achieved. It may be argued for example, that an overall performance score of 46% for KwaZulu-Natal services indicated that the standards were too high, rather than the service is too poor.[29]

Standards levels and policy expectations

Standards and criteria should also be consistent with current South African health and mental health policy developments. Health policy inevitably tends to be somewhat idealistic. Standards may be seen as the basis by which policy may be translated or operationalised into reality for the mental health services. The gap between health policy and "reality" inevitably impacts upon the level of standards developed.

The standards developed in this project express this "idealism" most clearly in areas of progressive transformation emphasised by current health policy. This includes, areas of service equity, integrated care, and patients' rights, language policy, and user, caregiver and community participation. It also appears in service delivery interventions that fall outside direct curative services, e.g. rehabilitation, prevention and promotion. Baseline standards in these areas will inevitably seem unrealistic for many provinces, and beyond their service resources. The position taken by this study, however, is long-term and comprehensive. It is recognised that greater resource allocation in the "soft" areas, such as adequate discharge rehabilitation and support to patients and caregivers, will have long-term treatment outcomes and cost benefits.

Conclusion

Some of the debate around the level or form that a standard or its' evaluation takes must not submerge the basic premises and goals of the development of standards: the development of standards and criteria should be a mechanism to improve service quality; the best care and interests of the patient should be prioritised in decisions about acceptable levels of care, as opposed to currently available resources; and standards seek to guide the health services to greater national equity.

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that your valuable inputs, time and effort shall see fruit in the further development and implementation of these national norms and standards.

References

1. Republic of South Africa Department of Public Service and Administration, The White Paper on Transforming Public Service Delivery (Batho Pele White Paper). Notice 1458, Vol 338, Government Gazette, 1997.

2. Flisher AJ, Lund C, Muller L, Tongo N, Dartnall E, Ensink K, et al. Norms and standards for services for South Africans with severe psychiatric morbidity. Report to the Directorate: Mental Health and Substance Abuse, Department of Health, Republic of South Africa. Cape Town: Department of Psychiatry, University of Cape Town, 1998.

3. Lund C, Ensink K, Flisher AJ, Muller L, Robertson B, Dartnall E, et al. Facing the absolute need: norms and standards for severe psychiatric morbidity in South Africa. S Afr Med J 1998;88:1480-148.

4. Lund C, Flisher AJ, Lee T, Porteus K, Robertson BA. A model for estimating mental health service needs in South Africa. S Afr Med J 2000;90:1019-1024.

5. Lund C, Flisher AJ, Porteus K, Lee T. Bed/population ratios in South African public sector mental health services. Soc Psychiat Psychiatric Epidemiol 2002;37:346 - 349.

6. Lund C, Flisher AJ. Hospital/community ratios in South African mental health services. Journal of Mental Health Policy and Economics 2003;6:181 –'96 187.

7. Lund C, Flisher AJ. South African mental health process indicators. Journal of Mental Health Policy and Economics 2001;4:9-16.

8. Lund C, Flisher AJ. Staff/bed and staff/patient ratios in South African public sector mental health services. S Afr Med J 2002;92:157 - 161.

9. Lund C, Flisher AJ. Staff/population ratios in South African public sector mental health services. S Afr Med J 2002;92:161 - 164.

10. Muller L, Flisher AJ. Standards for the mental health care of people with severe psychiatric disorders in South Africa: Part 2. Methodology and results. S Afr Psychiatry Rev 2005 (in press).

11. Porteus, K.A. Considering service standards: lessons drawn from a quality of care assessment study. Johannesburg: Centre for Health Policy, University of the Witwatersrand, 1997.

12. Fauman, M. Quality assurance monitoring in psychiatry. Am J Psychiatry 1989;146:1121-1130.

13. Elliot, R. Applying quality improvement principles and techniques in public health systems. Hosp Commun Psychiatry 1994;45(5):439-443.

14. Society for Education and Research in Psychiatric-Mental Health Nursing (SERPN). Quality indicators for primary mental health within managed care: A public health focus. Unpublished document, 1997.

15. Klegon, D. JCAHO mental health care network accreditation as a performance improvement project. Psychiatr Serv 1997; 48:359-363.

16. Brown, L, Franco L, Rafeh N, Hatzell, T. Quality assurance of health care in developing countries. Quality assurance project. Unpublished, 1997.

17. Bertolote, J M. Quality assurance in mental health care. In Sartorius N , (ed). Treatment of mental disorders: A Review of effectiveness. Geneva: World Health Organisation and American Psychiatric Association, 1994:443-461.

18. Valentine N, Kayne P, Chapman M, King K, Dahl S. Developing psychiatric nursing standards in a changing mental care system. Psychiatry Quart 1994;65: 221-241.

19. Smith G, Manderscheid R, Flynn L, Steinwachs D. Principles for assessment of patient outcomes in mental health care. Psychiatr Serv 1997;48:1033- 1036.

20. Republic of South Africa Department of Health, Mental Health Care Act (No 17 of 2002), Notice 24024, Vol 449, Government Gazette, 2002.

21. Republic of South Africa Department of Health, National Health Act (No 61 of 2003), Notice 26595, Vol 469, Government Gazette , 2004.

22. Beattie A. Cost and quality in the delivery of primary health care: Evidence for South Africa. Unpublished PhD Thesis. University of London, 1996.

23. Russo J, Roy-Byrne P, Jaffe C, Ries R, Dagadakis C, Avery D. Psychiatric status, quality of life and level of care as predictors of outcomes of acute patient treatment. Psychiatr Serv 1997;48(11: 1427 –'96 1434.

24. De Bruyn T. Quality care and outcome indicators in the mental health field: A guide to the lliterature. Ottawa: Health Canada;1994.

25. Smith G, Manderscheid R, Flynn L, Steinwachs D. Principles for assessment of patient outcomes in mental health care. Psychiatr Serv 1997;48:1033- 1036.

26. Srebnik D, Hendrynx M, Stevenson J, Caverly S, Dyck D, Cauce, A. development of outcome indicators for monitoring the quality of public mental health care. Psychiatr Serv 1997;48 (7): 903-909

27. Ingram B, Chung R. Client satisfaction data and quality improvement planning in managed mental health organisations. Health Care Manage Rev 1997; 22:40-52.

28. Australian Health Minister's Advisory Committee National Mental Health Working Group. National Standards for Mental Health Services. Canberra: Mental Health Branch, Department of Health and Family Services, 1996.

29. Uys LR, Tandjekwayo L, Volkwyn L. Measuring the quality of public psychiatric care. Unpublished Document. Durban: Health Systems Trust, 1996.