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Standards for the mental health care of people with severe psychiatric disorders in South Africa: Part 2. Methodology and results

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ABSTRACT
Objective: Mental health care standards have been developed to describe what is an acceptable and adequate quality of mental health care for service users in South Africa. Part two describes the standards development methods, the range of standards developed and, as an example, the rights and protection standards domain. **Methods:** a systematic literature review and broad consultation to develop a set of normative- based standards. Consultation included widespread draft document distribution/feedback, in-depth provinical workshops, and focus groups. Structually, detailed criteria and sub-criteria were developed for measurability and adequate detail in key service areas. **Results:** Three types of standards were developed: core standards, standards for service delivery and for specific settings. Standards to ensure the rights and protection of varied service users within a range of contexts are described. **Conclusion:** A standards document is an essential component of a quality improvement process, within the context of a supportive legislative, political and managerial framework.

Keywords: Standards; Mental health care; South Africa; Methodology, Results

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Introduction

In the first part of this two-part series, a number of conceptual issues regarding the development of standards for the mental health care of people with severe psychiatric disorders in South Africa were addressed.[1] This part presents the methods that were followed to develop standards, and the results of the process.

Methods

Systematic literature review

The following methods have been used to locate literature involving standards:

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- searching the MEDLINE and PSYCHINFO data bases;
- hand searching all issues of the following journals in the past decade: Acta Psychiatrica Scandinavica; American Journal of Psychiatry; British Journal of Psychiatry; Psychiatric Services (previously Hospital and Community Psychiatry); and Psychological Medicine;
- scanning the reference lists in articles already located; and
- suggestions from colleagues

In addition, unpublished national health and organisational standards from other countries were included. Documents were obtained from Australia, England and Wales, Scotland, and Canada. It was necessary to cast the net rather widely since important material appears in literature in fields such as mental health policy, human rights and rehabilitation.

The preliminary set of standards of care drew heavily

on this international literature and the clinical experience of the research team.

Consultation with provincial mental health managers
The preliminary set of standards was mailed to the mental health managers in each province who were requested to discuss the document with other key provincial role players. Each province was visited with a view to intensive discussions, to ensure that the proposed set of standards is acceptable to managers in each province.

Consultation with other experts and stakeholders
The preliminary set of standards was circulated (by e-mail and snail-mail) to a wide range of individuals and organisations, with a request that they discuss the document within their organisations (where appropriate) and inform the research team of any recommendations or opinions. Over two hundred documents were distributed in this way. Consultation has been as broad as possible, within the constraints of the project's time and resources. The following people and organisations were approached: professional academic departments (e.g. occupational therapy, psychiatry, nursing and social work); professional organisations, statutory bodies, and trade unions; relevant service organisations, agencies and NGOs (e.g. Cape Mental Health Society); health and mental health advocacy groups (e.g. Health and Human Rights Project); gender and human rights groups/ commissions; consumer groups (the project has a page on the only consumer website in South Africa); and key experts or organisations in specific areas, e.g. health systems research, anthropology, law, and religion.

A broad group of professional's knowledge and skills were brought to bear upon the development of the standards document. This has occured both in term of the research team's professional compliment, but also in terms of groups and individuals who participated through post based document distribution, local task groups and provincial meetings. This breadth is appropriate not only in terms of the full range of clinical disciplines, but also the multilayered nature of mental health aetiology and human experience.

Task groups
Task groups were established to provide input in selected areas which required specific expertise or would benefit from more intensive examination. Each task group developed ideas for a specific section of the preliminary set of standards. Eight groups were established and were facilitated by members of the Department of Psychiatry and Mental Health at the University of Cape Town.

Each group had between eight and fifteen members of diverse professional backgrounds. One meeting of about ninety minutes was held. The recommendations and conclusions developed in the meetings were incorporated into the final proposed document. In addition, some task group members were requested to comment on the later draft of the document (e.g. rights development) The task groups addressed the following domains: Emergency Psychiatric Services (all levels of care); Rehabilitation and Community Living; Medico-legal & Human Rights; Language and Cultural issues; Health and Physical Care; and Pharmacology and Medication

Provinces at the provincial workshops were also encouraged to select key areas not covered during the visits, and hold local task groups to address these. These results were then posted or faxed later to the team. Two task groups were also run in Gauteng by the Centre for Health Policy staff covering Psycho-social rehabilitation and Medication management. Finally, staff at the Red Cross Children's Hospital's, Child and Family Unit also attended a meeting to give feedback on aspects of the Draft applicable to child and adolescent mental health care.

Formulation of proposed standards
A final set of proposed standards was produced taking all the above aspects into account including the data from the above sources, namely the literature review, including standards developed in other countries; opinions of provincial mental health managers and providers; consultations with other key stakeholders; and the deliberations of the task groups.

A first draft of a standards document was prepared by the authors, based on their clinical experience and the literature review (including unpublished national health and organisational standards from other countries). This first draft formed the basis of the subsequent consultation process. Once consensus hasd been reached within the research team about a proposed change to the document, the change was immediately incorporated in the document. The revised version then formed the basis of the remaining consultation process. Thus, the document was continually modified in an iterative manner until the final version, which was submitted to the Department of Health in accordance with the tender requirements.

Results

Sources for the development of the proposed standards
The first draft of the standards document was shaped primarily by the Australian National Standards for Mental Health Services.[2] These standards guided the initial structure of and concepts in the document, including most of the basic standard domains, e.g. rights, safety, consumer and carer participation, privacy and confidentiality and cultural awareness. Our project was influenced by the strong progressive emphasis within the Australian standards document,[2] such as partnerships and collaboration with patients/users, caregivers and the community.

The Australian standards document was developed between October 1995 and October 1996.[2] They emerged out of a broad initiative started in 1992 to develop a National Mental Health Policy, and the final standards emerged out of clear policy guidelines, service model development and consultation.[3] The Australian standards address a vertical mental health service, and although

they stress continuity of care and integration with specific standards, they do not appear to operate within the same model of primary health service integration as South Africa.

Other standards guiding the process were the Kings Fund Organisational Audit[4], the document produced by the World Health Organisation entitled "Quality Assurance in Mental Health Care: Check List & Glossaries, Vol 1"[5], and the only local version located, by Uys et al.[6]

The structure of the proposed standards has also been based upon suggestions from the World Health Organisation.[7] This includes the use of three levels of standards: key issues and principles in national and local mental health policy; specific mental health programmes and settings (e.g. impatient facilities); and specific interventions (e.g. psycho-pharmacotherapy) or the management of specific disorders (e.g. schizophrenia).

The structure of the standards

The standards presented here have been divided into three sections: Core Standards; Standards for Service Delivery; and Standards for Specific Service settings. Core standards cover those ethical and general policy related aspects, which guide and underpin services at all levels of care. Service Delivery and Specific Setting standards focus upon specific service practices and the sites in which they occur. Table I provides the domains for the proposed standards.

TABLE I: Domains of standards for the care of people with severe psychiatric disorders in South Africa

Core Standards
- Rights and legal protection
- Safety and Risk management
- Access
- Privacy and confidentiality
- Personal interaction and communication
- Treatment and support environments
- Patient and caregiver participation
- Community participation and development
- Community living
- Mental health promotion and prevention
- Language, culture and context
- Resource management and affordability
- Service development
- Documentation
- Provider training and support

Standards for service delivery
- Entry and admission
- Emergency care
- Screening, assessment and review
- Treatment, care and therapies
- Medication and other technologies
- Psycho-social therapies rehabilitation
- Discharge and re-admission

Standards for specific settings
- Hospital Care
- Primary Health Care
- Supported accommodation and group homes

The standards, criteria and sub-criteria

As mentioned in Part 1 of this series[1], standards are qualitative statements, which describe acceptable and adequate service performance or provision. They outline the essential aspects of care for the treatment and rehabilitation of people with SPC's.

For each standard, there are a number of more detailed criteria. Criteria describe and explain what needs to occur, or be in place, to reach that standard. The criteria provide greater detail in particular areas where there is little clear policy or guidelines (e.g. language interpreting), or in areas where there is a need to emphasise specific neglected aspects of care, (e.g. user's rights and physical environments). The criteria here have been developed so as to describe the general principle and domain of evaluation or care. The criteria in this project have accompanying sub-criteria.

The sub-criteria function in a number of ways. They can: elaborate on frequently overlooked or neglected aspects of care that need to be addressed; elaborate on mechanisms or processes which may need to be in place in order to achieve a criterion - in this sense they may describe steps to achieve a standard; and describe aspects of care which may be a target of higher level of care. Sub-criteria provide additional detail to the proposed standards which hope to address the range of contexts and processes which need to be addressed in order to develop quality of care. Sub-criteria provide a resource for the development of more local, context specific standards documents (e.g. at provincial or institutional level), or may be used for teaching purposes.

The full set of standards, with their criteria and sub-criteria, are available from the Department of Health. By way of example, the standards, criteria and sub-criteria for the domain of rights and protection are presented in Appendix 1. The standards, substandards and criteria for the reaming domains will appear as a supplement to a subsequent edition of *"South African Psychiatry Review."*

Discussion

The standards, criteria and sub-criteria produced in this study are normatively derived, that is, they have been recommended based on the judgement and experience of a group of people guided by international and local literature. They are not strictly empirical, in that they did not emerge out of mental health service research conducted in South African mental health services. Although empirical research has guided service models underlying the standards, criteria and sub-criteria, the study has rather emphasised broad-ranging stakeholder consultation in their development. This is in keeping with the Batho Pele[8] principles of consultation for standards developments. They reflect the perspectives of mental health workers and academics, consumers, caregivers and welfare and other agencies or NGO's.

It is necessary to emphasise that the standards, criteria and sub-criteria developed for this tender are applicable only to services for people with severe psychiatric disorders. Clearly, they are generally applicable to services for people with psychiatric disorders of a less

severe nature, but they were not developed with the full range of services in mind. A separate set of standards has been developed for substance dependence in-patient centres.[9] The standards, criteria and sub-criteria were developed for public mental health services in South Africa, as this is the sector for which the Department of Health is responsible. There is no reason to think that they would not be applicable to services provided in the private sector, although additional standards might be necessary for the private sector to address financial and contractual issues.

Conclusion

It is beyond the scope of this paper to describe the process of standards implementation. The WHO has developed a set of guidelines to inform quality improvement for mental health services.[10] The guidelines are organised in the form of seven cyclical steps: align policy for quality improvement; design a standards document; establish accreditation procedures; monitor the mental health service by using the quality mechanisms; integrete quality improvement into the ongoing management and delivery of services; consider systematic reform for the improvement of services; and review the quality mechanisms. A standards document cannot therefore stand alone, but is an essential component of a quality improvement process. Such a process must however be supported by clear legislative and policy guidelines, practical quality assurance tools, and a clear political and managerial commitment to improve the quality of care for all people with severe psychiatric disorders.

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Appendix 1: Standards in the domain of rights and protection

The rights and legal status of people affected by severe psychiatric conditions are upheld by the services within an ethos of care, equity and respect for human rights.

Guarantee of Human Rights

The human rights of people affected by severe psychiatric conditions are guaranteed by the Constitution of South Africa in the Bill of Rights and Health Rights Charter.

1.1.1. Users and their caregivers are guaranteed equal rights, as specified in the Bill of Rights of the Constitution of the Republic of South Africa.[1]

These include the right to:

a) Health care services, including reproductive health, Clause 27 (1).
b) Sufficient food and water, Clause 27 (1).
c) Social security, including appropriate social assistance if unable to support themselves or their family, Clause 27 (1).
d) The right to emergency treatment, Clause 27 (3).
e) The development of legislature and other measures to achieve the progressive realisation of their rights, Clause 27 (2).

1.1.2. The services seek to ensure that there is no discrimination on the basis of race, class, gender, ethnicity, colour, age, location, social status, language, sexual orientation, diagnosis, clinical or forensic status in the quality of care offered.[2]

1.1.3. The fundamental rights of people with severe psychiatric conditions are identical to other citizens.[3]

This includes:

a) The right to dignified and humane treatment and care.
b) The right to access to care, irrespective of users ability to pay.
c) The rights to effective communication in a language and manner which users can understand.
d) The right to reasonable expectations in terms of a range of services and the quality of care.
e) The right to locally available community health-care providers.
f) The right to exercise choice and guide treatment through informed consent.
g) Freedom from discrimination in terms of inequitable access to treatment.
h) The right to privacy and confidentiality.
i) The right to appropriate treatment and medication.
j) The right to protection from psychological and physical abuse.
k) The right to adequate information about his/her clinical status, or the range and options of treatments and care available.
l) The right to prompt care, especially in emergency situations.
m) The right to safe treatment environments, and adequate water, sanitation and waste disposal.
n) The rights to reproductive choice.
o) The rights to protection from life-threatening diseases.
p) The right to express opinion and make complaints which receive investigation.

1.1.4. Specific care is taken to ensure that users are not deprived of their basic constitutional rights.

This includes:

a) The right not to be deprived of freedom arbitrarily or without just cause, Clause 12 (1).
b) The right not to be treated or punished in a cruel, inhumane or degrading way, Clause 12 (1).
c) The right not to be subject to forced labour, Clause 13, and fair labour practices Clause 23.
d) The right to bodily and psychological integrity, Clause 12 (2).
e) The right to freedom of religion, belief and opinion, Clause 15.
f) The right to freedom of expression, Clause 16.
g) The right to basic education, Clause 29.

1.1.5. The right to equality, and equal protection and benefit before the law, Clause 9 (1)

1.1.6. Limitations on user rights must be reasonable, and justifiable within an open and democratic society based on human dignity, equality and freedom, Clause 36 (1), Bill of Rights.

This implies:

a) Limitation of rights occurs under the strict auspices of the current Mental Health Act.
b) Limitation of rights occurs with clear, important purpose Clause 36 (1).
c) Limitation of rights occurs with the least restrictive means to achieve the purpose, Clause 36 (1e.)
d) There is a clear and demonstrable positive relationship between the limitation and the effect it is supposed to have, or the purpose espoused, Clause 36 (1)

Historical Redress

Service provision for people affected by severe psychiatric conditions must work to redress the imbalances and inequitable service delivery traditions of the past.

1.1.7. Historical Racial Inequtities: The services are committed to redress, and actively work to redress, past inequities and racism in the provision of services.

a) The services seek to rectify imbalances within the services as a result of apartheid legislation and service development.
b) The services are open to examining their role and possible complicity with apartheid discrimination and practices in the provision and use of mental health care.
c) The services are proactive in exposing, and making amends for, past injustices and abuses, by the services upon users and their communities.
d) There is parity across state / state subsidised facilities, especially with reference to historical lack of parity in terms of race and urban/rural access.

1.1.8. Racial distribution across facilities is monitored to ensure adequate integration and service equity.

1.1.9. Historical Neglect of Mental Health Services: The services seek to rectify the imbalances and neglect of mental health services within general health resources allocation.

a) The services at all times seeks to ensure that the needs of people affected by severe psychiatric conditions in specific, and the mentally ill more generally, are given due priority.
b) The services dedicate funds for the collection of valid South African epidemiological data on people affected by severe psychiatric conditions in specific, and the mentally ill more generally.

General Service Principles

In order to ensure guaranteed rights are upheld, and historical imbalances are redressed, care is framed both within clear and practical service guidelines and principles, as well as user responsibilities.

1.1.10. In order to protect guaranteed user rights, care is framed within clear and practical guidelines and principles.

This implies:

a) The services support the adequate allocation of funds and resources to the care of patients with severe psychiatric conditions, at all levels of care, in order to create the conditions for rights-based care.
b) Services promote the greatest degree of appropriate empowerment and personal responsibility of users.
c) The rights of potentially dangerous users are balanced against those of caregivers, the community, and providers, in a context of pragmatic user advocacy.
d) Every effort is made to obtain user's voluntary admission within a context of partnership and a therapeutic relationship.
e) Services ensure that informed consent is sought for all types of medical/ psychiatric procedures and testing proposed for users, including the testing for HIV infection. .
f) Care occurs in the least restrictive environment possible.
g) Admission and treatment is carried out in the user's best interests.
h) The services are committed to work towards the safety and protection of users from abuse, violence and exploitation.
i) The services address and provide for the physical and medical care of users.
j) Adequate accessible independent mechanism are established and supported to monitor the care and rights of users.
k) The services are (appropriately) accessible for review and inspection by rights-related bodies and community groups, within a framework of service transparency, user privacy and confidentiality.

l) The services vigorously address ignorance, fear and prejudice regarding patients with severe psychiatric conditions among providers, caregivers and the general public.

1.1.11. The services seek to support and empower user and caregiver groups and other advocacy bodies to monitor and lobby for user rights and quality care.

1.1.12. Users have responsibilities and obligations[4] commensurate with their current abilities.

These include:

a) Realistic expectations of the health service.
b) Taking care of their health and mental health.
c) Sensitivity to the rights of others
d) Observing the rules and regulations of the service or facility.
e) Making responsible use, and not abusing, the benefits of care, including disability grants.
f) Being courteous to providers, and respect their privacy and dignity.
g) To collaborate in keeping their environments pleasant and clean.
h) Providing accurate information to providers.
i) Taking care of health records (where appropriate).
j) Presenting themselves on time and complying with treatment.
k) Being constructive in their complaints.
l) Being non-discriminatory, non-sexist, non-racist.
m) Not endangering, threatening or abusing others.
n) Not using illegal substance and alcohol in health facilities (or encouraging others to do so).
o) Not carring or hiding weapons or dangerous objects.

Rights-Based Care in Specific Contexts

The services are sensitive the rights of historically vulnerable groups in our society, and works to address the special rights and needs of these groups.

1.1.13. Women: The service ensures the rights and protection of women users and caregivers.

This includes adequate address for :

a) reproductive rights.
b) protection from sexual abuse and harassment.
c) the sensitive support and advocacy of women who have been sexually abused.
d) specific indications for treatment, including psychotropic medication.
e) adequate provision to empower women and address their specific social vulnerability.

1.1.14. Children and Adolescents: The services seek to ensure the rights of severe psychiatric conditions children and adolescent with their care.

This includes:

a) Age Appropriate Services: Wherever possible, the services provide age appropriate services and care for children and adolescent s with severe psychiatric conditions, that takes account of their age (Clause 28 (1)) and developmental status, with a specific emphasis on the prevention of their deterioration and disability in adulthood.
b) Development and Rehabilitation: The services provide age appropriate developmental care and rehabilitation for children and adolescents with severe psychiatric conditions to help them to develop to their maximum potential.
c) Protection from Abuse and Neglect: The services seek to ensure that children and adolescents with severe psychiatric conditions, and the children of parents with severe psychiatric conditions, are protected from abuse, exploitation and neglect.
d) Protection within the Criminal Justice System: The services seek to address and support the needs of children and adolescent with severe psychiatric conditions within the criminal justice system (e.g. prisons and Places of Safety).
e) Separate Facilities: The services respect the rights of children to be cared for separately from adults, clause 28 (1); wherever possible children and adolescents are accommodated and treated in separate wards and units.
f) Institutionalised Children: The services seek to provide hospitalised or abandoned children and adolescents with severe psychiatric conditions with parental type care and support.
g) Right to Education: The services respect the right of children and adolescent with severe psychiatric conditions to basic education, Clause 29 (1), and when possible, vocational guidance and support. The services support the appropriate placement and mainstreaming of children with severe psychiatric conditions within public schools.

1.1.15. HIV infection: The services prioritise the development of appropriate care and services to address HIV infection within mental health care.

This implies:

a) The services are involved with the prevention and care of HIV infection among users and caregivers.
b) The services prioritise and support ongoing research regarding HIV infection among people with severe psychiatric conditions.
c) Providers are trained and prepared to recognise and manage the psychiatric presentation of AIDS.
d) User's consent is always sought when testing for HIV, and the services have clear, ethically based guidelines regarding testing without consent or disclosure of user's HIV status.
e) Providers are able to offer appropriate HIV counselling to users, including pre and post testing preparation.
f) The services act as advocates for users and caregivers who have the dual disability and stigma of both HIV infection and severe psychiatric conditions.
g) The services ensure non-discriminatory, but safe, health practices for HIV positive users.
h) The services collaborate and work with other organisation to provide education regarding HIV infection to people with severe psychiatric conditions and their caregivers.
i) The services provide condoms to sexually active users (with severe psychiatric conditions) who are in danger of transmitting or receiving the HIV virus.
j) The services are actively support women users with severe psychiatric conditions their caregivers to promote greater autonomy and protection in sexual behaviour, in order to avoid HIV infection.
k) The services provide timely AZT treatment to users and providers who have been put at risk of exposure to the HIV virus, (e.g. providers with needle stick injuries, users and providers who have been raped).
l) The services provide adequate management and palliative care for users with AIDS.

1.1.16. Elderly people: The services seek to provide care which is appropriate and sensitive to the needs of elderly or aged people with severe psychiatric conditions.

a) Institutional care for elderly people with severe psychiatric conditions addresses their specific needs, such as adequate safety and assistive devices, dietary provisions, temperature control, medical needs and, when necessary, reality orientation.
b) Where possible, and appropriate, long-term elderly users with severe psychiatric conditions in a stable condition have access to mainstream aged care services and facilities (e.g. accommodation and care is provided in community-based old age institutions).

1.1.17. Death and Dying: The services seek sensitively to manage the death and dying of hospitalised users with severe psychiatric conditions within its care.

a) Users have the right to die with care and dignity.
b) All attempts are made to inform the deceased's family.
c) The services take responsibility for burying long-stay users in a manner consistent with his/her traditions if at all possible.
d) The mortal remains will be treated with dignity in accordance with the deceased's traditional practices.
e) The services assist other users and providers to attend, if they wish, the deceased funeral, and work through the death of the user.
f) The services investigate, as appropriate, any unusual or suspicious issues related to the user's death.

Special Issues Facing the Care of People with Severe Psychiatric Conditions

The services recognise the special issues facing the care of patients with severe psychiatric conditions, and are guided by clear policy guidelines in these areas.

1.1.18. There are policies and guidelines which comply with current legislation, which and have received ethical approval on:

a) mechanical restraint,
b) emergency medication,
c) involuntary HIV testing,
d) certification (especially in isolated rural areas),

e) involuntary admission and user's refusal of treatment and care, and
f) searching of users.

1.1.19. Sedation: The sedation of users with severe psychiatric conditions is non-abusive and occurs within clear treatment parameters and guidelines.

a) Sedation is used only as a prescribed measure.
b) Sedation is prescribed in the best interest of the user, and not as a disciplinary measure.
c) Sedation may only be prescribed, as appropriate, when other treatment measures fail (e.g. interpersonal means / talking down).
d) Sedation should not be used for prolonged periods of time.
e) Sedation is not a long-term substitute for adequate environmental or provider containment.

1.1.20. Seclusion: The seclusion of users is non-abusive and occurs within clear treatment parameters and guidelines.

a) Seclusion may only be used when prescribed by a medical practitioner.
b) Seclusion is prescribed in the best interest of the user, and not as a disciplinary measure.
c) A team reviews seclusion prescriptions as soon as possible.
d) Seclusion may only be prescribed when other treatment measures fail, (e.g. medication and interpersonal means).
e) Users within seclusion are subject to regular review and observation on an hourly basis.
f) Seclusion occurs in a sensitive manner, without unnecessary force, or any injury or degradation to the user.

1.1.21. Labour: Users should be protected against labour exploitation within care facilities

a) All work programmes within facilities should be soley for user's benefit as part of a supervised rehabilitation programme.
b) There should be no unfair discrimination in employment or work tasks.
c) The services monitor all income generating projects for mismanagement and abuse.

1.1.22. Contracted Services: Contracted services for the care of users with severe psychiatric conditions should be held accountable to adequately meet the norms and standards of care as laid out in the present document.

a) Contracted services are to be accountable to the norms and standards as laid out in the present document.
b) Future contracts will be negotiated on the basis of these standards as explicit performance indicators with penalties for non-performance.
c) The public service will actively monitor the attainment of these standards in contracted services.
d) New contracts are subject to equity review.
e) Fair and legal tendering processes occur for the benefit of users.

1.1.23. Ethical issues are reviewed in all research protocols and practices involving people with severe psychiatric conditions.

Legal, Police and Correctional Services

The services recognise and work to protect the rights and needs of people with severe psychiatric conditions in the context of the criminal justice system.

1.1.24. Police: The services work to establish a collaborative and mutually co-operative relationship with the police service to ensure rights based treatment and care for people with severe psychiatric conditions and their caregivers.

a) The services seek to collaborate with the police services at a local and national level, including to ensure rights based treatment of people with severe psychiatric conditions by the police training and guidelines to ensure user appropriate care.
b) The services formulate the role of the police in of transport of users, involuntary admission and criminal justice.
c) The services avoid the detention of acutely ill users in police cells, and prioritise prompt access to local hospitals.

1.1.25. Fair Trials: The services uphold the right of all those charged with criminal offences to a fair trial based on an assessment of the role of severe psychiatric conditions in determining criminal culpability and intent

a) The services seek to ensure that the rights of forensic users, and those people with severe psychiatric conditions in jails or places of safety, are recognised.
b) Where possible attempts are made to ensure that forensic users are aware of their legal rights and the process of forensic classification and trial. Rights are communicated in an understandable manner.
c) The services seek to ensure the timely legal review of forensic users and, whenever possible, to limit unnecessary detention or restriction of forensic users.

1.1.26. The services seek to ensure the provision of appropriate treatment and care for people with severe psychiatric conditions who have committed an offence and are detained in prisons, police cells, places of safety or hospital prison beds.

Dealing with Abuse and Complaints

The services provide user-friendly systems for the identification of mistreatment by users, caregivers, and providers; and follow up these concerns in a thorough and responsible manner.

1.1.27. The services ensure that users, caregivers, and providers are aware of their rights. Rights are communicated in an understandable manner.
1.1.28. The services ensure that users, caregivers, and providers have clear, confidential, and supported mechanisms by which they may make complaints or seek redress for rights abuses.[5]

a) Any user, caregiver, or provider is entitled to lay a complaint about the manner in which s/he has been treated, and have this be regarded in a serious manner and investigated.
b) The user, caregiver, or provider laying the complaint has the right to be fully informed in writing of the effect or outcome of the complaints.

1.1.29. There are clearly documented, distributed and displayed complaints procedures for users, caregivers and providers.[6]

a) It is the responsibility of the health authorities to diligently follow-up any complaint, or forward this to the correct authority.
b) It is the responsibility of the health authorities to acknowledge every compliant they receive.
c) Users, caregivers and providers are informed how to make a complaint , if necessary and appropriate, and are assisted in doing so.

1.1.30. The services inform the relevant state authorities and act on human rights abuses of users within their care.
1.1.31. The services seek to ensure the establishment of an independent "ombudsperson" in mental health care, and ensure that this "ombudsperson" protects consumer rights.

a) Ombudspersons consist of people skilled in legal and mental health issues, as well as appropriate community representatives.

1.1.32. The service will be transparent and open to community and public scrutiny with regard to human rights abuses and standards of care.
1.1.33. The service acts to remove from their service providers who, through due process, are identified as perpetrators of human rights abuses.
1.1.34. Every suspicious death of a hospitalised user should be subject to investigation by a suitably qualified and independent review tribunal.

a) The review body includes one or more independent members (e.g. community representatives).
b) The review body seeks to identify both individual and systemic factors, and when relevant, related service problems and culpability.

References:

1. *Health Rights Charter (1997).*
2. *Constitution of the Republic of South Africa.*
3. *Health Rights Charter (1997).*
4. *Health Rights Charter (1997) and National Health Bill (Draft 11).*
5. *National Health Bill (Draft 11).*
6. *National Health Bill (Draft 11).*