THE EVALUATION OF PUBLIC PSYCHIATRIC SERVICES IN THREE PROVINCES OF SOUTH AFRICA

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Objectives. To describe the quality of care in community- and hospital-based care in three provinces in terms of 13 standards of care and the criteria associated with each; and to explore the similarities and differences between provinces.

Design. A descriptive study in the form of a survey using interviews, observation and questionnaires.

Setting. Three provinces of South Africa, namely Gauteng, KwaZulu-Natal and the Eastern Cape. In each of the provinces hospitals and clinics were the focus of the study.

Subjects. The person heading the mental health service in each province completed a questionnaire about the services in the province. Consumers (both direct consumers and family) received questionnaires or were interviewed if illiterate. In each province a sample of hospital units and clinics was visited and interview and observation schedules were completed.

Outcome measures. Thirteen previously tested standards of care were addressed covering a comprehensive array of indicators of care. Management, research and development, structural and process standards were included.

Results. All three provinces fared well for three standards (staff attitudes, process of hospital admission and availability of forensic care). On another three all the provinces fared poorly (management, regular review and/or evaluation of services, and research activity). In terms of clinic services all three provinces scored low for the availability of weekend and emergency services and psychosocial rehabilitation. In terms of hospital care the criteria referring to human rights of patients produced the lowest scores.

Conclusions. The paucity of management information on some aspects makes planning and evaluation difficult. However, the report does indicate specific areas that need improvement in each province.

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In 1996 a project was launched to develop standards for psychiatric care based on both the literature and consumer expectations. After the standards had been developed and validated, instruments were developed to measure these. Both of these steps have been described in a previous article.[1] Having developed a satisfactory set of instruments, these were used to measure the quality of care in three provinces of South Africa, namely the Eastern Cape (E Cape), KwaZulu-Natal (KZN) and Gauteng.

The aim of this phase of the research was to establish baseline data that could be used to monitor future development of the public psychiatric services. The specific objectives were: (*i*) to describe the quality of care in community- and hospital-based care in three provinces in terms of 13 standards of care and the criteria associated with each; and (*ii*) to explore the similarities and differences between provinces.

A standard is a statement describing an acceptable level of performance and is measured in terms of measurable criteria. In this study the acceptability of standards was defined by consumers. Consumers are persons who have had or currently have a mental illness and have used the public sector psychiatric services, as well as family members of such persons.

LITERATURE SURVEY

The process of establishing what constitutes quality is by no means simple. People representing different treatment frameworks, different disciplines or professions and even different life experiences, may define quality very differently.[2] Furthermore, while input and process standards received much attention during the 1980s, the researchers of the 90s are being urged to concentrate on outcomes. Quality care is then defined as the care that delivers the best outcomes. An example is the quality assurance toolkit developed by the International Association of Psychosocial Rehabilitation Services (IAPRS),[3] which concentrates exclusively on outcomes in different areas.

One of the innovations in recent years has been the increasing emphasis on consumer involvement in quality improvement.[4] In the 1970s consumer surveys were common, and specific instruments were developed to measure client satisfaction.[5] At the end of that decade Sorensen *et al.*[6] found that consumer surveys had been conducted in 48% of community mental health centres sampled.

However, the nature of consumer involvement has changed during the 1990s. Firstly, consumer groups have become major evaluators of services, even though they often employ professionals to conduct the evaluations. An example is the regular rating of State programmes for the seriously mentally ill in the USA undertaken for the National Alliance for the Mentally Ill.[7] This kind of report has become a valuable tool in

advocacy. Secondly, the increased use of qualitative studies has led to a new understanding of consumer agendas.[8] The World Health Organisation has summarised these changes as follows: 'Such participation may now be able to go beyond mere consultation on service planning issues, token membership of committees, or more adversarial advocacy to a recognition that the accounts which users can give of their experiences is material for central inclusion in evaluations'.[9]

In 1988 the Mannheim principles were adopted as the basis of WHO projects for the support of people disabled by mental illness. These principles can be viewed as constituting the most basic set of international standards of care. They are: (*i*) semantic: terminology used must not devalue or marginalise the project itself, its users or its workers; (*ii*) empowerment: users of the service must be clearly and visibly a part of the decision-making process at several levels; (*iii*) focus: the aim and focus of the service and the overall project should be on the enhancement of the individual's capabilities rather than on disability or deficits; (*iv*) nature of the project: the project must be socially valued and must exist in as normal a setting as possible in terms of its location, name, physical appearance, etc. so as not to marginalise it; (*v*) quality of life: the primary goal of the project must be to maximise all facets pertaining to the quality of life of consumers; (*vi*) choice: a major goal must be to maximise all possible choices and opportunities available to users and to avoid limiting opportunities as far as possible; (*vii*) transparency/openness: the consumer must have guaranteed access to all facets and processes of the project; (*viii*) co-operation: a feature of the project should be that co-operation between users, workers, the community and other interested organisations and individuals is stressed.[9]

The striking accent on destigmatisation is clear from these standards.

In South Africa, both formal quality assurance programmes and consumer satisfaction studies are in their infancy. The Council for Health Service Accreditation of South Africa commenced work approximately a decade ago, but has not yet penetrated the public psychiatric services.

Research methodology

Three instruments were developed to address the 13 identified standards and their associated criteria. These were as follows:

1. A questionnaire to consumers covering those aspects they were in the best position to evaluate, e.g. accessibility of services, and attitude of staff. This instrument had 78 items, mostly in the form of a rating scale, except for the demographic items.

2. A questionnaire to service providers, addressed to Directors of Mental Health in each province, regarding information that should be available to such policy makers, e.g. statistics and financial data. This instrument consisted of 26 items, and asked respondents to estimate answers if such data were not available.

3. Two observation/interview schedules used during site visits to clinics and hospital units respectively. Each included approximately 28 items of different types.

During testing of these instruments the inter-rater reliability of the site visit schedules was found to be 0.9372 on a Spearman's rank correlation. Groups of professionals and consumers validated the instruments during focus group discussions.[1]

The sampling was done in phases. Three provinces were selected to represent different types of provinces: a well-resourced, mainly urban province (Gauteng), one that was relatively well-resourced, but with resources poorly distributed and with a very high population density (KZN) and a poorly resourced, mainly rural province (E Cape).

During the second phase lists were made of all clinics and hospital units in each province serving this population. A stratified random sample of hospital units and clinics was then drawn using random numbers. These samples are described in Tables I and II. In KZN a Lifecare unit was also included since this was seen as being part of the public psychiatric service. In all provinces psychiatric units within general hospitals were included in the acute sample.

Table I. Sample of hospital units

Type of unit	E Cape	Gauteng	KZN	Total
Acute	3	5 (35)	2 (20)	10
Long-term	4	5 (40)	5 (45)	14
Total	7	10	7	24

Figures in parentheses = total numbers of units in province.

The full-time clinics or fixed clinics also included the outpatient departments at hospitals. Not all these clinics were included in observational visits. Some were used only to distribute consumer questionnaires. Consumers were either interviewed while they were waiting at clinics, or questionnaires were distributed and sent back through the freepost system directly to the researchers.

Table II. Sample of clinics and consumers

Type of clinic	E Cape	Gauteng	KZN	Total
Full-time	5	6 (91)	16 (374)	27
Part-time and mobile	1	4 (10)	1 (238)	6
Total clinics	6	10	17	33
Consumers (*N*)	217	136	145	498

Figures in parentheses = total number of clinics rendering a psychiatric service.

Data collection in each province took between 6 and 8 months. Consumers were involved in observational site visits in two of the three provinces. The consumers included a businessman, a disabled person, a pastor and a retired nurse. A mental health professional always formed part of the observational team.

The ethical aspect of the research presented a challenge since staff were often very defensive about giving permission for observational visits, especially for the record reviews that were part of the audit. Some units had to be replaced or excluded on these grounds. However, no consumer refused to be interviewed when approached.

RESULTS

Overall quality of care

The overall quality of care of the psychiatric services in these provinces on all 13 standards is summarised in Table III. None of the data necessary to measure the first standard was available in the provinces. One could not say whether psychiatric beds had decreased, whether resources had been moved to the community or whether the percentage of forensic beds had proportionately increased. There is clearly a need for more targeted information systems.

There were three standards for which two out of the three provinces achieved high marks, namely staff attitudes (No. 2 in Table III), process of hospital admission (8) and the availability of forensic care (10). With regard to the attitude of staff, E Cape consumers gave staff a negative rating on items such as stealing from and exploiting patients, threatening or physically abusing clients and discussing one client with another. In terms of the admission process the consumers of the same province complained about being stripped naked during admission, being over-sedated, and the unnecessary use of the police during admission procedures.

All three provinces did poorly on the following three standards: consumer participation in managemen (4), regular review and/or evaluation of services (12) and research activity (13).

Two of these standards consist of major sub-standards; achievement on these is summarised in Tables IV and V. Overall the performances of all three provinces was in the middle of the range for both these standards.

Table III. Average percentage achieved in all 13 standards

Category	E Cape	Gauteng	KZN	Mean
1. Community-based approach to care	–	–	–	–
2. Staff attitudes	55	78	74	69
3. Head office management	39	89	39	56
4. Consumer participation in management	0	27	5	11
5. Multi-sectoral, continuity of care approach	36	53	56	48
6. Provincial legislation and procedures acceptable	90	30	–	60
7. Comprehensive primary psychiatric care offered in nearest clinic	51	62	53	55
8. Hospital admission done in a therapeutic manner	46	79	78	68
9. Optimal hospital treatment and care	52	50	52	53
10. Forensic psychiatric care available	100	100	50	83
11. Funding adequate for the services	56	50	14	40
12. Regular review and/or evaluation of services done	33	44	27	35
13. Relevant research encouraged	31	15	0	15
Mean	49	56	41	50

— = data not available.

Table IV. Performance in terms of comprehensive primary psychiatric care at nearest clinic (%)

Criteria	E Cape	Gauteng	KZN	Mean
7.1 Physical and human resources, as well as policy structures promote primary health care	58	60	62	60
7.2 Every patient receives optimal bio-psychosocial treatment based on a comprehensive assessment and accurate diagnosis	49	69	52	57
7.3 Every patient with long-term mental illness is involved in a process of psychosocial rehabilitation to promote optimal functioning and re-entry into society	45	56	45	49
Mean	51	62	53	55

Table V. Performance in terms of specialised treatment and hospitalisation in the district or region (%)

Criteria	E Cape	Gauteng	KZN	Mean
9.1 Physical and human resources, as well as policy structure, promote specialised care	47	48	42	55
9.2 Hospital facilities and policies promote continued contact of the patient with his/her social network	59	46	60	55
9.3 Appropriate and effective treatment: diagnosis and treatment, management and discharge	47	54	51	51
9.4 Care optimises functional status and enhances quality of life	54	43	56	51
Mean	52	48	52	51

Clinic services

In terms of clinic services, the availability of emergency and weekend services was problematic in all three provinces, but most seriously in the E Cape where the average scores for these two criteria were 10%. In Gauteng the actual treatment was rated better overall than the resources (60% v. 69%), while in the other two provinces this was not the case. There are some very fundamental criteria in this category for which performance in these two provinces was very low. For instance, a clear diagnosis was found in only 27% of patient records in the E Cape, while in KZN only 38% of patient records had a comprehensive psychiatric history. Other low-scoring criteria in these two provinces were documentation not done in a way that facilitated continuity and evaluation of care (32% and 28% respectively), and lack of documented psychosocial interventions (10% and 22% respectively). All three provinces scored their lowest for the subsections on the psychosocial rehabilitation criteria (average 49%) (Table IV).

Hospital care

There is not much difference between the average ratings for clinic (Table IV) and hospital (Table V) scores, although hospital scores are a little lower, and Gauteng does not perform better than the other two provinces on this standard.

In terms of the first sub-standard, namely resources and policies, the lowest scores were in the human rights criteria. Percentages with regard to informing patients of their rights and giving them access to appropriate legal and advocacy services varied between 0 and 50%, with an average of 18%. In terms of the second sub-standard, namely continued contact with social network, performance varied. In the E Cape and KZN the lowest score was for excursions for long-term patients (28% and 35% respectively), while in Gauteng it was for maintaining contact with the significant others of long-term patients (14%). In terms of the diagnosis and treatment sub-standard, the E Cape generally scored very low (20 - 30%), with a few very high criteria bringing their average score up, while in the other two provinces the scores were more consistent. The

ast sub-standard, rehabilitation-focused care, was relatively consistent over the three provinces and the different criteria.

DISCUSSION

The first point that needs to be made pertains to the paucity of management information, which made it impossible for Directors of Mental Health to answer many of the questions. No manager can plan or evaluate without relevant management information, and the totally inadequate information system with regard to psychiatric care needs urgent attention. It is essential that the kind of information gathered in the different provinces is the same so that comparison is possible, and that the data allow decision-makers to evaluate the implementation of policies such as de-institutionalisation and primary health care.

In each province a different pattern of service emerged, highlighting the importance of provincial audits and provincial lobbying by stakeholders. The similarities between the highly resourced Gauteng and the poorly resourced E Cape and KZN emphasise the fact that it is not only resources that determine service quality. This raises the possibility of improving service quality even within limited resources.

In the light of consumer priorities the poor performance on consumer participation and human rights criteria throughout the study raises serious concerns. These two issues are clearly linked, since without adequate consumer participation in management it is doubtful whether the service will succeed in transforming itself into a system that respects the human rights of the vulnerable people in its care. This is especially important when the scores on some criteria indicate that consumers are being subjected to harmful practice and lack of care. It would seem that more of the philosophy underlying the Italian psychiatric care revolution,[10] with its emphasis on human rights, is needed in the South African system.

The very average scores obtained for the two major 'clinical' standards (clinic care and hospital care) also point to the need for urgent attention to be given to the quality of care in psychiatric services. The fact that there is no indication of a full psychiatric history or completed diagnosis in most patient files, and that evidence of psychosocial interventions is absent, indicates serious flaws in service delivery. As such the current quality of care cannot be viewed as being acceptable or as being the benchmark against which innovations should be evaluated.

The low scores on the classic 'research and development' activities, which are a yardstick of quality in the modern industrial system, also raise concern. It would seem that the public psychiatric system is still largely a closed system, with limited new information, ideas or people entering it. In terms of the systems theory such relatively closed systems deteriorate since input is too low for sustainability.[11] This poor performance in terms of research activity also compares poorly with other sectors of the health care system where ongoing research is a fact of life, especially in large academic hospitals.

CONCLUSION

Approaches to psychiatric care have changed dramatically over the last 50 years. Such changes bring with them changed expectations of what quality care involves. Since public psychiatric care is usually rendered within a hierarchical structure, it is inevitable that practice standards change faster than the system within which such care has to be rendered. This leads to a time lag, with serious implications for the quality of care. The data from the three provinces described in this article show that psychiatric services need attention in many areas, and that service delivery falls far short of both consumer expectations and international standards.

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