Editorial

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Safety and quality in mental health: The business of every Psychiatrist

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Abstract

Safety and quality remain underdeveloped priorities in mental health services, particularly where resources are constrained and clinicians work in trying circumstances. Psychiatrists in these contexts may perceive safety frameworks as external impositions, adding burdens without addressing structural deficiencies. However, avoidable harm-including inpatient suicide, sexual assault, medication error, and premature mortality-remains widespread and cannot be considered inevitable in any mental health system, regardless of resource.

This editorial argues for reframing safety and quality systems as fundamentally relational: grounded in trust, communication, and culture rather than solely technical processes or compliance exercises. Evidence-based practice remains essential but must be pragmatically adapted to local resources, emphasising low-cost, high-impact interventions and aligning care with patient and family goals. Clinical governance should be reconceptualised as supportive rather than punitive, enabling peer learning, advocacy, and necessary system improvement.

Ultimately, safety in mental health care is about people – patients, families, and staff – and the relationships that sustain them. By building safety systems, resource-limited services can move beyond fear of unknown and unexpected mishaps, and toward a culture where accountability, learning, and compassion are shared responsibilities.

Keywords: Mental health services; Safety and quality; Clinical governance; Resource-limited settings; Patient safety; Just culture; Evidence-based practice

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Introduction

Mental health services across the world face profound challenges in ensuring safe, high-quality care. In low and middle-income countries where resources are limited, these challenges are particularly acute. Psychiatrists often practise in environments marked by staff shortages, inadequate facilities, and competing demands on scarce health budgets. In such settings, the introduction of safety and quality frameworks is sometimes viewed with scepticism and perceived as burdensome rather than as a support for clinical work. The old adage that "every system is perfectly designed to get the results it gets" is particularly apt for mental health (1).

We argue that safety and quality systems are essential, but they must be understood and implemented as relational systems built on trust, partnership and culture, rather than imposed solely as technical processes. Safety in mental health care is not just about standards, incident reviews, audits, or protocols. It is about the ways psychiatrists, patients, and families relate to one another, and the shared responsibility they take for reducing harm.

Methods

Evidence from high-income settings makes clear that mental health services continue to tolerate levels of harm that would be unacceptable in other areas of medicine. Inpatient suicide remains a leading cause of death in psychiatric hospitals, with one study estimating a rate of one per 676 admissions (2). Women admitted to psychiatric wards in Victoria, Australia, reported sexual assault at rates as high as 45% during their admission (3). People with psychosis face an average life expectancy reduction of 15-20 years, much of it attributable to preventable physical health conditions (4).

While comparable data from low-resource settings are limited, clinical experience suggests that the same types

of harm occur, often magnified by infrastructural deficits such as overcrowded wards, lack of gender segregation and insufficient supervision. Staff are victims of harm also, facing regular verbal and physical assaults, chronic stress, and moral injury.

To dismiss these harms as inevitable is to fail both patients and clinicians. Safety and quality frameworks are needed not because they satisfy external standards, but because they protect people – patients, families, and staff – from avoidable suffering.

Clinical governance has been defined as the framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care (5). In reality it is a framework whereby psychiatrists can ensure that their patients consistently receive the best care that their resources will allow.

This requires governance systems that:

- **Engage clinicians directly**, valuing their expertise and context-specific knowledge.
- **Simplify processes** so that safety measures do not add disproportionate administrative burdens and discourage already overburdened staff.
- **Involve families and communities**, recognising their indispensable role in supporting patients in settings where formal resources are scarce.
- **Generate advocacy data**, enabling psychiatrists to make visible the needs of their patients to policymakers and funders.

When reframed in this way, governance becomes less about compliance and more about building an internal culture of accountability, solidarity, and learning.

The principle of evidence-based practice (EBP) to deliver quality care remains central to modern psychiatry, but its translation into real-world practice is fraught with challenges. Harvey et al describe the "voltage drop" by which interventions lose effectiveness in routine care, and the "implementation cliff" whereby interventions fail to be adopted at all (6). These problems are intensified in low-resource contexts, where the infrastructure required to deliver interventions is often absent.

Nevertheless, the **principles of EBP remain valuable.** What is needed is pragmatic adaptation:

- Training generalist staff in basic psychosocial interventions.
- Using community health workers to deliver psychoeducation and adherence support.
- Prioritising low-cost, high-yield interventions such as safety planning, family involvement, and medication monitoring.
- Collaborating with NGOs and community organisations to extend reach.

Importantly, evidence must **be aligned with patient and family goals.** Kilbourne et al. argue that recovery is not solely about symptom reduction but about enabling people to lead meaningful lives – to be independent, have relationships, sustain employment, and participate in their communities (4). In resource-limited settings, aligning care with these relational goals is often both more feasible and more culturally resonant than attempting to replicate high-resource models wholesale.

Too often, failures in psychiatric care are attributed to the errors of individual clinicians. When a suicide, assault, or medication error occurs, investigations may focus narrowly on whether a staff member followed protocol. While individual accountability matters, safety science consistently demonstrates that harm more often arises from latent system weaknesses – understaffing, poor supervision, inadequate facilities – than from isolated errors (7).

Conklin's principles of Human and Organisational Performance reinforce this:

1. **Error is normal**; even skilled staff make mistakes.
2. **Blame fixes nothing**; punitive responses obscure root causes.
3. **Context drives behaviour**; unsafe systems foster unsafe practices.
4. **Learning is vital**; incidents should inform system redesign.
5. **Response matters**; leaders must respond with curiosity and support, not punishment (8).

Perhaps the most important lesson from human-centred design is that systems must be built for people, not the other way around (9). Safety and quality are not abstractions; they are lived experiences shaped by relationships between patients, families, and staff.

Relational safety systems recognise that:

- **Trust is foundational.** Patients must trust staff to protect their dignity; staff must trust their organisation to support them.
- **Communication is central.** Failures of handover, documentation, and consultation are among the most common contributors to harm.

- **Engagement is essential.** Patients and families bring expertise that systems ignore at their peril.
- **Culture outweighs checklists.** Standardisation and protocols are useful, but they only succeed when embedded in cultures of respect, empathy, and accountability.

Where material resources are scarce, relationships are the primary resource. Systems that strengthen trust, communication, and collaboration can significantly improve safety even in the absence of advanced infrastructure.

An essential step toward improving safety is to define harms that are so serious they cannot be tolerated. In mental health, these "never events" include inpatient suicide, sexual assault, and preventable medication errors (2). While complete elimination may be difficult, particularly in low-resource contexts, the act of defining and tracking such events sends a powerful message: these harms are not inevitable.

By systematically recording incidents, even with simple tools, psychiatrists and services can generate data to support advocacy. All such incidents should be subject to a formal incident review methodology so that learning can occur on the underlying contributing factors and system improvements can be made (10). Such data can also demonstrate to policymakers that investment in staffing, infrastructure, and training is not optional but essential for reducing preventable harm.

Ultimately, safety and quality in mental health cannot be divorced from politics. As Berwick (1) reminds us, health care is inherently redistributive. In developing countries, where inequality is often stark, investing in safe, effective psychiatric care is both a health and justice imperative.

Conclusion

Addressing safety and quality in the mental health service should not be postponed until psychiatrists have more time or resources, nor should we be reduced solely to compliance with external standards (10) or bureaucratic oversight. Improving the safety and quality of the service we provide is our responsibility every day at work. It is a relational endeavour, grounded in trust, engagement, and culture.

For resource-limited settings, this means developing pragmatic, context-sensitive governance systems that support rather than punish clinicians; prioritising low-cost, high-impact interventions; and placing relationships at the centre of care. It also means embracing a just culture in which errors are understood as system phenomena rather than individual failings and used as opportunities to learn.

Ultimately, safety systems must be about people. Patients, families, and staff all share the risks of unsafe care, and all have a role in creating safer, better quality, more compassionate systems. In recognising this, psychiatrists can move beyond fear of litigation to a more collective vision: one in which safety is not a burden imposed from outside, but a shared responsibility rooted in the very essence of care.

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