IMPROVING HEALTH SYSTEMS AND SERVICES FOR MENTAL HEALTH

World Health Organization

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FOREWORD

For too long, mental disorders have been largely overlooked by health systems. This is despite the fact that mental disorders are found in all countries, in women and men, at all stages of life, among the rich and poor, and in both rural and urban settings. If people with mental disorders fail to receive the treatment and care they require, they risk becoming marginalized from society; many descend into poverty and homelessness.

Lack of political support, inadequate management, overburdened health services and, at times, resistance from policy-makers and health workers have hampered the development of coherent mental health systems. Misunderstandings about the nature of mental disorders and their treatment have further complicated progress. For example, many people think that mental disorders affect only a small subgroup of the population, but the reality is that 25% of people will have a diagnosable mental disorder at some point during their lifetimes. Others think that mental disorders cannot be treated, but effective treatments exist and can be successfully delivered in outpatient settings. Some may believe that some people with mental disorders are violent or unstable, and therefore should be locked away, while in fact the vast majority of affected individuals are nonviolent and capable of living productively within their communities.

The scant resources that are dedicated to mental disorders are often inappropriately deployed. Most resources are spent on expensive, and sometimes inhumane, and ineffective care in psychiatric hospitals, rather than on effective treatment through primary health care, community-based care, and short-term hospital care near to where people live.

Treating mental disorders as early as possible, holistically and close to the person's home and community lead to the best health outcomes. In addition, primary care offers unparalled opportunities for the prevention of mental disorders and mental health promotion, for family and community education, and for collaboration with other sectors. In the words of WHO's Director-General, Dr Margaret Chan, *"Mental health is essential for achieving person-centred and holistic primary health care."* To be fully effective and efficient, primary care for mental health must be complemented by additional levels of care. These include secondary care components to which primary care workers can turn for referrals, support, and supervision. Linkages to informal and community-based services also are necessary. Collectively, these components comprise a mental health system, which functions coherently to provide services to those in need.

This document should not be seen as a replacement for the more detailed guidance that can be found in the WHO Mental Health Policy and Service Guidance package. It does nonetheless introduce the essential ingredients for strengthening mental health systems within a context of overall health system development. As such, it forms a fitting summation to recent WHO initiatives to improve access to and quality of treatment and care for people with mental disorders.

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INTRODUCTION

Key messages

- Mental disorders affect 1 in 4 people around the world.
- The burden of mental disorders could be largely prevented with known, affordable treatments, but inadequate health systems limit progress.
- This document describes a comprehensive strategy for how to improve mental health policy and service development.
- By using this strategy as a guide, countries can ensure that their mental health systems are not haphazard, but rather, the products of careful consideration and planning.

A mental health system, like any other system, is a set of interconnected parts that must function together to be effective. Yet frequently, crucial aspects of mental health systems are poorly functioning or missing altogether. The results are inefficiencies, service gaps, and compromised health outcomes.

This document presents a process through which country-level policy-makers and planners can assess the current state of their mental health system, identify gaps, and then plan and implement improvements.[a] The suggestions and recommendations are not prescriptive, but rather, outline available evidence and good practice examples that can be adapted by countries.

Although this document focuses on mental health systems and services, it is important to note that at country level, mental health and overall health system planning and development must be integrated to the greatest extent possible. In the absence of this approach, countries risk fragmentation across a range of particular health conditions, resulting in further inefficiencies and inequities.

The global situation: mental health needs and services

An estimated 450 million people worldwide have a mental disorder. At any given time, approximately 10% of adults are experiencing a current mental disorder, and 25% will develop one at some point during their lifetimes.[1] Mental disorders are found in all countries, in women and men, at all stages of life, among the rich and poor, and in both rural and urban settings.

Mental disorders account for 13% of the global burden of disease, and this figure will rise to nearly 15% by 2030. Depression alone is likely to be the second highest contributor to the global burden of disease by that date.[2]

Mental disorders also are associated with more than 90% of the one million suicides that occur annually. In reality the number is likely to be far greater, due to common underreporting of this cause of death.[3]

People with mental disorders have a heightened risk of suffering from physical illnesses because of diminished immune function, poor health behaviour, poor adherence to medical treatments, and social barriers to obtaining treatment.[4]

a Detailed information and recommendations can be found in the *WHO Mental Health Policy and Service Guidance Package*. Readers are strongly recommended to consult these materials. This document provides an overview of the package, and also aims to help readers identify specific modules to examine more thoroughly at particular points in policy, systems and service development.

The economic and social costs of mental disorders also are substantial. In the United States of America, direct treatment costs of mental disorders were estimated to be around 2.5% of the gross national product.[5] Indirect treatment costs are two to six times higher. In developing countries, families bear a significant proportion of both the economic and social burden, because of the absence of a publicly-funded network of comprehensive mental health services. Families also are affected by social exclusion and stigmatization.

Effective treatments are available for a range of mental disorders. Many people with depression can be treated successfully with low-cost antidepressants or psychological interventions, while first generation antipsychotic drugs are both effective and cost effective for the treatment of schizophrenia. Evidence-based treatment across a population for a package of disorders–schizophrenia, bipolar disorder, depression and panic disorder–would require only an additional investment of US$ .20 per capita per year in low-income countries and US$ .30 per capita per year in lower-middle income countries.[6]

Despite the ubiquity and prevalence of mental disorders, many countries have inadequate mental health systems and services. In most countries, especially those with low- and middle-income economies, there is an enormous gap between those who need mental health care, on one hand, and those who receive care, on the other hand.[7] Fewer than 28% of countries have a specific budget for mental health care, and many countries face acute shortages of mental health workers.[8] Worryingly, many mental health systems still rely on institutional care in psychiatric hospitals, despite having been discredited on humanitarian grounds and becoming largely unnecessary since the 1950s with the advent of new psychotropic medications and psychosocial rehabilitation programmes.[9] The well-being of people with mental disorders, their families, and communities could be significantly improved with the development of good-quality mental health systems. Instead of being perceived as a burden to others and countries as a whole, people with mental disorders could contribute to the social and economic well-being of society and have improved quality of life. Nevertheless, this requires concerted and focused policy, planning, and service development, as well as implementation.[10]

In particular, primary health care is the foundation for high-quality mental health care. Mental health services integrated into primary care include the identification and treatment of mental disorders, referral to other levels where required, attention to the mental health needs of people with physical health problems, and mental health promotion and prevention. Where mental health is integrated into primary care, access is improved, mental disorders are more likely to be identified and treated, and comorbid physical and mental health problems managed in a seamless way. To be fully effective and efficient, primary mental health care must be complemented by additional levels of care. These include secondary care components to which primary health workers can turn for referrals, support, and supervision. Linkages to informal and community-based services also are necessary. Understanding and appreciating these relationships is crucial to understanding the role of integrated primary mental health care within the context of the overall health system.

This document presents an integrated strategy for mental health system development that will lead to enhanced service delivery, improved outcomes, and improved human rights for people with mental disorders. By using the practical guidance provided in this document, countries can ensure that their mental health systems are not haphazard, but rather, the products of careful consideration and planning.

MENTAL HEALTH POLICY, PLANS, AND PROGRAMMES

Key messages

- Mental health issues should be incorporated within general health policies and plans, and supplementary mental health policies and plans also should be developed to provide the details required for implementation.
- Policies and plans in themselves can just be pieces of papers, or alternatively, they can be highly effective and efficient drivers of improved mental health in a region or country. Specific actions are necessary to facilitate their effective implementation.
- Policies and plans must be monitored carefully and evaluated to determine whether they are creating their desired outcomes.

The most important step towards providing well-considered and comprehensive mental health care is the drafting of a policy and a plan that will guide mental health system and services development. A mental health policy is an official statement by a government or health authority that provides the overall direction for mental health by defining the vision, values, principles, and objectives, and establishes a broad model for action to achieve that vision (see Figure 1). To be effective, a policy should be accompanied by a more detailed and specific action plan to be implemented in a systematic and well-coordinated way.

The content areas of a mental health policy and plan, as well as the level of detail that goes into a mental health policy, will invariably differ from country to country. Nonetheless, fundamental steps based on good practice principles and experience can be followed to ensure that the most important processes have been undertaken and key content issues have been included. As WHO's Director-General, Dr Chan, states, *"As health systems are highly context-specific, there is no single set of best practices that can be put forward as a model for improved performance. But health systems that function well have certain shared characteristics."* [9]

In some countries, mental health issues and actions will be incorporated within a general health policy and plan, while in others the mental health policy and plan will appear as separate documents. The ideal situation is one in which mental health is incorporated within the general health policy and plan, with a supplementary, more comprehensive mental health policy and plan to provide details for how the country plans to address mental health issues.

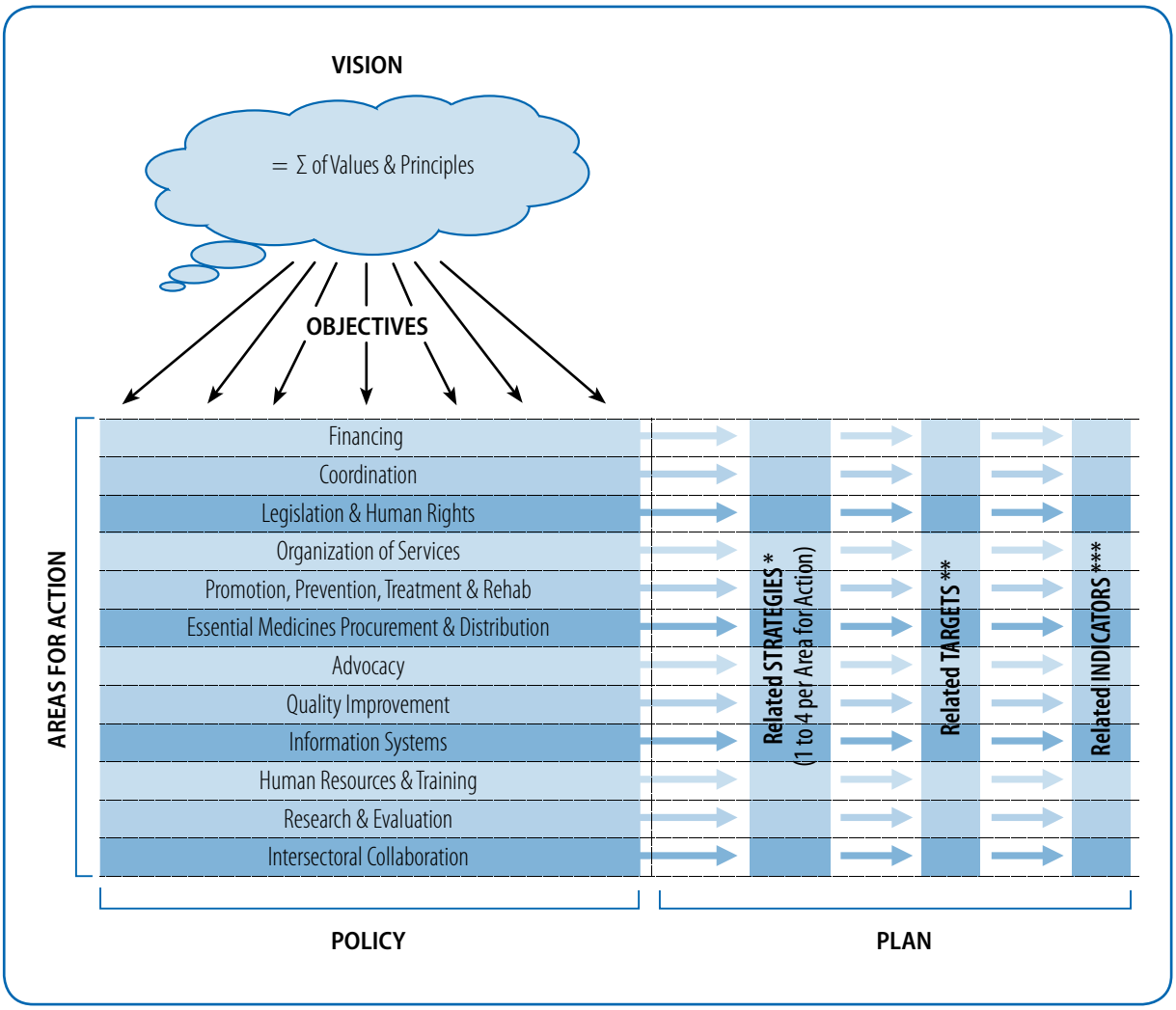
It is important to have a timeline in mind when developing a mental health policy. Experience shows that it takes approximately one to two years to develop a mental health policy, and five to ten years to implement it.

The following section outlines a best practice process for developing a mental health policy and plan, and then addresses a number of implementation issues that are essential to their effective realization.

Developing a mental health policy

The reality of mental health policy development is frequently complex, in that it can be incremental and opportunistic in nature. Nonetheless, mental health policy development typically involves several steps, as outlined in Box 1. The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS)[11] also is useful in assessing key components of a mental health system (see Box 2).

Figure 1. Key components of a mental health policy and plan



Box 1. SUGGESTED STEPS FOR DEVELOPING A MENTAL HEALTH POLICY

Step 1: Gather information for policy development

Collect information about the mental health needs of the population, as well as the current mental health system and services. Determine population needs from, for example, prevalence and incidence studies, community-identified problems, and information about the major reasons people seek assistance. Prioritize key mental health issues.

Step 2: Gather evidence for effective policy

Obtain evidence by visiting and evaluating local services, and by reviewing national and international literature.

Step 3: Consult and negotiate

Listen to various stakeholders and make proposals that blend their different views with evidence derived from national and international experiences.

Step 4: Exchange with other countries

Share experiences with other countries to learn about the latest advances and any creative experiences for effective mental health interventions that should be incorporated into policy.

Step 5: Define the vision, values, principles, and objectives

Establish the substance of the policy through describing the vision, values, principles, and objectives for mental health.

- The vision usually sets high but realistic expectations for mental health, describing what is desirable for a country or region.
- Values and principles represent ethical standards and core rules driving the policy.
- Objectives should aim to improve the health of the population, respond to people's expectations, and provide financial protection against the cost of ill-health.

Step 6: Determine areas for action

Transform the objectives of the mental health policy into specific areas for action. Consider the simultaneous development of several areas such as:

- legislation and human rights;
- financing;
- organization of services, planning, and budgeting;
- drug procurement and distribution;
- human resources and training;
- information systems;
- quality improvement;
- advocacy;
- evaluation of policy and plans;
- special interests (e.g. child and adolescent mental health issues – see **Box 6**).

Step 7: Identify the major roles and responsibilities of different sectors

Decide on the specific roles and responsibilities for:

- governmental agencies (health, education, employment, social welfare, housing, justice);
- academic institutions;
- professional associations;
- general health and mental health workers;
- consumer and family groups;
- nongovernmental organizations.

Box 2. WHO-AIMS ASSESSMENT TOOL [11]

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) is a tool designed to assess key components of a mental health system of low- and middle-income countries or regions, and thereby provide essential information to strengthen mental health systems. Through WHO-AIMS, it is possible to identify major weaknesses in mental health systems in order to have essential information for relevant public mental health action.

WHO-AIMS consists of six domains (covering the 10 World Health Report 2001 recommendations through 28 facets and 156 items). The six domains are interdependent, conceptually linked, and somewhat overlapping. All six domains need to be assessed to form a relatively complete picture of a mental health system.

WHO-AIMS data can assist countries in developing information-based mental health plans with clear baseline information and targets. Countries also are able to monitor progress in implementing reform policies, providing community services, and involving consumers, families, and other stakeholders in mental health promotion, prevention, care, and rehabilitation. Through using WHO-AIMS, countries will have a clearer and more comprehensive picture of the main weaknesses in their mental health system; this knowledge should facilitate improvements over time.

Developing a mental health plan

A mental health plan should outline the tangible details that will allow the implementation of the policy. Steps in developing a plan include: determining the strategies and timeframes; setting indicators and targets; determining the major activities; establishing the costs and available resources; and budgeting accordingly. Box 3 provides additional information on these suggested steps, and Box 4 describes the experiences of the Gambia in developing a mental health policy and plan.

Box 3. SUGGESTED STEPS FOR DEVELOPING A MENTAL HEALTH PLAN

Step 1: Determine the strategies and timeframes

Formulate the core strategies of the mental health plan with respect to each of the areas for action. Consult with stakeholders. Define a timeframe for each strategy, indicating in what year each strategy will begin and for how long it will function.

Step 2: Set indicators and targets

Define targets and indicators for each strategy. Ensure that the targets and indicators are clear and explicit, and state precisely what must be achieved within given timeframes.

Step 3: Determine major activities

Define detailed activities that will enable the strategy to be realized. Outline the expected outputs of each activity, as well as the potential obstacles and delays that could inhibit the realization of the activity.

Step 4: Determine the costs and the resources available and budget accordingly

Calculate the cost of each activity as well as the total cost of the plan for each year. Adjust timeframes in accordance with the resources that will be available in different years.

Box 4. THE GAMBIA: A MENTAL HEALTH POLICY AND STRATEGIC ACTION PLAN TO IMPROVE CONDITIONS FOR PEOPLE WITH MENTAL AND SUBSTANCE USE DISORDERS[12]

In 2007, the Republic of the Gambia, in collaboration with WHO, completed its first-ever mental health policy and strategic action plan. These documents were formulated on the basis of a situation assessment of mental health in the country, as well as wide consultation with key stakeholders. Concrete strategies were identified for strengthening the overall mental health system, providing effective treatment and care to those in need, and promoting the mental health of all Gambians.

The major objectives of the Gambia's mental health policy include: deinstitutionalization of the Campama Psychiatric Unit; the provision of equitable, accessible, cost-effective, and good-quality mental health and substance abuse services in the community; and the promotion and protection of the rights of people with mental and substance use disorders.

The Gambia's strategic action plan provides a roadmap for meeting the objectives of the policy, by outlining concrete strategies, activities, timeframes, and budgets for their attainment. Some strategies include:

- strengthening the national mental health coordinating unit at the Department of State for Health;
- mobilizing resources to provide good-quality mental health services;
- improving the availability, distribution, and cost-effective use of psychotropic medicines;
- creating inpatient mental health units and outpatient clinics integrated in the general hospitals;
- improving treatment and human rights conditions in the Campama Psychiatric Unit;
- recruiting and training a sufficient number of health workers at the specialized, community, and primary health care levels in order provide good-quality mental health care at all levels;
- training and supporting traditional healers in mental health.

Implementing mental health policy and plans

Policies and plans in themselves can just be pieces of paper, or alternatively, they can be highly effective and efficient drivers of improved mental health in a country. Several actions are necessary to facilitate their implementation. These include:

- disseminating the policy;
- generating political support and funding;
- creating an implementation group;
- establishing a demonstration area;
- empowering mental health providers to implement the plan;
- reinforcing intersectoral coordination and promoting interaction among stakeholders.

Additional details about implementing mental health policies and plans are provided in Box 5.

Box 5. SUGGESTED STEPS FOR IMPLEMENTING MENTAL HEALTH POLICIES AND PLANS

Step 1. Disseminate the policy

Widely disseminate the new policies and plans to all stakeholders.

Step 2. Generate political support and funding

Undertake targeted advocacy and communications activities to garner sufficient political support and funding for implementation. (See subsequent section in this document on advocacy.)

Step 3. Create an implementation group

Establish a competent group of professionals with collective expertise in both public health and mental health. Make this group responsible for managing the plan and programme(s), facilitating the active participation of consumers and families in all components of the mental health network, and establishing collaborative intersectoral actions.

Step 4. Establish a demonstration area

Consider establishing a demonstration area prior to full implementation of the policy and plan. The demonstration area could be a geographical region or a sector of a large city that is representative of the majority of the population of the country concerned. Use knowledge gained from the demonstration area experience to improve the policy and plan before full implementation.

Step 5. Empower mental health workers

Develop and implement strategies to influence the delivery of services in line with the mental health policy and plan. Strategies will differ according to whether providers are public, private, nongovernmental organizations, consumers, or family groups, and could range from simple education and support activities through to contracting and implementation of incentives or contracting.

Step 6. Reinforce intersectoral coordination

Ensure that mental health specialists in the ministry of health are made responsible for: coordinating activities with other ministries to jointly formulate, implement, and evaluate mental health interventions; supporting mental health workers in health districts to implement district intersectoral interventions; and supporting mental health workers in health districts to enhance coordination among local health teams and other sector teams.

Step 7. Promote interaction among stakeholders

Organize multiple, ongoing interactions among stakeholders to ensure the smooth delivery of mental health interventions. These interactions should occur at different levels of the organization of a country or region, for example, between the ministry of health and other sectors, or between health districts and the ministry of health.

Developing more specific mental health policy and plans

While drafting a mental health policy, decisions will need to be made regarding whether to integrate all population subgroups within one policy, or whether to create several policies, each directed towards a different subgroup. More focused policies may be needed for children and adolescents (see Box 6), the elderly, or people who abuse substances. In some countries, specific cultural or ethnic groups also might warrant specific attention.

The special needs of women also merit consideration, especially in underserved populations. In addition to multiple social and role pressures, they often must contend with significant gender discrimination and the associated factors of poverty, hunger, malnutrition, overwork, domestic violence, and sexual

violence. In addition, women are more likely than men to be adversely affected by specific mental disorders, including depression and anxiety.[13]

For more information on mental health policy, plans and programmes, please see the WHO Module on Mental Health Policy, Plans and Programmes (updated) and the WHO Checklists for Evaluating a Mental Health Policy and Plan. [14]

Box 6. MENTAL HEALTH POLICIES AND PLANS FOR CHILDREN AND ADOLESCENTS

Children and adolescents with good mental health are able to achieve and maintain optimal psychological and social functioning and well-being. Nonetheless, the burden associated with mental disorders in children and adolescents is considerable and made worse by stigma and discrimination. It is therefore essential to provide effective interventions and support to the 20% of children and adolescents believed to be suffering from mental health problems or disorders.[15]

There are three compelling reasons for developing effective interventions for children and adolescents. First, because mental disorders occur at certain stages of child and adolescent development, screening programmes and interventions can be targeted to the stage at which they are most likely to occur. Second, because there is a high degree of continuity between child and adolescent mental disorders and those in adulthood, early intervention can prevent or reduce the likelihood of long-term disability. Third, effective interventions reduce the burden of mental disorders on individuals and families, and reduce costs to health systems and communities.

The basic principles for developing any mental health policy that have been outlined in this document also apply to the development of a specific child and adolescent mental health policy. The main difference is that the specific needs of adolescents and children should be considered carefully at each step and with regard to each area of action. In addition, several different systems of care might need to be involved to ensure that services are effective. For example, schools should be considered and can be used as an important context for mental health prevention and promotion.

For more information on child and adolescent policies and plans, please see the WHO Module on Child and Adolescent Mental Health Policies and Plans. [16]

Monitoring and evaluating mental health policy and plans

Governments are accountable to their constituents for their policies and plans, and for their use of public funds. It is therefore crucial that policies and plans are assessed carefully as part of governance and leadership, and that changes are made if they are not having their desired outcomes or effects. The mental health plan, which delineates the expected outputs, targets, and indicators, can be used to assess whether the policy and plan have been implemented successfully as intended.

To understand whether the policy and plan have achieved their intended objectives, it is necessary to take the following steps:

- Evaluate the merits of the policy and plan. An evaluation of the policy and plan, from both a process and content perspective, can determine its worth, feasibility, and likelihood of success. A successful policy and plan usually have undergone an inclusive process of development, in which the content follows best practice principles. The WHO checklist for evaluating a mental health policy and plan (see Annex 1) can be useful for examining these process and content issues.
- Monitor and evaluate the implementation of the plan. Close monitoring is required to understand whether the activities outlined in the plan have been completed within the required timeframe, whether inputs and outputs for activities have been delivered, and whether targets have been reached. If targets have not been reached, it is important to evaluate the reasons why this has happened.
- Assess whether, or to what extent, the policy objectives have been met. It is not sufficient to assume

that policy objectives will be achieved simply because targets have been met. Explicit evaluation of policy objectives is required, and the plan's strategies and targets might need to be revised accordingly.

Suggested steps for evaluating mental health policies and plans are listed in Box 7.

Box 7. SUGGESTED STEPS FOR EVALUATING MENTAL HEALTH POLICIES AND PLANS

Step 1. Clarify the purpose and scope of the monitoring and evaluation

Clarify the purpose of the evaluation, and then plan the evaluation accordingly.

Step 2. Identify the evaluators and funding for the evaluation

Ensure that any government-provided resources for evaluation are well-distributed across priority areas. If no or few resources have been allocated, develop funding strategies to secure resources from other sources, such as local or international donors. Decide whether the evaluation will be conducted by the government or alternatively, if an external agency will be employed.

Step 3. Manage ethical issues

Ensure that ethical practices are upheld when evaluations are conducted. Strictly follow procedures for obtaining informed consent, and protecting confidentiality and anonymity.

Step 4. Prepare and implement the operational plan for the evaluation

Develop a clear operational plan that details the research design, methods, timeframe, and data to be collected. Depending on the size and scope of the evaluation, assemble a team of people to complete the work. Team members might include field workers to conduct surveys, skilled interviewers for focus groups, and a statistician and a person with an in-depth understanding of mental health policy and planning, who can interpret results and make recommendations. Decide how to involve consumers and family members in the evaluation process. Service users are not only able to help identify key evaluation questions and provide information, but also are more likely to take ownership of the results if they are involved in the evaluation from the outset.

Step 5. Analyse data and report results

Collect, clean, sort, and analyse data. Make conclusions and recommendations on the basis of a clear and broad understanding of public mental health as well as the particular circumstances of the country concerned. Provide the report and recommendations in an appropriate language, level of technical detail, and format for the specific end users of the information.

For more information on monitoring and evaluation, please see the WHO Module on Monitoring and Evaluation of Mental Health Policies and Plans. [17]

MENTAL HEALTH LEGISLATION AND HUMAN RIGHTS

Key messages

- Mental health legislation is essential to complement and reinforce mental health policy, but is not a substitute for it.
- Legislation provides the legal framework for protecting individuals against human rights violations and also for providing mental health services that promote access to care.
- Mental health legislation can be consolidated into a single instrument or dispersed across several documents. A combination is likely to be the most effective.
- Mental health legislation extends beyond the health sector and includes issues related to education, housing, and employment.

Mental health legislation is equally important as mental health policy. Legislation provides the legal framework for protecting individuals against human rights violations and also for providing mental health services that promote access to care.

Mental health legislation is essential because of the unique vulnerabilities of people with mental disorders. They face stigma, discrimination, and marginalization in most societies, and there is a heightened probability of human rights violations.

Mental health legislation, when formulated according to human rights principles, provides a legal framework to address important mental health issues such as access to care, rehabilitation, integration of people with mental disorders into the community, and promotion of mental health in different sectors of society. It also addresses issues such as involuntary admission and treatment, the status of criminal offenders and prisoners with mental disorders, and the prevention of discrimination and upholding of the full human rights of all people with mental disorders.

Approaches to mental health legislation

There are different ways of approaching mental health legislation. In some countries, separate mental health legislation does not exist. Rather, provisions relating to people with mental disorders are inserted into health and relevant legislation in other areas. This is referred to as dispersed legislation. Other countries have consolidated mental health legislation, in which all issues of relevance to people with mental disorders are incorporated into a single instrument. Various combinations of these models also are possible.

Interface between mental health policy and legislation

Mental health legislation is essential to complement and reinforce mental health policy, but is not a substitute for it. Legislation provides a legal framework for achieving the goals of mental health policy. Key aspects of the interface between policy and legislation include:

- human rights issues, including protection against inhumane and degrading treatment;
- integration of people with mental disorders into their communities;
- improving quality of care, including general living conditions;
- fostering intersectoral linkages.

Content of mental health legislation

Important issues that should be addressed by legislation are indicated below.

Access to mental health care

Mental health legislation can promote access through funding mental health services at parity to physical health services, or by specifying that services need to be provided through primary health care centres and in general hospitals.

Legislation also can ensure that people are offered least-restrictive treatment settings, allowing them the possibility to continue working and participating in their communities.

Rights of users

Legislation can specify that the rights of people with mental disorders be respected, including:

- access to information, including information about their basic rights;
- confidentiality and privacy;
- humane mental health facilities;
- protection from cruel, inhumane, and degrading treatment, including forced labour;
- the option to communicate freely with friends, family, and others.

Competence and capacity

People with mental disorders have the right to exercise their legal capacity and to make informed choices and decisions. In some circumstances people may require support and assistance in exercising this right; provisions for this possibility should be legislated carefully.

Admission, treatment, and discharge from mental health facilities

Legislation should state that people with mental disorders, like all other people, are entitled to free and informed consent with regard to admission and treatment. Provisions must be built into the law to promote voluntary admission and treatment, and to safeguard against unjustifiable involuntary admission and treatment. Review and appeal processes, complaints procedures, and other relevant protective measures must be legislated in accordance with human rights principles. Legislation also must provide for the establishment of monitoring and review mechanisms to protect the rights of people with mental disorders.

Special treatments, seclusion and restraint, and clinical and experimental research

Legislation can outline safeguards in relation to procedures such as psychosurgery, electroconvulsive therapy and seclusion and restraint. Medical review boards may be established to determine the necessity of such treatments. Safeguards in relation to the participation of patients in clinical and experimental research is another important legislative area.

Families

Families play an important role in supporting and caring for people with mental disorders. Legislation should take into account the needs and rights of families, and should balance these with the needs and rights of people with mental disorders.

Legislation provisions relating to criminal offenders and prisoners with mental disabilities

Mental health legislation can prevent people with mental disorders from being kept in prisons when they should be receiving mental health care. This diversion can occur at the pre-trial stage, at the trial itself, post-trial stage, post-sentencing, and even while a person is serving a sentence.

Additional provisions

There are numerous other areas in which legislation can be used to protect people with mental disorders and promote their rights and well-being. Legislation might contain antidiscrimination clauses; it might deal with specific issues of housing, employment, social security; or civil issues such as the right to vote, to marry and to own property. Legislation also might address the protection of minority groups including minors, women, minorities, and refugees. Finally, legislation might be used to promote mental health and prevent mental disorders.

Activities preceding the formulation of legislation

A country that has decided to draft and enact new mental health legislation should conduct preliminary activities that can inform the process. These include:

- identifying barriers to implementation of mental health policies and plans;
- reviewing existing legislation;
- reviewing international human rights conventions and standards;
- examining legislation from other countries;
- building consensus and negotiating for change;
- educating the public.

A more detailed review of suggested steps prior to drafting mental health legislation is provided in Box 8.

Box 8. SUGGESTED STEPS PRIOR TO DRAFTING MENTAL HEALTH LEGISLATION

Step 1. Identify barriers to implementation of mental health policies and plans

Identify at an early stage major problems and barriers to the implementation of mental health policies and plans. Orient legislation to overcome these barriers, in particular those that relate to access, equity, and violations of human rights such as people's right to be treated in a humane manner.

Step 2. Review existing legislation

Critically review existing legislation to identify gaps and difficulties and identify those issues that need to be addressed by new legislation. Such a review might reveal that existing legislation does not have adequate provisions for ensuring care of a satisfactory quality and protecting the rights of people with mental disorders. It also might show that the existing legislation contravenes international human rights standards and conventions.

Step 3. Review international human rights standards

Countries that have ratified international human rights treaties have an obligation to protect, respect, and fulfil the rights enshrined in these treaties, through legislative and other measures. The International Covenant on Economic Social and Cultural Rights, the International Covenant on Civil and Political Rights (which most countries have ratified), and the International Convention on the Rights of Persons with Disabilities contain important standards in relation to the rights of people with mental disorders, and need to be reflected in national mental health legislation.

Step 4. Examine legislation from other countries

Examine other countries' legislation to determine components that generally are included. This exercise can identify useful components that are protective of human rights, as well as provisions that limit or violate human rights and should therefore be avoided in the proposed legislation.

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Step 5. Build consensus and negotiate for change

Consult and negotiate in drafting, adopting, and implementing the new legislation. Liaise with stakeholders including politicians and parliamentarians, policy-makers, government ministries (health, social welfare, law and finance), users and user groups, mental health professionals, family members of people with mental disorders, advocacy organizations, health workers, nongovernmental organizations, civil rights groups, religious organizations, and congregants of particular communities. In some countries, consultations also should be conducted with traditional leaders and traditional healers. Consultation provides a valuable opportunity to address misconceptions, misapprehensions, and fears about mental disorders.

Step 6. Educate the public

Inform and educate the public about the scope and nature of mental disorders, rights of people with mental disorders, and the proposed legislation.

Drafting, adopting, and implementing mental health legislation

The drafting and adoption process varies in different countries depending on the particular legislative, administrative, and political structures (see Box 9 for suggested steps). In many countries, the following steps would be important:

- establishing a drafting committee;
- engaging in consultation;
- preparing a draft for consideration by the lawmaking body;
- adoption by the law-making body.

Box 10 describes Ghana's recent experiences with drafting and adopting new mental health legislation.

Box 9. SUGGESTED STEPS FOR DRAFTING AND ADOPTING MENTAL HEALTH LEGISLATION

Step 1. Establish a drafting committee
Establish a drafting committee with sufficient collective expertise and understanding of mental health and legal issues (e.g. patients, lawyers, psychiatrists, and family representatives).

Step 2. Engage in consultation
Consider various viewpoints to ensure that the legislation is thorough, comprehensive, and reflects a balance of competing–though reasonable–priorities and opinions of different stakeholders.

Step 3. Prepare a draft for consideration by the law-making body
After the key principles of the legislation have been agreed through the consultation and negotiation process, prepare the legislation for submission to the law-making body.

Step 4. Adoption by the law-making body
Submit the draft legislation to the law-making body, where, depending on the particular legislative framework in a country, it will be debated and passed into law.

Box 10. PROTECTING RIGHTS THROUGH MENTAL HEALTH LEGISLATION IN GHANA[18]

Ghana, in collaboration with WHO, recently developed a new Mental Health Bill to replace its outdated 1972 law. The old law strongly emphasized institutional care, to the detriment of primary mental health care and contrary to international human rights standards. Procedures for involuntary admission in the 1972 law did not sufficiently protect people against unnecessary admission and serious mistreatment: some people were involuntarily locked away in institutions for decades under this law.

Through a series of training workshops, broad consultations with key national stakeholders, and ongoing analyses and reviews of drafts of the new law using WHO materials and tools, Ghana developed a comprehensive Mental Health Bill that protects the rights of people with mental disorders and promotes mental health care in the community, in accordance with international human rights standards.

Specifically, the new law aims to:

- improve access to inpatient and outpatient mental health care in communities in which people live;
- regulate mental health practitioners in both public and private sectors;
- combat discrimination and stigmatization, and promote human rights;
- promote voluntary treatment and, if necessary, voluntary admission to mental health facilities;
- introduce safeguards to protect against arbitrary and unjustified involuntary admission and treatment.

Currently, Ghana is preparing to implement the new legislation, and has elaborated a detailed action plan and regulations for putting the law into effect. Ghana's Mental Health Bill has gained the support of doctors, nurses, and traditional healers and can serve as a model for other African countries wishing to develop progressive mental health laws that respect international human rights standards.

The next important steps concern implementation of the legislation (see **Box 11** for additional details):

- appointing a body to oversee implementation;
- training people directly affected by legislation;
- providing adequate resources for implementation;
- preparing and producing regulations, codes of practice, and other guideline documents;
- monitoring legislation implementation.

For more information about mental health, human rights and legislation, please see the WHO Module on Mental Health Legislation and Human Rights, The WHO Resource Book on Mental Health Law and Human Rights [19] [20], as well as the WHO Checklist on Mental Health Legislation in Annex 2.

Box 11. SUGGESTED STEPS FOR IMPLEMENTING MENTAL HEALTH LEGISLATION

Step 1. Appoint a body to oversee implementation
Establish a body with a focused mandate to oversee implementation and to provide close governance.

Step 2. Train people directly affected by the legislation
Train service users, their families, health workers (including mental health workers), lawyers, magistrates, review board members, and others on the new legislation so that they can give effect to the spirit and the letter of the new law.

Step 3. Provide adequate resources for implementation
Identify or mobilize resources – human and financial–to support implementation of the new legislation. Usually before passing a law, the legislature will ensure that adequate resources will be made available to implement it. Where this occurs, these resources might need to be mobilized. Where this does not occur, resources will need to be identified.

Step 4. Prepare and produce regulations/proforma/codes of practice and other guideline documents
Once the legislation has been accepted formally, draft and adopt regulations, proforma, and codes of practice through a consultative process. Regulations provide detailed guidelines for how the legislation should be implemented. Proforma facilitate the easy implementation of the legislation and obtain consistency in information on the various processes of the legislation. Codes of practice and guidebooks provide information to different stakeholders.

Step 5. Monitor legislation
Monitor legislation and address any problems identified in its implementation.

MENTAL HEALTH ADVOCACY

Key messages

- Mental health advocacy influences others to create change using information in strategic ways.
- Advocacy is different from education. Education informs and helps create understanding of an issue. Advocacy, on the other hand aims to persuade. This is done through requests and calls for specific actions.
- One basic principle is that advocacy is effective only when the target audience is asked to do something. Mobilizing people means asking them to become part of the solution.
- Mental health advocacy movements in several countries have helped to change the way in which mental disorders are perceived and managed in health systems and society in general.

Mental health advocacy uses information in deliberate and strategic ways to influence others to create change. It involves the promotion of the needs and rights of people with mental disorders, as well as the mental health needs and rights of the general population.

There is nothing mysterious or complex about successful advocacy. On the other hand, it is not something that most people naturally know how to do without some education. Fundamentally, advocacy is a skill that can be learned and mastered.

Advocacy can result in positive outcomes such as:

- mental health being placed on government agendas;
- increased attention to mental health issues from donors and development partners;
- improvements in policies and practices of governments and institutions;
- changes made to legislation and government regulations;
- improvements in the promotion of mental health and the prevention of mental disorders;
- the protection and promotion of the rights and interests of people with mental disorders and their families;
- improvements in mental health services, treatment, and care;
- reduction in stigma and discrimination.

To maximize the impact of advocacy initiatives, it is important for governments to engage and build coalitions with users of services, families, and groups assisting consumers such as nongovernmental organizations (see Box 12).[21] Thousands of voices speaking independently can be ignored or dismissed. But by working together to deliver a message with one voice, advocates can make a real difference. Suggested steps[22] in designing and implementing an advocacy plan are listed in Box 13.

Box 12. EXAMPLES OF ACTIONS THAT CAN BE TAKEN BY GOVERNMENTS TO PROMOTE ADVOCACY WITH DIFFERENT STAKEHOLDER GROUPS

Advocacy actions with consumer, family, and nongovernmental organizations:

- develop and disseminate a database of consumer groups, family groups, and nongovernmental organizations;
- invite representatives of organizations to participate in the formulation and evaluation of policies; participate on commissions, committees or other bodies; conduct activities with the media; or organize public events;
- invite representatives of organizations to help train mental health and general health workers.

Advocacy actions with health and mental health workers:

- promote an understanding of the importance of community care, community participation, and human rights;
- promote good working conditions for mental health workers;
- provide adequate training and support to mental health and general health workers.

Advocacy actions with policy-makers, planners, and donors:

- share information about the prevalence of mental disorders, the burden they impose if left untreated, the human right violations that often occur in psychiatric hospitals, and the existence of cost-effective primary care and community-based treatment options;
- identify themes that rank high in public opinion and hence likely to be of interest to policy-makers (e.g. adolescent suicide, crime and violence, HIV/AIDS);
- develop alliances with other groups to promote key mental health messages and actions.

Advocacy actions with the general population:

- Use the mass media to increase awareness of mental health issues, for example through public service announcements or magazine features;
- provide education about mental health issues in schools;
- hold public events and lectures around mental health themes.

Box 13. SUGGESTED STEPS IN DESIGNING AND IMPLEMENTING AN ADVOCACY PLAN

Step 1: Define the local situation

Obtain information about, for example, the nature and scope of mental disorders, availability of treatments, and knowledge and attitudes in different populations. This information can be obtained through established sources or through observation, surveys, or key informant interviews.

Step 2: Establish the goals and objectives

Consider opportunities and obstacles, taking into account the overall environment and levels of public understanding and support for change. Identify specific areas for change and translate them into an overall long-term goal and a series of short-term objectives.

Step 3: Identify the target audience

Spend time identifying the target audience. Who needs to be targeted in order to achieve the objectives? What will motivate and influence them?

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Step 4: Develop key messages to influence the target audience

Develop messages that will convince the target audience to take action, rather than messages that simply convey information. Ideally, one primary key message and two or three secondary key messages should be developed.

Step 5: Develop and implement the advocacy plan

Consider the wide range of available communication methods, including face-to-face meetings, letters, events and the media. Choose communication channels that will suit the audience and that they will find accessible and credible.

Step 6: Monitor and evaluate the advocacy plan

Monitor and evaluate progress to determine whether the work is having an impact and to identify areas needing modification.

Mental health advocacy movements in several countries have helped to change the way in which people with mental disorders are perceived (see Box 14 for an example from Mexico). Consumers have begun to articulate their own vision of the services they need and want, and increasingly are making informed decisions on treatment and other matters in their daily lives.

Box 14. ADVOCATING FOR THE RIGHT TO REHABILITATION OF PEOPLE WITH MENTAL DISORDERS IN MEXICO [23]

The Mexican Foundation for Rehabilitation of People with Mental Disorders is a nongovernmental organization that was initiated in 1980 and pioneered the implementation of psychosocial rehabilitation programmes. It began its activities in psychiatric hospitals and extended them to the community. The foundation developed the country's first community day centre for people with mental disorders and a community residence for former patients of psychiatric hospitals. It has denounced national and international institutions in relation to human rights violations in Mexican psychiatric hospitals and has promoted the formation of citizens' committees in these facilities. In 1999 and 2000, the foundation joined forces with the national Secretary of Health to create the Hidalgo model of mental health services, a demonstration area in the State of Hidalgo with 10 small houses for intensive psychosocial rehabilitation, and two halfway houses for social integration. These new services made it possible to close the state psychiatric hospital and to improve the quality of life of consumers.

In its work to promote rehabilitation for people with mental disorders, this nongovernmental organization used several advocacy methods. It denounced human rights violations, promoted consumer participation in mental health facilities, implemented pilot projects, and provided community services. It also lobbied and influenced policy-makers, leading to changes in mental health policy, the direct collaboration between the nongovernmental organization and the government, and the creation of a community mental health demonstration area.

For more information on mental health advocacy, please see the WHO Module on Advocacy for Mental Health. [23]

ORGANIZATION OF MENTAL HEALTH SERVICES

Key messages

- The *WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health* describes the necessary components of any mental health system.
- Primary care for mental health, as defined in the WHO model, is fundamental but must be supported by other levels of care including community-based and hospital services, informal services, and self-care to meet the full spectrum of mental health needs of the population.
- Integrated mental health services reduce stigma, address health worker shortages, and improve access to services.
- Conversely, psychiatric hospitals are outdated, ineffective, and result in human rights violations.

In any mental health system, good health services are those that deliver effective, safe, and high-quality care to those that need it, when needed and with minimal waste. Although there is no single organizational model for good service delivery, there are common factors that underlie successful approaches.

The WHO model of optimal mental health care

WHO has developed previously a model describing the optimal mix of mental health services. The *WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health* proposes the integration of mental health services with general health care. Integrated primary mental health care is a fundamental component of this model, and is supported by other levels of care including community-based and hospital services.[24]

The WHO model is based on the principle that no single service setting can meet all population mental health needs. Support, supervision, collaboration, information-sharing and education across the different levels of care are essential to any system. The model also assumes that people with mental disorders need to be involved, albeit to differing degrees, in their own recovery from mental disorders. It promotes good use of resources, the involvement of individuals in their own mental health care, and a human rights and community-based orientation. Regardless of resource level, all countries should aim to procure the best possible mix of services from all levels of the pyramid and regularly evaluate what is available, with the aim of gradually improving the range of available services.

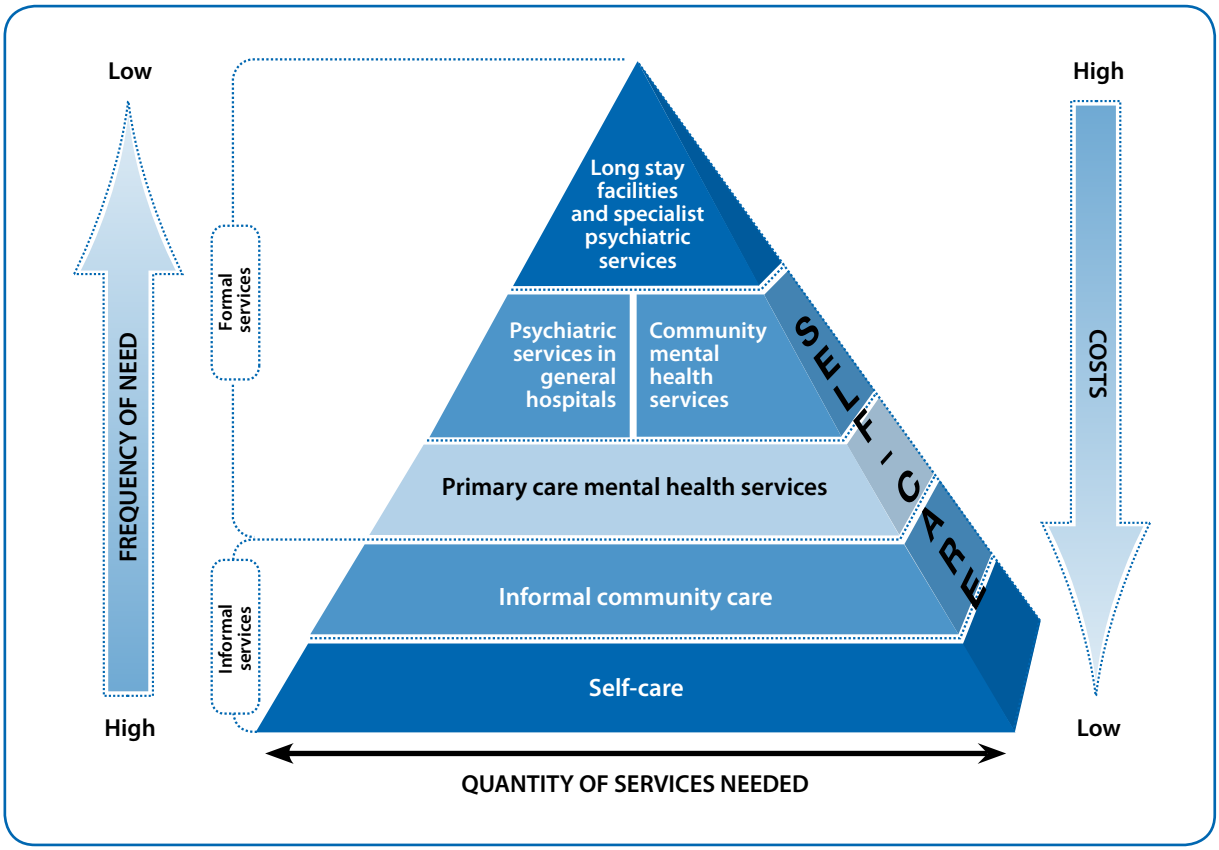
The WHO model has been further elaborated by WHO and the World Organization of Family Doctors (Wonca) to emphasize the dimension of self-care that is required at each service level (see Figure 2). Self-care is reflected at the bottom of the pyramid, and at this level refers to care without individual professional input. At all levels of the system, self-care is essential and occurs simultaneously with other services. This is reflected by the three dimensional nature of the pyramid. At each higher level of the pyramid, individuals become more engaged with professional assistance. However, self-care continues at all levels, which in turn promotes and encourages recovery and better mental health.

The emphasis on self-care in this model should not be confused with blaming affected individuals for having mental disorders, nor for shifting undue responsibility on people to “get themselves together”. Rather the model emphasizes health worker-patient partnerships and collaboration to promote an active role of people with mental disorders in their own care. Individuals’ roles may range from collaborative decision-making concerning their treatment, to actively adhering to prescribed medication, through to

changing health-related behaviours such as drug and alcohol use or stress management. Self-care is important not only for mental disorders, but also for the prevention and treatment of physical health problems.

The different levels of WHO model are illustrated in the figure below.

Figure 2: WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health



The model recommends that countries build or transform their mental health services to:

- promote self-care;
- build informal community care services;
- integrate mental health services into primary health care;
- build community mental health services;
- develop mental health services in general hospitals;
- limit psychiatric hospitals.

The different levels of the model are described below.

Self-care

Most people manage their mental health problems themselves, or with support from family or friends. Self-care is thus the base of the service pyramid, upon which all other care is based. Self-care is most effective when it is supported by formal health services. The formal sector has an essential role in providing information such as how to deal more effectively with stress, the importance of physical

activity in staying mentally well, effective ways of dealing with relationships and conflict management, and the dangers of hazardous alcohol and drug use. Self-care should be facilitated through all services and at all levels of the WHO service pyramid.

Informal community care

Informal community care comprises services provided in the community that are not part of the formal health and welfare system. Examples include traditional healers, professionals in other sectors such as teachers, and police, services provided by nongovernmental organizations, user and family associations, and lay people. This level of care can help prevent relapses among people who have been discharged from hospitals. Informal services are usually accessible and acceptable because they are an integral part of the community. Nonetheless, informal community care should not form the core of mental health service provision, and countries would be ill-advised to depend solely on these services.

Primary care mental health services

Mental health care provided within general primary health services is the first level of care within the formal health system. Essential services at this level include early identification and treatment of mental disorders, management of stable psychiatric patients, counselling for common mental disorders, referral to other levels where required, and mental health promotion and prevention activities. Depending on who provides first-level health care in a particular country, general practitioners, nurses or other health workers may provide these assessment, treatment and referral services.

Services at the primary health care level are generally the most accessible, affordable and acceptable for communities. Where mental health is integrated as part of these services, access is improved, mental disorders are more likely to be identified and treated, and comorbid physical and mental health problems managed in a seamless way.

An example of primary mental health care in South Africa is described in Box 15. As a result of analysing and synthesizing the South Africa experience and many other best practice examples, 10 common principles that can be applied to all mental health integration efforts have been identified (see Box 16).[25] Across the full spectrum of political and economic contexts, and levels of the health system, these 10 principles are 'non-negotiable' for integrated primary mental health care.

Box 15. MAKING MENTAL HEALTH CARE ACCESSIBLE THROUGH PRIMARY HEALTH CARE INTEGRATION IN SOUTH AFRICA[25]

In 1994, at the end of Apartheid rule, the newly-formed Mpumalanga Province of South Africa had no mental health services whatsoever. Within 10 years, it developed and implemented integrated primary mental health care throughout the region.

The Ehlanzeni District (one of three local authority districts that make up the province of Mpumalanga) provided the site for establishing two different models of mental health care integration into primary health care settings.

In the first model, a skilled psychiatric nurse is present in the primary health care setting to consult with people with mental health problems. General health workers are trained to detect mental disorders and refer patients to the designated psychiatric nurse as necessary. The nurse schedules a specific time each week for mental health consultations and patients know to attend the clinic at this time. These patients do not queue with patients who are attending the clinic for other reasons. The nurse's primary functions are to conduct routine assessments of people with mental disorders, to dispense psychotropic medication or recommend medication changes to the medical officer, to provide basic counselling, and to identify social issues for amelioration. Patients are referred to complementary services if available, although in many cases community-based social services are sparse.

In the second model, mental disorders are managed as any other health problem. People with mental disorders wait in the same queues and are seen by the next available primary care practitioner when they reach the front of the queue. Nurses are trained to assess and treat both mental and physical health problems, and patients with comorbid problems are treated holistically. Referrals to secondary care or community-based services are made as needed.

Importantly, clinics have tended to adopt the model that best accommodates their available resources and local needs.

By the end of 2002, 50% of clinics in the Ehlanzeni District were delivering mental health services, and by early 2007, 83% of clinics were delivering these services. Primary care nurses and patients are satisfied with the integrated approach.

Box 16. 10 PRINCIPLES FOR ACHIEVING INTEGRATED MENTAL HEALTH CARE[25]

1. Policy and plans need to incorporate primary care for mental health.
2. Advocacy is required to shift attitudes and behaviour.
3. Adequate training of primary care workers is required.
4. Primary care tasks must be limited and doable.
5. Specialist mental health professionals and facilities must be available to support primary care.
6. Patients must have access to essential psychotropic medications in primary care.
7. Integration is a process, not an event.
8. A mental health service coordinator is crucial.
9. Collaboration with other governmental non-health sectors, nongovernmental organizations, village and community health workers, and volunteers is required.
10. Financial and human resources are needed.

Community mental health services

Community mental health services include day centres, rehabilitation services, hospital diversion programmes, mobile crisis teams, therapeutic and residential supervised services, group homes, home help, assistance to families, and other support services. Although only some community mental health services will be able to provide the entirety of these services, a combination of some components based on needs and requirements is essential for successful mental health care. In particular, strong community mental health services are essential as part of any deinstitutionalization programme, as well as to prevent unnecessary hospitalization. People receiving good community care have been shown to have better health and mental health outcomes and better quality of life than those treated in

psychiatric hospitals (see the example of Belize, Box 17). To maximize effectiveness, strong links are needed with other services up and down the pyramid of care.

Box 17. INTRODUCING PSYCHIATRIC NURSE PRACTITIONERS INTO COMMUNITY-BASED CARE IN BELIZE[25]

In the 1990s, Belize introduced a programme in which psychiatric nurse practitioners were trained and integrated into community-based care. Psychiatric nurses attend to patients at the outpatient clinic at district hospitals in which they are based, and also provide community mental health services through mobile clinics and home visits.

The introduction of psychiatric nurse practitioners in Belize facilitated numerous improvements that are in evidence today: admissions to the psychiatric hospital have been reduced; outpatient services have increased; and community-based mental health prevention and promotion programmes are now in place.

The next phase of the programme will strengthen psychiatric nurse practitioners' direct interactions with primary care practitioners, to increase their awareness and train them to manage mental health issues within their general practices.

Psychiatric services in general hospitals

The development of mental health services in general hospital settings is another essential element of the organization of services. Given the nature of certain mental disorders, hospitalization during acute phases might be required occasionally. District general hospitals provide an accessible and acceptable location for 24-hour medical care and supervision of people with acute worsening of mental disorders, in the same way that these facilities manage acute exacerbations of physical health disorders. Mental health services provided in district general hospitals also enable 24-hour access to services for any physical health problems that might arise during the course of inpatient stays.

Long-stay facilities and specialist services

For a small minority of people with mental disorders, specialist care is required beyond that which can be provided in general hospitals. For example, people with treatment-resistant or complex presentations sometimes need to be referred to specialized centres for further testing and treatment. Others occasionally require ongoing care in residential facilities due to their very severe mental disorders or intellectual disabilities and lack of family support. Forensic psychiatry is another type of specialist service that falls into this category.

The need for referral to specialist and long-stay services is reduced when general hospitals are staffed with highly-specialized health workers such as psychiatrists and psychologists. However, this is seldom possible in low-income countries, where ratios of mental health professionals to the population are very low.

Long stay and specialist service facilities should not be equated with the psychiatric hospitals that dominated mental health care through most of the 20th century. Psychiatric hospitals have a history of serious human rights violations, poor clinical outcomes, and inadequate rehabilitation programmes. They also are costly and consume a disproportionate proportion of mental health expenditures. WHO recommends that psychiatric hospitals be closed and replaced by services in general hospitals, community mental health services, and services integrated into primary health care.

Other principles for organizing mental health services

Even if the 'ideal' service organization model were to be adopted, it would not result in optimal treatment and care for people with mental and substance use disorders unless a number of key principles for organizing services were respected. These include the following.

Accessibility

Essential mental health care, including outpatient and inpatient care, should be available locally so that people do not have to travel long distances. Accessibility also implies that services should be affordable and acceptable.

Comprehensiveness

People with mental disorders need and can benefit from a range of different coordinated services incorporating case management, multidisciplinary teams, crisis intervention, assertive outreach, patient advocacy, practical support, as well as a range of treatments. In addition to managing acute and chronic health needs, services need to address longer-term community integration needs, such as social services, housing, education, and employment. Collaboration with other sectors is essential in this regard.

Continuity and coordination of care

Health systems in most countries, and especially those in developing countries, are designed to provide health care on the basis of the throughput model, which emphasizes intensive treatment of acute episodes in the expectation that most patients will make a reasonably complete recovery without a need for ongoing care until the next acute episode. Many mental disorders, especially those with a chronic course or with a relapsing-remitting pattern, are better managed by services that adopt a continuing care model. A continuing care approach also emphasizes the need to address the totality of patients' needs, including their social, occupational, and psychological requirements.

Needs-led care

To be effective, mental health services should be designed on a needs-led basis, rather than on a service-led basis. This means adapting services to users' needs.

Effectiveness

Service development should be guided by evidence of the effectiveness of particular interventions and models of service provision. There is growing evidence of effective interventions for many mental disorders.

Equity

People's access to services of good quality should be based on need. Equity means that all segments of the population are able to access services. For most policy-makers, the improvement of equity involves working towards greater equality in outcomes or status among individuals, regardless of their income group or geographic region.

Respect for human rights

International human rights norms and standards should be respected when providing services for people with mental disorders. People with mental and substance use disorders have the same civil, economic, political, social, and cultural rights as everyone else in the community, and these rights should be upheld.

For more information about the organization of mental health services, please see the WHO Module on Organization of Services for Mental Health. [26]

PLANNING AND BUDGETING FOR MENTAL HEALTH

Key messages

- Rational planning and budgeting can help build effective mental health services.
- Methods are available to help determine the physical and human resource requirements for high-quality mental health services.
- The planning and budgeting process is cyclic; as new information emerges, changes can be made to subsequent planning and budgets.

Once countries decide on their preferred service model, they need to plan and budget for the services to be delivered. Planning is not only a technical exercise, but also a political process that should take into account the needs of all mental health stakeholders, as well as the wider health and social needs of the population.

Planning and budgeting seldom begin from a base of no services or budget. Planners therefore need a thorough understanding of the current services offered in relation to the model of service they are aiming towards. They also must grasp how their plan and budget will shift over several years to meet the desired organizational outcomes.

There are four essential processes in planning for mental health services. Each of these has particular tasks attached to them. The processes are:

- conducting a situation analysis;
- assessing needs;
- setting targets for mental health services;
- implementing the service targets through budget management, monitoring and evaluation.

Conducting a situation analysis

Conducting a situation analysis can be a complex process. A number of different contextual aspects need consideration; suggested steps are contained in **Box 18.**

Box 18. SUGGESTED STEPS IN CONDUCTING A SITUATION ANALYSIS

Step 1. Identify the population to be served

Identify the population or catchment area to be served by the mental health system.

Step 2. Understand the context of mental health planning

Gather information on the country context in relation to mental health care. This could include information such as the history of mental health services in the area, the current policy on mental health (both centrally and locally), the economic circumstances, and the cultural context. Also consider the degree to which the health workforce is motivated and supported, as well as the overall quality of current mental health care.

Step 3. Consult with relevant stakeholders

Identify and consult with relevant stakeholders to better understand differing service priorities and interpretations of mental health issues.

Step 4. Identify who is responsible for the mental health plan and budget

Ascertain areas of responsibility for the mental health budget and plan, including the limits of the available budget and its integration with general health and other sectors. Identify key stakeholders who have some part to play in authorizing the size and deployment of the mental health budget.

Step 5. Review current public sector service resources

Conduct a specific review of current public sector service resources, including the number of inpatient beds, health workers, and service facilities, as well as medication accessibility. Ensure that the review encompasses all services across primary, secondary, and tertiary levels, and includes both speciality and integrated services.

Step 6. Review other sector service resources

Review other sector service resources provided outside the public health sector to establish the extent to which other sectors are meeting mental health care needs. Consider whether these services could continue or be expanded.

Step 7. Review current service utilization in all sectors

Establish the demand for local mental health services by reviewing the extent to which services are used both within and outside the public sector. Consider useful indicators of service utilization such as admissions; bed occupancy; average length of stay or admission; outpatient attendances (annual and average daily patient visits); patients or users on case registers; filled day-service places; and number of people participating in programmes for the prevention of mental disorders or the promotion of mental health. Check equity in service utilization: low utilization of services in certain areas, for example, might indicate problems of access (both financial and geographical) or inadequate service provision.

Assessing needs

Following a situation analysis, it is important to establish the needs of the local population for mental health care. Broad priorities should be established regarding the mental disorders to be treated. A series of suggested steps is given in Box 19.

Box 19. SUGGESTED STEPS IN ASSESSING NEEDS

Step 1. Establish prevalence or incidence of priority conditions

Use information on local annual prevalence to establish the prevalence of targeted conditions. As an alternative, use estimates from "comparable" countries or regions, adjusted for local sociodemographic characteristics. Consider disability indicators, which are important measures of need.

Step 2. Adjust rates based on local population variables

Adjust prevalence data according to local population variables, for example, age distribution, gender, and social status.

Step 3. Identify the number of expected cases in a year

On the basis of consultation, priority setting, prevalence figures and adjustments according to the local population, specify the expected number of cases per year for the target population.

Step 4. Estimate the services required for the identified need

Describe the service items and components of care required for identified cases during a specified year. These should include outpatient services, day services, inpatient services, medications, and staff.

Step 5. Cost the resources for the estimated services

Cost the services that have been estimated as necessary for the identified cases in the local population. This will enable priority setting, option appraisal, and target setting. Identify all costs that will arise and upon whom they will fall. For example, a community-based mental health service for psychosis might incur costs for the health service (medications, personnel, transport); patients (charges, accommodation, transport, time – including lost working time); families (time caring for patients instead of working); and other sector services such as social services, criminal justice, and housing.

Setting targets for mental health services

The next crucial process is to set targets. It is important to reconcile the differences between current service realities and estimates of need. Data comparisons can highlight the most urgent service priorities. Suggested steps are outlined in Box 20.

Box 20. SUGGESTED STEPS FOR TARGET SETTING

Step 1. Appraise options

Consider the most urgent priorities and their service options. For each option, consider the technical, administrative, and legal feasibility; financial and resource availability; long-term sustainability; acceptability; potential secondary or indirect consequences; equity and distributional effects; and potential for transition from pilot project to full implementation. Use any available criteria or checklists that have been developed in the general health sector to appraise options for service development.

Step 2. Set targets

On the basis of the option appraisal, set targets that detail specific plans for service delivery. The latter should include information on expected costs, activities, and the timeframes for implementation.

Implementing service targets through budget management, monitoring, and evaluation

The final process of planning and budgeting is implementation. If the previous steps have been completed comprehensively, implementation is far easier to accomplish. Monitoring and evaluation is a key aspect of the implementation process.

Suggested steps in implementation, monitoring and evaluation are presented in Box 21.

Box 21. SUGGESTED STEPS IN IMPLEMENTATION, MONITORING, AND EVALUATION

Step 1. Manage the budget

Familiarize oneself with the budgeting process. Ensure that financial management and accounting systems are operational, which will allow for the effective management and monitoring of the mental health budget and those aspects of the general health budget that are pertinent to mental health.

Step 2. Monitor and evaluate

Monitor on an ongoing basis through, for example, the development of information systems and quality improvement mechanisms (see following sections of this report). Design evaluations that will provide managers and planners with necessary information on both the costs and outcomes of service delivery.

Planners might encounter difficulties associated with political differences, personal power struggles, and conflicting needs of different stakeholders. The process of mental health reform can take time and is likely to require the mobilization of political will as well as advocacy from various constituents (see previous section on advocacy).

For more information about planning and budgeting for mental health services, please see the WHO Module on Planning and Budgeting to Deliver Services for Mental Health. [27]

QUALITY IMPROVEMENT FOR MENTAL HEALTH

Key messages

- Quality improvement helps ensure that scarce resources for mental health are used effectively and efficiently.
- Different quality improvement approaches have been developed; each has unique strengths and advantages.
- Quality improvement is a continual process, which requires the active participation of all stakeholders on an ongoing basis.

Quality is important in all mental health systems. A focus on quality helps to ensure that resources are used properly and that the latest scientific knowledge is incorporated into treatment. Quality improvement helps to identify overuse of ineffective services, as well as underuse of effective services. In addition, a focus on quality helps to build trust in the effectiveness of the system and to overcome barriers to appropriate care. Good-quality services help to build people's confidence in mental health treatment, so that they are more likely to seek the care that they need. For family members, quality means that support is provided and that help is given for the preservation of family integrity. From the perspective of service providers or programme managers, effectiveness and efficiency are ensured, while for policy-makers quality is the key to improving the mental health of populations and ensuring accountability and value for money.

Without satisfactory quality, people with mental disorders, their families, and the general public become disillusioned with mental health treatment and care. Lack of focus on quality also results in resources being wasted.[28]

Improving quality is a cyclical process. Once policy, standards, and accreditation procedures are established, continually improving the quality of care requires ongoing monitoring of services, integration of quality improvement strategies into service management and delivery, and the improvement or reform of services. On a less frequent basis, a review of the policy, standards, and accreditation procedures is necessary. Key steps include:

- aligning policy for quality improvement;
- designing a standards document;
- establishing accreditation procedures;
- monitoring mental health services' quality;
- integrating quality improvement into the management and delivery of services;
- considering systematic reform for the improvement of services;
- reviewing the quality mechanisms.

Detailed information on each of these steps is provided in **Box 22** and an example of a quality framework is provided in **Box 23**.

Box 22. SUGGESTED STEPS FOR QUALITY IMPROVEMENT

Step 1. Align policy for quality improvement

Align health policy so that it facilitates – rather than acts as a barrier to – quality improvement.

Establish multisectoral partnerships to facilitate quality improvement. For example:

- Professional organizations: to define and maintain competency in an organization's membership;
- Academic institutions: to introduce education and training for health workers consistent with the mental health needs of the population;
- Human rights organizations, people with mental disorders, and family members: to increase advocacy;
- Primary health care and social care services: to meet the multiple needs of people with mental disorders, across different domains of their life.

Align legislation to promote quality. Legislation can promote quality through inclusion of minimum professional and service standards, establishing accreditation procedures for programmes and institutions, developing licensing and certification procedures for health workers, and mandating visiting boards and review bodies to review the conditions in mental health facilities to ensure that human rights are being respected.

Align financial systems for mental health care so that they maximize quality and do not become an obstacle to quality improvement. Consider establishing funding criteria related to quality, for example, requiring that services need to be accredited by an external body to receive funding, or providing financial incentives that reward quality. Ensure adequate payment levels for health workers to attract and maintain high-quality candidates.

Step 2. Design a standards document

Design a standards document against which services can be measured. The standards should cover all domains, such as:

- rights and legal protection;
- safety and risk management;
- access;
- privacy and confidentiality;
- personal interaction and communication;
- user and carer participation.

Stipulate criteria for each domain that are as specific as possible and not open to interpretation by people who rate the service. (See **Box 23** for an example from Ireland.)

Step 3. Establish accreditation procedures

Establish an accreditation board that has the legal authority to license mental health services, and to prevent services from continuing to function if the quality of care is considered unacceptable. Ensure that the board includes legal and clinical representatives, service managers, and people with mental disorders.

Step 4. Monitor the mental health service by using the quality mechanisms

Design a monitoring plan based on established standards. Include both a self-assessment process, where the organization rates its own performance against the standards, and also an external assessment where external experts rate the performance of the organization.

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Step 5. Integrating quality improvement into service management and delivery of services

Introduce a continuous quality improvement philosophy and practice into mental health services. Train managers and health workers that accreditation is a minimum norm in accordance with which services should function, whereas quality improvement is a process of continually striving for optimal norms, taking full advantage of the standards and criteria for accreditation which are already in place.

Step 6. Consider systematic reform for the improvement of services

After quality has been assessed, consider whether there is a need for systematic reform or improvements. Steps towards the attainment of particular service improvement goals might include reductions in hospital services and the development of community-based services, and improvement in the rights of people with mental disorders in inpatient facilities.

Step 7. Review quality mechanisms

Review the quality mechanisms themselves on an intermittent basis. This review will provide an opportunity to improve and update links with information systems, which provide the lifeblood for quality assessment and improvement.

Box 23. DESIGNING A QUALITY FRAMEWORK IN IRELAND[29]

A Mental Health Commission was established in Ireland to promote, encourage, and foster high standards and good practices of mental health services. To this end, the commission conducted extensive consultations with stakeholders to ascertain their views of what constitutes good-quality mental health services. Following this, standards for each of the key themes identified were developed, as well as defining criteria against which the outcomes are to be measured.

The themes are:

- provision of a holistic, seamless service across the full continuum of care and provided by a multidisciplinary team;
- respectful, empathic relationships between service users and providers;
- an empowering approach to service delivery, which is beneficial to both people using the service and those providing it;
- a good-quality physical environment that promotes good health and upholds the security and safety of service users;
- ready access to services;
- family/advocate involvement and support;
- development of health workers' skills, expertise, and morale;
- systematic evaluation and review.

When conducting quality improvement, a bottom-up approach should be used as much as possible. Positive incentives to improve quality, rather than critical or punitive methods, should be encouraged. This means:

- encouraging health workers to identify quality issues in their workplaces;
- consulting health workers in the design of quality improvement strategies;
- explaining the rationale and context of quality improvement;
- offering positive incentives and positive feedback for health workers to identify their own solutions to problems, rather than waiting for management authorities to do so;
- publicly acknowledging the contribution of health workers and managers towards implementing quality improvement.

For more information about quality improvement for mental health, please see the WHO Module on Quality Improvement for Mental Health. [30]

HUMAN RESOURCES AND TRAINING IN MENTAL HEALTH

Key messages

- The provision of good-quality mental health care often necessitates a transformation of the roles and responsibilities of both mental health specialists and general health workers.
- Transforming the workforce does not require simply increasing the number of health workers, but also redistributing existing workers, changing the skill mix, and developing new competencies.
- Workforce training should address integrated care and the rights of people with mental disorders.
- Distance learning and train-the-trainer approaches are particularly relevant for mental health training.

Human resources: policy and models of care

A clear national policy is necessary for the effective development of a mental health workforce. A human resources policy should define the overall values and goals and provide a coherent framework within which the country can plan, train, and develop their workforce for mental health. It also should provide a means of accountability and encourage continuous improvement in the quality of care (see previous section on quality improvement).

During the last 50 years, mental health care has undergone major changes, largely towards community-based care. And, as described in the previous section on organization of health services, the trend is for mental health services increasingly to become integrated into general health care. These changes have required a reallocation of health workers from hospital to community settings, a modification of roles, and new competencies. In addition, health workers are working increasingly in multidisciplinary settings and across sectors including health, education, criminal justice, housing, and social services. Changing roles represent challenges for management and health workers alike.

The 2001 World Health Report (*Mental Health: New Understanding, New Hope)*[1] stated that:

- countries need to develop a workforce capable of providing evidence-based interventions for mental health promotion, prevention, treatment and rehabilitation;
- health workers should be equipped to provide community-based services that are integrated into general health care;
- training programmes need to be increased and improved for both specialist mental health workers and general health workers at all service levels;
- people from a range of disciplines should work together in teams to provide seamless care for the multiple needs of people with mental disorders;
- workforce development and training must address issues of stigma in mental health and uphold the rights of all people with mental disorders.

Planning: what type of health workforce is needed for mental health care?

How many people, and with which competencies, are required to staff a mental health service? There is no absolute or global norm for the right ratio of mental health workers per population unit. Countries or regions must determine the 'right number' according to their specific needs and the mental health

system. To help establish the right number, planners need to undertake an analysis of the current situation, followed by a needs assessment. Targets must then be set on the basis of the information gathered. These targets are implemented through management, training, and supervision. The cycle then begins again for the next planning period. Details of this process are provided in Box 24, and additional suggestions are provided in Figure 3.

Box 24. SUGGESTED STEPS IN PLANNING AND IMPLEMENTING A MENTAL HEALTH WORKFORCE STRATEGY

Step 1. Conduct a situation analysis and needs assessment

Conduct an assessment of current human resources policies, as well as the number and type of current health workers and their distribution. Estimate the mental health service needs in the community and the human resources required to meet those needs. The WHO service organization pyramid **(see Figure 2)** can be used as the basis for these assessments to highlight needs and gaps at different service levels.

Step 2. Set targets

Based on the information gathered in Step 1, identify human resource gaps and set targets to reduce gaps. Understand that developing the workforce to better meet demand might not require simply increasing the number of health workers, but also redistributing existing workers and developing new competencies.

Step 3. Implement the strategy

Keep the following points in mind when implementing a new strategy for staffing mental health services.

Mental health workers often face burnout because of factors specifically associated with mental health care. For instance, they frequently deal with service users whose behaviour might be strange or bizarre. People with mental disorders can be demanding, occasionally blaming those who offer help for their problems. Moreover, people with severe and enduring mental disorders frequently make slow progress and as such, offer few rewards to health workers. On occasion, threats or acts of verbal and physical aggression from users can complicate matters. Health worker burnout needs to be managed directly.

Under-resourced services, neglected wards, unavailable medications, poor sanitary conditions, and overcrowding also can contribute to low morale of health workers. Against such considerations, mental health work provides opportunities for personal and professional fulfilment for many people.

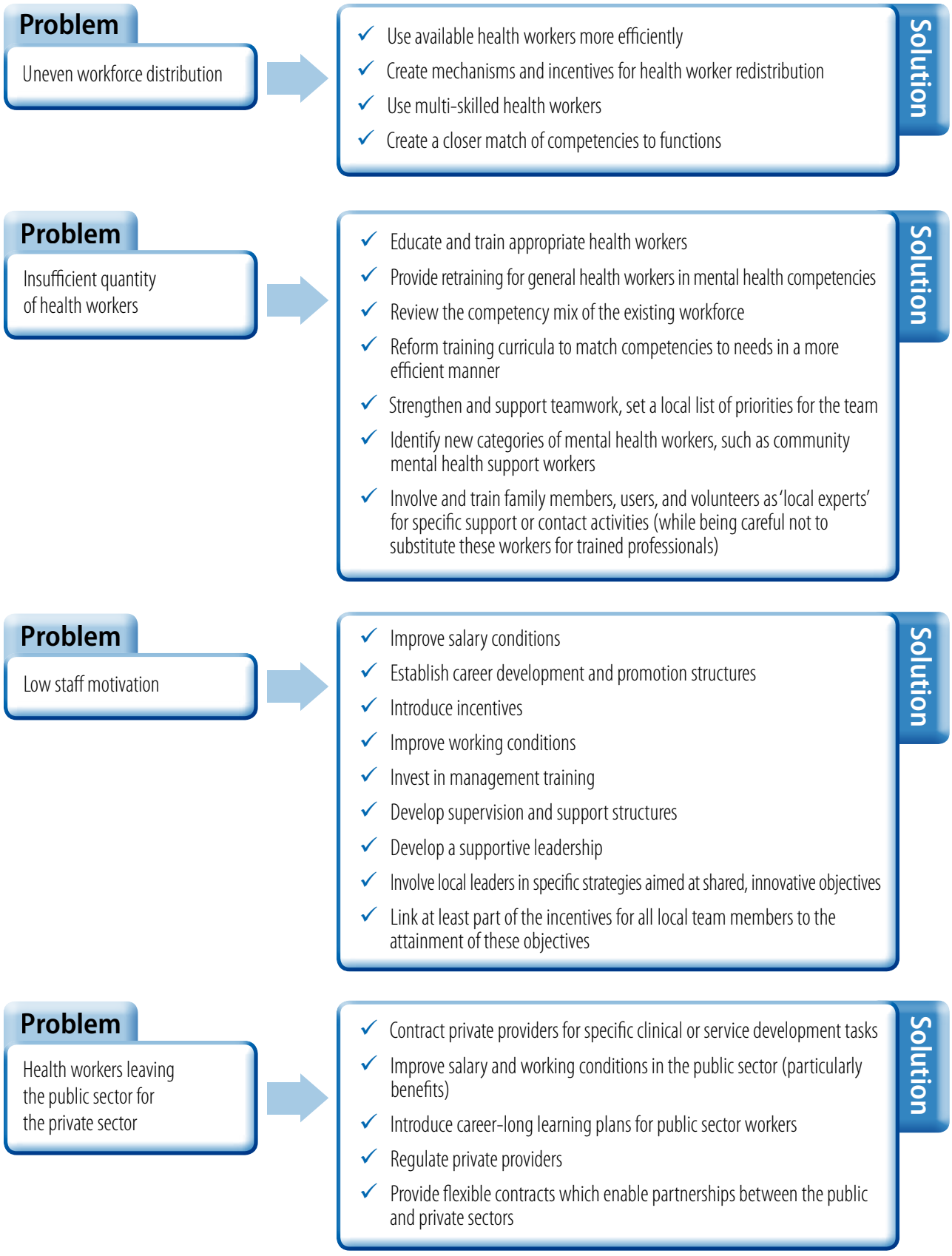
One of the most long-standing problems of human resources management in mental health services is finding health workers willing to work in remote, rural areas or otherwise unpopular areas of the country. Use financial, legal, educational, or other incentives to encourage the deployment of workers to these areas, where there is often great need.

Use of non-professionals for mental health care is feasible in many contexts. Non-professionals often have a thorough understanding of the community, language, and local customs. Service users often can identify more readily with them and form therapeutic alliances. Nonetheless, it is important to ensure that non-professional health workers are appropriately competent and that professional health workers can be drawn upon when necessary to deal with complex cases, provide supervision and consultation-liaison.

Nongovernmental organizations often play an important role in mental health promotion, prevention, and treatment. For the mental health human resources planner, nongovernmental organizations can provide useful resources in terms of competencies and expertise for training and supervision of public sector health workers, as well as consultation for service planning, and liaison over specific aspects of service provision. However, nongovernmental organizations need to be regulated with regard to their labour practices and the services they provide.

To improve workforce retention in developing countries, provide specialist training within the country rather than sending trainees to developed countries. If the competencies and financial resources are not available for specialist training, it might be more cost effective to send candidates out of the country for such training. During this process, prevent 'brain drain' by ensuring that the necessary incentives are in place to attract the qualified specialists back into the country.

Figure 3: the health workforce: Finding solutions that fit the problem



Education and training

Education and training of mental health workers should aim to serve the mental health needs of the society by producing a workforce competent to deliver care in a manner consistent with the goals of the human resources policy and planning.

This requires coordination and the development of consistent policies between the mental health delivery sector and the training sector. Training should be closely linked to the service levels outlined in the WHO service organization pyramid (see Figure 2).

Services, service functions, and health workers for each service level will vary for different countries (see Box 25 for suggestions for general practice physicians, and Box 26 for an example from Brazil). In addition, a mix of different workers with complementary competencies typically will work best for staffing each service level.

Box 25. SUGGESTED FUNCTIONS THAT GENERAL PRACTICE PHYSICIAN TRAINEES SHOULD BE ABLE TO PERFORM BEFORE GRADUATION

- Serve as the first point of contact with the health care system for all patients, regardless of age or gender.
- Use a patient-centred approach, oriented to the individual, his/her family, and the community.
- Use a biopsychosocial approach to understand and manage health problems.
- Identify health problems at an early stage where possible.
- Manage both acute and chronic health problems of individual patients.
- Provide care that is coordinated over time and determined by the needs of the patient.
- Efficiently use health care resources through coordinating care, collaborating with other primary health workers, and managing interfaces with medical specialists.
- Undertake health promotion with individual patients and communities.
- Provide population-based care by considering the health needs of the local population and undertaking interventions to reduce risks or improve quality of life in specified groups.

Box 26. ONGOING MENTAL HEALTH EDUCATION AND TRAINING FOR HEALTH PROFESSIONALS IN BRAZIL[31]

One of the most challenging aspects of the mental health reform in Brazil was related to health worker training, which was aimed at changing the traditional paradigm of mental health workers as guardians or tutors to a more patient-centred approach.

A specific human resource policy was elaborated to broaden and improve the recruitment, training, and management of mental health workers. The Brazilian government faced the challenge of providing more technical and theoretical education to health workers, who often had lost their professional motivation because of poor remuneration and precarious working conditions. For this reason, since 2002 the Ministry of Health established a permanent programme of formation for human resources through conventions with training institutes (especially federal universities). Since 2003, the Ministry instituted a wider organizational structure, the National Secretary of Management of Health Work, to meet quantitative and qualitative human resource needs.

As a result of these efforts, at least 8000 health professionals are exposed to regular ongoing training: every year around 1500 participate in long courses (over 360 hours) and at least 6000 follow a short course (over 40 hours).

Informal community care

This level of health worker refers to local community members who are not professionals in mental health or health care, yet provide a range of services. Some important functions performed by informal health workers are:

- supportive care, including counselling and self-help;

- assistance with activities of daily living and community reintegration;
- advocacy for the rights of people with mental disorders;
- mental health promotion, and prevention of avoidable mental disorders;
- practical support;
- crisis support;
- early identification of mental health problems and referral to health services.

Useful competencies at the level of informal community mental health services include:

- basic understanding of mental disorders;
- basic counselling skills;
- advocacy skills.

Primary care mental health services

Professionals working at this level include general practitioners, nurses, midwives, nursing assistants, and community health workers. The functions of workers at this level include:

- identifying mental disorders;
- providing basic medication and psychosocial interventions;
- referring to specialist mental health services;
- educating families and communities about mental health issues;
- crisis intervention;
- mental health promotion, and prevention of avoidable mental disorders.

While it is not expected that all workers at the primary health care level will have all the following competencies, those that should be practised at this level of care include:

- diagnosis and treatment of mental disorders;
- counselling, support, and psycho-education;
- advocating for the rights of people with mental disorders;
- crisis intervention;
- mental health promotion, and prevention of avoidable mental disorders.

Psychiatric services in general hospitals

Professionals working at this level include hospital physicians with a special interest in psychiatry, hospital psychiatrists, general nurses working in general health or psychiatric inpatient units, psychiatric nurses working in psychiatric inpatient units, psychiatrists and psychiatric nurses providing consultation-liaison services, social workers and psychiatric social workers, occupational therapists, psychologists, and other health workers in hospitals. Their functions include:

- inpatient and outpatient mental health care and treatment;
- consultation-liaison to other medical departments;
- education and training;
- linking to primary health care and tertiary care;
- mental health research.

Competencies required include:

- diagnosis and treatment;
- training and supervision;
- advocacy skills;
- knowledge of mental health legislation and other legislation related to mental health;

- administration and management;
- mental health research methodologies.

Community mental health services

Formal community mental health services cover a wide range of settings and different levels of care provided by mental health professionals and paraprofessionals. They include community-based rehabilitation services, hospital diversion programmes, mobile crisis teams, therapeutic and residential supervised services, as well as home help and support. Examples of health workers at this level include psychiatrists, community psychiatric nurses, psychologists, psychiatric social workers, occupational therapists, and community psychiatric workers. Their functions include:

- community-based rehabilitation and treatment;
- residential services;
- crisis intervention;
- education and training;
- collaboration with other community and hospital-based service providers;
- mental health research.

Competencies required include:

- diagnosis and treatment;
- knowledge of relevant legislation, including mental health legislation;
- advocacy and negotiation skills;
- administration and management;
- mental health research methodologies;
- training and supervision.

Long-stay facilities and specialist psychiatric services

These are usually facilities based in specialist hospitals, and offer various services in inpatient wards and specialist outpatient clinics. Examples of health workers at this level include psychiatrists, psychiatric nurses, social workers, and occupational therapists who are likely to be specialists of particular areas, such as forensics or children. Such specialist units are usually tertiary care referral centres. The exact functions of these services will depend on the specialization of the unit. Workers at this level of service provision need particular competencies in their particular specialty.

Continuing education, training and supervision

Continuing education and training (CET) benefits health workers and the quality of mental health services. CET helps ensure that care remains up-to-date and evidence-based. For health workers, it helps improve job satisfaction and career-long professional development.

For continuing education and training to function effectively, every mental health service needs to develop a sound policy and effective method for health worker development. The policy should include:

- a commitment by the service to continuous career-long staff development, including mapping of career paths;
- self-development as the responsibility of every individual within the service, guided and supported by a manager or supervisor;
- a commitment by the service to recognize improved performance and provide appropriate recognition and rewards;
- linking of CET to licensure and certification of professionals so that they are required to undergo continuing training in order to retain their professional registration. This also may be linked to quality improvement measures;

- a commitment to use new competencies in service provision or service organization;
- clear statements about who is responsible for the implementation and review of CET plans;
- clear statements regarding the channels through which plans for continuing education are communicated;
- appraisal and assessment methods;
- a policy on paid and unpaid leave for study during work time;
- fostering a positive environment for staff development, ensuring that all managers are committed to CET as an ongoing process;
- encouraging intersectoral training opportunities where possible, such as using mental health workers to educate school teachers, the police and the judiciary.

Approaches to training

Recent trends in training show a move away from traditional or lecture-based methods to active student-centred, problem-focused learning methods. Choices about specific methods will depend on training objectives, training materials, students, the learning environment, and available resources.

Two approaches that are particularly relevant for mental health training, especially where resources are limited, are open or distance learning and train-the-trainer. In open or distance learning, students use self-instruction with support via the Internet or telephone and periodic physical meetings or seminars with teachers and fellow students. The train-the-trainer approach involves trainers learning about specific areas such as mental health clinical skills in primary health care, as well as basic teaching methods. Trainees can be taught in such a way as to link training to clinical care by using tools common to both. Their teaching is evaluated by direct observation.

Suggested steps for developing a mental health curriculum are provided in Box 27.

Box 27. SUGGESTED STEPS IN DEVELOPING A MENTAL HEALTH CURRICULUM

Getting started

Step 1. Plan the curriculum according to current and future mental health needs

Step 2. Consult relevant stakeholders

Step 3. Develop a profile of the 'future mental health worker'

Step 4. Where no curriculum exists, obtain and adapt a relevant mental health curriculum; and where a curriculum exists, assess its usefulness

Step 5. Where no student evaluation system exists, develop or adopt a relevant evaluation system; and where a student evaluation system exists, assess that system

Step 6. Where no faculty or staff exist, create a viable faculty using an appropriate training group model; and where a faculty and staff exist, review them

Step 7. Assess the organizational structure and reward system

Step 8. Estimate the chances for successful change and prepare appropriate leaders

Development and early implementation

Step 1. Seek financial support

Step 2. Gather materials to develop a new curriculum

Step 3. Develop an organizational plan

Full implementation

Step 1. Develop a curriculum schedule

Step 2. Establish an appropriate curriculum governance structure

Step 3. Establish an ongoing evaluation plan for both short- and long-term

Step 4. Participate in community-based mental health programmes and mental health service research

For more information about human resources for mental health care, please see the WHO Module on Human Resources and Training in Mental Health. [32]

MENTAL HEALTH INFORMATION SYSTEMS

Key messages

- Mental health information systems are essential for a well-functioning mental health system.
- Information provides insights about how well the overall service and system are working and helps to inform choices.
- Privacy, confidentiality, access to information, and informed consent are especially important when implementing an information system for mental health.

What is a mental health information system?

A mental health information system is a system for collecting, processing, analysing, disseminating, and using information about a mental health service and the mental health needs of the population it serves.

Mental health information systems (MHIS) are essential for all aspects of the mental health system. For policy-makers and planners, they provide a mechanism for assessing whether goals and objectives are being achieved. For mental health workers, information systems provide a means of assessing the needs of service users and for monitoring their response to interventions. For people who use mental health services and the wider population, they provide a means of being informed about the services they can receive and their likely outcomes.

Information collected within a MHIS goes through five main stages. These are:

- collection – gathering of data;
- processing – movement of data from the point of collection to a place where they will be collated and prepared for analysis;
- analysis – examination and study of the data;
- dissemination – communication of the results of the analysis;
- use – application of the results to improve service delivery, planning, development, and evaluation.

Information should be collected from the range of the mental health service settings in a country. Four broad levels of information are relevant to MHIS:

- episode level – required to manage individual episodes of service contact;
- case level – required to proactively care for individual users over time;
- facility level – required to manage the specific service facility and to improve the quality of services;
- systems level – required to develop and monitor policies and plans.

Principles of mental health information systems

The following principles are essential for the development of any mental health information system:

- Start small, but keep the big picture in view. Rather than designing an unwieldy system that cannot be implemented, start with more limited information and fewer settings, and scale-up according to successes and revealed needs.
- Use indicators. Indicators are measures that summarize information relevant to the mental health

service and the population it serves. They are an essential means of summarizing large volumes of information and measuring change over time. Indicators can be used to measure various aspects of a mental health system including needs, inputs, processes, and outcomes.

- Establish a minimum data set. Gather and use only the least, most essential information.
- Make the MHIS user-friendly. The purpose for which information is being gathered and used should be clear, consistent, and accessible for all those involved – from the end-users who gather and use data during the clinical encounter, to those involved in processing, analysing and using the data to make planning and policy decisions.
- Clarify the relationship of the MHIS with information systems in general health and other sectors. A range of scenarios exist, including full integration, partial integration, or complete separation. Greater integration of information systems is preferable where there is a greater degree of service integration.
- Consult with all stakeholders. Consultation can result in useful contributions from stakeholders about the way the information system should be designed and implemented (see Box 28 for an example from Papua New Guinea).
- Link MHIS development to wider service development. This will result in an MHIS that is built on specific service and management functions.
- Consider routine and non-routine data. Routine data refer to data that are gathered on a regular basis and used in routine service planning. Non-routine data are gathered on an irregular basis and often are used to focus on a particular issue.
- Consider how epidemiological data should be included in the MHIS. Epidemiological data are different from service use data: they have a poor correlation with both the utilization of mental health services and the need for treatment. Psychiatric epidemiological studies are complex, resource-intensive undertakings that can absorb many of the resources more urgently needed to plan and develop services and information systems, particularly in low-income countries.
- Ensure privacy, confidentiality, access to information, and consent. A foundation of any MHIS should be the privacy of those people whose personal information is required for service delivery and planning.
- Address specific mental health information needs as required by law.

Box 29 presents suggested steps for assessing information needs, analysing the current information system, implementing new or improved systems, and then evaluating them.

Box 28. IMPLEMENTING AN IMFORMATION SYSTEM IN PAPUA NEW GUINEA[33]

Good information systems fail if they are poorly implemented. In Papua New Guinea, several strategies were used to reduce the risk of failure. Widespread consultation ensured that staff were aware of the changes and had contributed to them, and that the system's design was realistic. Testing on a limited scale helped to confirm the system's appropriateness. Improved analysis and dissemination of information before implementation created a more favourable climate in which to introduce new systems. It stimulated interest in information, generated support from senior levels in the Department of Health, and gave credibility to the programme managers leading the change.

Attention was given as to how the system would be introduced into each province, with the organization of workshops, printing and distribution of stationery, revision of computer software, and discontinuation of existing systems. Private printing companies and training schools were kept apprised of the changes. At national level, procedures were established for follow-up of missing reports, data quality control, updating coding systems, data summary, and provision of feedback. Provisions were included in the National Health Administration Act, 1997, to compel all health facilities to report using the National Health Information System. Certificates were awarded to the health facilities and provinces that provided the best reports. Financial support was secured for stationery, freight/postage, communications, and periodic upgrading of computers and software.

Box 29. SUGGESTED STEPS IN DESIGNING AND IMPLEMENTING A MENTAL HEALTH INFORMATION SYSTEM

Step 1. Conduct a needs assessment and situation analysis

Establish a multidisciplinary task team to take responsibility for designing and implementing the MHIS. The task team will assume the following responsibilities:

- Conduct a review of the mental health policy and planning objectives. Information systems that are consistent with policy are more likely to produce the required minimum information within the limited resources available. This task will require the development of an overall vision for the information system: what is the MHIS intending to achieve, and what policy and planning objectives need to be measured?
- Undertake a consultation process with all stakeholders.
- Translate the policy objectives and consultations into items that can be measured by an information system. Certain questions should guide the selection of indicators particularly their validity, reliability, cost, relevance, specificity, sensitivity, balance, and the feasibility of data capture.
- Identify a set of indicators to measure key policy objectives.
- Establish data collection and analysis procedures. Some data will be collected and analysed routinely, while other information will be collected only from time to time. Where there is a special issue of concern, for example the evaluation of a deinstitutionalization project, special collection processes will need to be established. Additional resources also will need to be allocated for the collection and analysis of these data.
- Examine the existing information system, including systematically mapping how information is managed through collection, processing, analysis, dissemination, and use; identify any problems and areas where they could be improved.

Step 2. Implement the MHIS

Finalize indicators to be used in the new MHIS. Design and distribute materials and train managers, administrators, and clinical staff in information gathering, analysis, and use. Decide how often data will be collected and areas of responsibility.

Address practical barriers to getting the needed information as they arise. Barriers can include staff opposition and inadequate technology.

Step 3. Evaluate the MHIS

Evaluate the MHIS itself to assess whether it is achieving its objectives.

For more information about mental health information systems, please see see the WHO Module on Mental Health Information Systems. [34]

ACCESS AND USE OF PSYCHOTROPIC MEDICINES

Key messages

- Psychotropic medicines, when used in combination with psychosocial interventions, reduce disability and prevent relapse of many mental disorders.
- Adherence to long-term medication therapy is important for mental disorders, yet presents unique challenges and considerations.
- Common psychotropic medicines should be made readily available for distribution in primary health care.

What are essential psychotropic medicines?

Essential psychotropic medicines are those that satisfy the priority mental health needs of a population. They are selected with due regard to public health relevance, evidence of efficacy and safety, and comparative cost effectiveness.[35] Ideally, they should be available within the context of a well-functioning mental health system, at all times, in adequate amounts, in the appropriate dosage forms with assured quality and adequate information, and at a price the individual and the community can afford.

Substantial and sustainable improvements to medicine access and use are possible with limited effort, a moderate amount of know-how, and relatively little additional funding. It is important to note that not all 'effective' therapies are 'essential', and careful selection of psychotropic treatments is of key importance.

Special considerations for essential psychotropics

Management of mental disorders with psychotropic medicines requires special consideration.

- Mental disorders are often chronic, with occasional periods of remission and relapse. Their chronic nature has particular implications for access to services and costs to patients and their families.
- Adherence to long-term medication therapy is particularly important for mental disorders, yet generally is difficult to achieve. Compared with short-term treatment, long-term treatment generally is associated with poorer adherence. Further, certain mental disorders are associated with symptoms (e.g., poor concentration, paranoia) that present additional adherence challenges.
- Certain essential psychotropics might be subject to regulations relating to controlled medicines in some countries. This might apply to phenobarbital, for example, but increasingly also to medicines such as chlorpromazine and diazepam.
- Physical and psychological dependence, together with subsequent difficulty in withdrawal, might occur with anxiolytics and hypnotics. This applies even to milder compounds.
- Substantial variability exists in individuals' response and tolerance of many psychotropics. Ranges for effective doses sometimes are difficult to define.

Improving access to psychotropics

Typically, it is most cost effective to select a limited number of psychotropic medicines as part of the national formulary. Careful selection facilitates bulk buying, easier management (e.g. storage and distribution) and allows for a more rational and efficient approach to training and dispensing. See

Figure 4 for a list of psychotherapeutic medicines on the WHO Model List of Essential Drugs, and Box 30 for an example of psychotropic medicine procurement from India.

Prices of psychotropic medicines vary considerably between countries, and active government involvement and intervention can assist in securing affordable prices. Strategies for lowering the prices of medicines include making global price information available, using good procurement practices, engaging professional price negotiators, procuring generic medicines, and reducing or abolishing import duties or taxes.

Other key points in improving access to psychotropics include:

- ensuring that access to safe and efficacious psychotropics is an integral part of the mental health policy and plan;
- verifying that legislation is enhancing–and not obstructing–access to essential psychotropics;
- using international trade agreements (e.g. The Agreement on Trade Related Aspects of Intellectual Property Rights – TRIPS) to improve access;
- carefully selecting the most needed psychotropics;
- ensuring sustainable financing that minimizes out-of-pocket expenditures;
- improving distribution strategies and safeguarding quality.

Box 30. PROCUREMENT OF PSYCHOTROPIC MEDICINES FOR PRIMARY HEALTH CARE IN THE THIRUVANANTHAPURAM DISTRICT OF KERALA STATE, INDIA

Since 1999, the Thiruvananthapuram District of Kerala State, India has been integrating mental health services into primary health care. A district mental health team provides outreach clinical services to a range of primary and community health centres.

Before the introduction of the district mental health programme, psychotropic medicines were not available in any of the primary health facilities. The district mental health team carried the medicines to and from the clinics, making them available free-of-charge to patients. This process worked well between 1999 and 2004, when the programme was funded fully by its initial grant. During this period, the programme coordinator was permitted to directly obtain medicines from the central purchasing committee-listed pharmaceutical companies. After 2004, the availability of funds for medicines became irregular. The team wanted to tap unused training funds for the purchase of medicines, but the programme coordinator was required to make a special application to the central government. The permission came only after appeals to the state high court and lobbying with local members of parliament.

Initially, general health workers and facility pharmacies were reluctant to request and stock psychotropic medicines, because there were no trained physicians or psychiatrists to make 'proper' prescriptions. However, over time the district mental health team was able to convince the general health facilities to request psychotropic medicines as part of their standard requests for medicines. The district mental health team prepared lists of psychotropic medicines according to the requirement of each centre (where the mental health clinics were operational) and gave these to the heads of these facilities and the pharmacists to include in the overall list for the centre. If there was any interruption in the availability of medicines, they were borrowed them from the mental health centre, and they were returned at a later date.

Currently, all primary health centres participating in the programme make direct requests for psychotropic medicines. Occasionally, supplies fall short and in these cases, the district mental health team helps by sending a request for additional medicines to the district medical officer.

Figure 4: Psychotherapeutic medicines on the WHO Model List of Essential Drugs [36]

24.1 Medicines used in psychotic disorders	
chlorpromazine	Injection: 25 mg (hydrochloride)/ml in 2-ml ampoule. Oral liquid: 25 mg (hydrochloride)/5 ml. Tablet: 100 mg (hydrochloride).
fluphenazine	Injection: 25 mg (decanoate or enantate) in 1-ml ampoule.
□ **haloperidol**	Injection: 5 mg in 1-ml ampoule. Tablet: 2 mg; 5 mg.
24.2 Medicines used in mood disorders	
24.2.1 Medicines used in depressive disorders	
□ **amitriptyline**	Tablet: 25 mg (hydrochloride).
fluoxetine	Capsule or tablet: 20 mg (present as hydrochloride).
24.2.2 Medicines used in bipolar disorders	
carbamazepine	Tablet (scored): 100 mg; 200 mg.
lithium carbonate	Capsule or tablet: 300 mg.
valproic acid	Tablet (enteric-coated): 200 mg; 500 mg (sodium valproate).
24.3 Medicines used in generalized anxiety and sleep disorders	
□ **diazepam**	Tablet (scored): 2 mg; 5 mg.
24.4 Medicines used for obsessive compulsive disorders and panic attacks	
clomipramine	Capsule: 10 mg; 25 mg (hydrochloride).
24.5 Medicines used in substance dependence programmes	
Complementary List	
□ *methadone**	*Concentrate for oral liquid: 5 mg/ml; 10 mg/ml (hydrochloride).* *Oral liquid: 5 mg/5 ml; 10 mg/5 ml.* ** The square box is added to include buprenorphine. The medicines should only be used within an established support programme*

Promoting appropriate use of psychotropics

Appropriate use of medicines requires that people receive medications appropriate to their clinical needs, in doses that meet their individual requirements, for an adequate period of time, and at the lowest possible cost to them and their community. Interventions to promote appropriate use in the private health care sector are as important as those in the public sector.

Strategies to promote appropriate use of medicines include:

- educational interventions: for example, providing training of health workers, people with mental disorders, and their caregivers;
- managerial interventions: for example, developing and disseminating treatment guidelines to all who need them, or involving end-users in decisions around essential drug lists;
- regulatory interventions: for example, establishing over-the-counter versus prescription-only medications, or regulating pharmaceutical marketing practices.

Assessing psychotropic access systems

Assessment of psychotropic access systems should cover several functions, including policy and legislation, selection of psychotropic medicines, affordability, financing, pharmaceutical logistics, pharmaceutical procurement, product quality assurance, and drug use. Management of the assessment itself is an absolute requirement and must include the following detailed arrangements:

- logistics planning;
- selecting sites to be visited;
- selecting indicator drugs;
- defining data collection methods;
- developing and defining data collection forms;
- selecting and training data collectors;
- analysing the data;
- formulating conclusions and recommendations;
- presenting the findings.

Performance indicators are a fundamental part of any such assessment. Quantitative data are useful to numerically describe access systems, while qualitative data might provide insights into reasons behind poor access. Quantitative and qualitative data might be obtained from document reviews, key informant interviews, existing record systems, or field observations. Detailed surveys of pharmaceutical management of the supply system help determine possible waste or the degree of efficiency of the system.

Suggested steps for improving access to psychotropic medicines are provided in **Box 31.**

For more information about improving access to and use of psychotropic medicines, please see the WHO Module on Improving Access and Use of Psychotropic Medicines. [37]

Box 31. SUGGESTED STEPS FOR IMPROVING ACCESS TO PSYCHOTROPIC MEDICINES

Step 1. Organize the process

Decide how to organize the process of improving access, and identify the different required activities. Identify the interested parties, resources required, and how these will be obtained.

Step 2. Assess the psychotropic medicines access system

Assess all components of the psychotropic medicines access system.

Step 3. Identify the main problems and make a detailed analysis

Undertake a detailed analysis of the findings from the previous step to identify the major problems and their causes. Based on this analysis, identify potential solutions.

Step 4. Set goals and objectives to improve services

Decide priority objectives, which might include improving the selection, affordability and financing of essential psychotropic medicines, improving the prescribing practices of health workers, or improving adherence by people with mental disorders.

Step 5. Design intervention programmes and select indicators

Design the intervention programmes based on a systematic assessment of options. Select indicators of progress that will enable monitoring and evaluation of the impact of the interventions.

Step 6. Implement the intervention

Design and implement a plan that will span several years. Key features of a well-prepared plan are defined activities per component, specified responsibilities and major tasks, clear targets, and a detailed timeframe and budget (see previous section on policy and plans).

Step 7. Monitor and evaluate

Undertake monitoring to continuously review implementation of activities and to determine whether targets are likely to be met. Conduct an evaluation midway and/or at the end of the implementation period to assess whether objectives and goals have been met. Based on evaluation results, design future intervention programmes.

MENTAL HEALTH FINANCING

Key messages:

- People with mental disorders are typically poorer than the rest of the population and are faced with substantial hardships by out-of-pocket payments.
- Governments should achieve mandatory coverage for mental health services through either national tax-based or social insurance.
- Specific budgetary allocations should be made for mental health within overall health financing.

This section describes how mental health financing can be organized and managed in a way that maximizes efficiency and effectiveness of resources.

Integration with general health financing

In all countries, it is vital to ensure that coverage of mental health services is included within general health financing. Specific allocations should be made for mental health financing.

When integrating mental health services within general health care, mechanisms to prevent funding from remaining static or diminishing include:

- tracking funds spent on mental health;
- developing line items for specialized services for mental health populations;
- establishing and protecting levels of funding for mental health services. It also is important to use funds to promote innovation through demonstration and pilot projects.

A systematic approach to mental health financing

Box 32 describes a series of steps that policy-makers and planners can take to build a mental health financing system. Box 33 describes the shifting of financing from institutional to community care in Padwa psychiatric hospital in Mexico.

Box 32. SUGGESTED STEPS FOR THE FINANCING OF MENTAL HEALTH CARE

Step 1. Map the mental health system

Map the mental health system to establish a better understanding of funding sources, purchasing mechanisms, mental health services, and health outcomes.

Step 2. Develop the resource base for mental health services

Address reasons for underfunding and find ways to overcome it. Reasons might include stigma and discrimination, the poor recognition of mental disorders, and policy-makers' lack of knowledge about cost-effective interventions. Because people with mental disorders are typically poorer than the rest of the population, consider increasing the share of prepayment that is directed towards mental disorders.[38] Where possible, governments should attempt to achieve mandatory coverage for mental health care, either through national tax-based or social insurance.

Step 3. Allocate funds to address planning priorities

Tie the allocation of funds to policy and planning priorities. Allocations to regions based on per capita funding do not take into account potential differences in the prevalence of mental disorders, level of resources, and accessibility of services. Consider these factors and allocate to different components and interventions based on target populations and types of service.

Step 4. Build budgets for management and accountability

Ensure that planning drives the budgetary process, rather than the converse. Build the budget so that it serves four main functions:

- planning – defining the service delivery system by defining the costs of its components;
- policy – reflecting the reality or ability to implement the policy;
- control – monitoring of actual expenditure against projected activities;
- accountability – holding people accountable for their expenditures.

Consider establishing a special mental health innovation fund, especially in places where mental health services have been neglected. The fund could be used for demonstration and evaluation projects, which, if successful, could serve as the rationale for additional funding in the future.

Step 5. Purchase mental health services to optimize effectiveness and efficiency

Decide how mental health services should be purchased to maximize effectiveness. The three broad types of purchasing systems between funders and providers are:

- reimbursement models (providers receive retroactive payments for services supplied);
- contract models (an agreement between payers and providers to provide services at predefined costs);
- integrated models (the same agency controls both the funding and the provision of care).
- Each of these purchasing arrangements has particular incentives associated with it, allowing government (or purchasers) to decide the most appropriate mechanism. Most countries include elements of all three systems.

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Step 6. Develop the infrastructure for mental health financing

Develop financing management infrastructure while taking into account the following points.

- Management/purchasing structures. Business and management techniques used in the private health industry increasingly are being adopted or adapted for use in the public sector. For example, managed care principles are being used increasingly in public health care.
- Information systems. Mental health financing depends fundamentally on the availability of timely, accurate, and complete information.
- Evaluation and cost-effectiveness analysis. Expenditure choices need to be made between different treatments, treatment settings, and disorders to allow judicious use of scarce resources.
- Information-sharing and the involvement of key stakeholders. To achieve collaboration from partners, key stakeholders need to be informed systematically about budgets, budget processes, and allocation methods.

Step 7. Use financing as a tool to improve the delivery of mental health services

Use financing mechanisms to facilitate change and introduce innovations in systems. Financial and budgetary factors can encourage the transfer of services from psychiatric hospitals to the community (see **Box 33** for an example from Mexico). Mechanisms include:

- budget flexibility – allowing permeability between line items (for example, between hospital and community-based settings);
- financial incentives – rewards for fulfilling tasks or meeting quality indicators;
- ring-fencing of funding for community services – providing resources that can be used only for community-based services;
- coordination of funding between ministries or agencies – allowing budgetary transfers across ministries (for example, for social support programmes following deinstitutionalization).

Box 33. CLOSURE OF PACHUCA PSYCHIATRIC HOSPITAL IN MEXICO[39]

The closing of Pachuca Psychiatric Hospital in Mexico is a good example of shifting funds from institutional to community care. The hospital had 287 beds and served long-stay patients whose diagnoses were primarily schizophrenia and mental retardation. Following exposés about poor conditions at the hospital, it was decided to use the funding for the hospital to develop community-based mental health services. Funds that previously funded the hospital were used to fund 10 houses (each accommodating 12 people), an acute 30-bed inpatient unit in the hospital, an outpatient department, and two halfway houses for 34 people. To implement this model, 117 hospital residents were transferred to institutions in other states. The new model started operating in November 2000 and after one year the results were positive, notably in patients' improved psychosocial functioning and quality of life.

For more information about mental health financing, please see the WHO Module on Mental Health Financing.[40]

CONCLUSION

A high-quality mental health system requires forethought and planning long before a health worker engages with a patient. For policy-makers and health planners, the challenges are great: providing mental health services to all who need them, in an equitable way, in the most effective manner possible, and in a fashion that promotes human rights and health outcomes.

This document has shown the way forward by describing a comprehensive strategy for developing or improving mental health systems.

As suggested in this document, policy-makers and health planners should consider their country's current mental health system through drafting, implementing, and evaluating mental health policies, plans, and legislation, and by undertaking advocacy to ensure that mental health is given its rightful prominence in health care. The document also describes how mental health services can be organized into efficient and effective systems that promote human rights, how services can be budgeted and planned, and how quality improvement mechanisms can contribute to systems' continued effectiveness and efficiency. The health workforce also can be developed to adequately meet population mental health needs, including ensuring sufficient quantities of health workers, their equitable distribution, as well as their productivity and efficiency. Adequate information for mental health planning and delivery of services is crucial for any policy-maker or planner, and requires the establishment of mental health information systems. The availability and efficient use of psychotropic medications is another important factor, in which careful attention must be paid to their availability, distribution and efficient use. Finally, it is essential to ensure that that mental health care receives sustainable financing and people with mental disorders have social protection.

By following the areas of action and processes identified in this document (and using the WHO Mental Health Policy and Service Guidance Package for more detailed information), policy-makers and health planners will be able to provide high-quality and evidence-based mental health services to the many people in need. They also will be able to ensure that mental health services are integrated with the general health system to the greatest extent possible. Perhaps most importantly, their steps will help reduce the substantial burden of untreated mental disorders, thereby reducing human rights violations and improving the quality of life for one of the most the most vulnerable and marginalized subgroups in society.

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ANNEX 1: WHO Checklists for Evaluating a Mental Health Policy and Plan

WHO checklist for evaluating a mental health policy

Once a policy or draft policy has been developed, it is important to conduct an assessment of whether certain processes have been followed that are likely to lead to the success of the policy; and whether various content issues have been addressed and appropriate actions included in the policy. This checklist is intended to assist with this evaluation.

Although the checklist is limited in that it does not enable assessment of the *quality* of the processes or contents of the policy, evaluators are encouraged, when completing the checklist, to consider the *adequacy* of both the process and content. Particularly where a response is "no" or "to some extent", it is suggested that they provide either an action plan to remedy the situation or a comment. (In some instances the comment might, for example, merely be that a particular action is covered in a different policy, or that it is not possible to implement given the current resources available.) The different modules in the WHO *Mental Health Policy and Service Guidance Package* can be consulted for more guidance on how to address relevant sections and for a better understanding of the policy issues mentioned in the checklist.

This checklist might usefully be completed by those who drafted the policy and/or by employees in the government itself. However, it also is important to have independent reviewers. Those involved in drafting the policy might have personal or political interests or might be too closely involved with the policy to see anomalies or provide critical input. Ideally, an independent multidisciplinary team should be convened to conduct an evaluation. A team also is advantageous because no single person is likely to have all the relevant information required, and debate is crucial for arriving at an optimal policy for the country. Furthermore, when relevant interest groups have been involved in the process of the development of the policy and/or in their evaluation, which leads to changes being made to the policy, it is likely that they will be implemented more effectively. It is useful to include consumer organizations, family organizations, service providers, professional organizations and nongovernmental organizations, as well as representatives of other government departments affected by the policy.

Finally, although the checklist should be interpreted in terms of the mental health policy document, it is important to have, or be familiar with, other relevant and related documentation. Often, items are not covered in the mental health policy because they are covered comprehensively elsewhere. For example, policies on health information systems or human resources might include mental health and are therefore deliberately not repeated in the mental health policy. This explanation should then be noted in the relevant section.

This checklist has been developed by Dr Michelle Funk (Coordinator), Ms Natalie Drew, and Dr Edwige Faydi, Mental Health Policy and Service Development, Department of Mental Health and Substance Abuse, World Health Organization; and Professor Melvyn Freeman, National Department of Health, Pretoria, South Africa.

WHO CHECKLIST FOR EVALUATING A MENTAL HEALTH POLICY			
Please use the following rating scale to rate each item: **1 = yes/ to great degree 3 = no/not at all** **2 = to some extent 4 = unknown**	**Rating**	**If "yes" or "to some extent", please state how.** **If not, please state reason(s).**	**Action required (if any)**
PROCESS ISSUES			
1a. Was there a high-level mandate to develop the policy (e.g. from the Minister of Health)?			
1b. At what level has the policy been officially approved and adopted (e.g. the Department of Mental Health, Ministry of Health, Cabinet, Minister of Health)?			
2. Is the policy based on relevant data:			
– from a situation assessment?			
– from a needs assessment?			
3. Have policies relating to mental health that have been utilized within the country and in other countries with similar cultural and demographic patterns been examined and integrated where relevant?			
4. Has a thorough consultation process taken place with the following groups:			
– representatives from the health sector, including planning, pharmaceutical , human resource development, child health, HIV/AIDS, epidemiology and surveillance, epidemic and disaster preparedness divisions.			
– representatives from the Finance Ministry?			
– representatives from Social Welfare and Housing Ministries?			
– representatives from the criminal justice system?			
– consumers, or representatives of consumer groups?			
– family members or their representatives?			
– other nongovernmental organizations?			
– private sector?			
– any other key stakeholder groups? If so, please list them.			
5. Has an exchange taken place with other countries concerning their mental health policies and experiences?			
6. Has relevant research been undertaken to inform policy development (e.g. pilot studies)?			

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WHO CHECKLIST FOR EVALUATING A MENTAL HEALTH POLICY			
Please use the following rating scale to rate each item: **1 = yes/ to great degree 3 = no/not at all** **2 = to some extent 4 = unknown**	**Rating**	**If "yes" or "to some extent", please state how.** **If not, please state reason(s).**	**Action required (if any)**
CONTENT ISSUES			
1. Is there a realistic **vision** statement?			
2. Are **values and associated principles**, which inform the policy, included?			
3. Do these values and associated principles emphasize and/or promote:			
– human rights?			
– social inclusion?			
– community care?			
– integration?			
– evidence-based practice?			
– intersectoral collaboration?			
– equity with physical health care?			
4. Have clear **objectives** been defined?			
5. Are objectives consistent:			
– with the vision?			
– with the values and principles?			
6. Are the **areas for action** clearly described to indicate the main policy directions and what will be achieved?			
7. Are the areas for action written in a way that commits the governments (e.g. do they state "will" instead of "should")?			
8. To what extent do the areas for action comprehensively address **coordination and management**?			
(a) Does the policy specify a dedicated mental health position/post within the Ministry of Health to coordinate mental health functions and services?			
(b) Does the policy establish or refer to a multisectoral coordinating body to oversee major decisions in mental health?			
9. To what extent do the areas for action comprehensively address **financing**?			
(a) Does the policy indicate how funding will be utilized to promote equitable mental health services?			
(b) Does the policy state that equitable funding between mental health and physical health will be provided?			
(c) If health insurance is utilized in the country, does the policy indicate whether/how mental health would be part of it?			

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WHO CHECKLIST FOR EVALUATING A MENTAL HEALTH POLICY			
Please use the following rating scale to rate each item: **1 = yes/ to great degree 3 = no/not at all** **2 = to some extent 4 = unknown**	**Rating**	**If "yes" or "to some extent", please state how.** **If not, please state reason(s).**	**Action required (if any)**
10. To what degree do the areas for action comprehensively address **legislation and/or human rights**?			
(a) Does the policy promote human rights?			
(b) Does the policy promote the development and implementation of human-rights-oriented legislation?			
(c) Is the setting up of a review body envisaged to monitor different aspects of human rights?			
11. To what extent do the areas for action comprehensively address **organization of services**?			
(a) Does the policy promote the integration of mental health services into general health services?			
(b) Does the policy promote a community-oriented mental health approach?			
(c) Does the policy promote deinstitutionalization?			
12. To what extent do the areas for action comprehensively address **promotion, prevention and rehabilitation**? Does the policy make provision for:			
– the prevention of mental disorders?			
– interventions that promote mental health?			
– interventions for the rehabilitation of people with mental disorders?			
13. To what extent do the areas for action comprehensively address access to **essential psychotropic medicines**?			
(a) Does the policy commit to improving availability of and accessibility to essential psychotropic medicines at all levels of care (e.g. cost issues)?			
(b) Does the policy emphasize the need for health workers working in facilities where essential psychotropic medicines are available to have appropriate training (for identification, prescription, monitoring of treatment and follow-up of patients)?			
(c) Does the policy identify a range of professionals allowed to prescribe essential psychotropic medicines at the different levels of the health service?			
14. To what extent do the areas for action comprehensively address **advocacy**?			
(a) Is the policy supportive of consumers and family organizations?			
(b) Is there emphasis on raising awareness of mental disorders and their effective treatment?			
(c) Does the policy promote advocacy on behalf of people with mental disorders?			

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WHO CHECKLIST FOR EVALUATING A MENTAL HEALTH POLICY			
Please use the following rating scale to rate each item: **1 = yes/ to great degree 3 = no/not at all** **2 = to some extent 4 = unknown**	**Rating**	**If "yes" or "to some extent", please state how.** **If not, please state reason(s).**	**Action required (if any)**
15. To what extent do the areas for action comprehensively address **quality improvement?** Does the policy:			
– make a commitment to providing high quality, evidence- based interventions?			
– include a process to measure and improve the quality of services?			
16. To what extent do the areas for action comprehensively address **information systems?**			
(a) Will mental health information systems be set up to guide decision-making for future policy, planning, and service development?			
17. To what extent do the areas for action comprehensively address **human resources and training?**			
(a) Does the policy commit to putting in place suitable working conditions for mental health providers?			
(b) Have appropriate management strategies been discussed to improve recruitment and retention of mental health providers?			
(c) Are training in core competencies and skills seen as central to human resources development?			
18. To what extent do the areas for action comprehensively address **research and evaluation?**			
(a) Does the policy emphasize the need for research and evaluation of services and of the policy and strategic plan?			
19. To what extent do the areas for action comprehensively address **intrasectoral collaboration** within the health sector? Does the policy:			
– emphasize collaboration with planning, pharmaceutical, human resource development, child health, HIV/AIDS, epidemiology and surveillance, epidemic and disaster preparedness divisions within the health sector?			
– contain clear statements of what role each department will play in each area for action?			

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WHO CHECKLIST FOR EVALUATING A MENTAL HEALTH POLICY			
Please use the following rating scale to rate each item: **1 = yes/ to great degree 3 = no/not at all** **2 = to some extent 4 = unknown**	**Rating**	**If "yes" or "to some extent", please state how.** **If not, please state reason(s).**	**Action required (if any)**
20. To what extent do the areas for action comprehensively address **intersectoral collaboration**? Does the policy:			
– emphasize collaboration with all other relevant government departments?			
– emphasize collaboration with all relevant NGOs, including consumer and family groups?			
– contain clear statements of what role each sector will play in each area for action?			
21. Have all of the following **groups been considered**:			
– people with severe mental disorders?			
– children and adolescents?			
– older persons?			
– people with intellectual disability?			
– people with substance dependence?			
– people with common mental disorders?			
– people affected by trauma?			
22. Given the available resources, has a 'reasonable balance' been achieved between the above groups?			
23. To what degree have the key mental health policy issues been integrated with/or are consistent with the country's			
– mental health law?			
– general health law?			
– patients rights charter?			
– disability law?			
– health policy?			
– social welfare policy?			
– poverty reduction policy?			
– development policy?			
Taking into account the financial and human resources available in the country, please comment on the general feasibility for implementation of the policy.			

WHO checklist for evaluating a mental health plan

Once a plan or draft plan has been developed, it is important to conduct an assessment of whether certain processes have been followed that could lead to the success of the plan, and whether various content issues have been addressed and appropriate actions included in the plan. This checklist is intended to assist with this approach.

Although the checklist is limited in that it does not enable assessment of the *quality* of the processes or contents of the plan, evaluators are encouraged, when completing it, to consider the *adequacy* of both the process and content. Particularly where a response is "no" or "to some extent", it is suggested that they provide either an action plan to remedy the situation or a comment. (In some instances the comment might, for example, merely be that a particular action is covered elsewhere, or that it is not possible to implement given the current resources available.) The different modules in the WHO *Mental Health Policy and Service Guidance Package* can be consulted for more guidance on how to address relevant sections and for a better understanding of the issues mentioned in the checklist.

This checklist might usefully be completed by those who drafted the plan and/or by employees in the government itself. However, it also is important to have independent reviewers. Those involved in drawing up the plan might have personal or political interests or might be too closely involved with the plan to see anomalies or provide critical input. Ideally, an independent multidisciplinary team should be convened to conduct an evaluation. A team also is advantageous because no single person is likely to have all the relevant information required, and debate is crucial for arriving at an optimal plan for the country. Furthermore, when relevant interest groups have been involved in the process of the development of the plan and/or in their evaluation, which leads to changes being made to the plan, it is likely that they will be implemented more effectively. It is useful to include consumer organizations, family organizations, service providers, professional organizations and nongovernmental organizations, as well as representatives of other government departments affected by the mental health plan.

Finally, although the checklist should be interpreted in terms of the document that outlines the mental health plan, it is important to have, or be familiar with, other relevant and related documentation. Often, items are not covered in the plan because they are comprehensively covered elsewhere. For example, plans for health information systems or human resources might include mental health and are therefore deliberately not repeated in the mental health plan. This explanation should then be noted in the relevant section.

This checklist has been developed by Dr Michelle Funk (Coordinator), Ms Natalie Drew and Dr Edwige Faydi, Mental Health Policy and Service Development, Department of Mental Health and Substance Abuse, World Health Organization; and Professor Melvyn Freeman, National Department of Health, Pretoria, South Africa.

WHO CHECKLIST FOR EVALUATING A MENTAL HEALTH PLAN			
Please use the following rating scale to rate each item: **1 = yes/ to great degree 3 = no/not at all** **2 = to some extent 4 = unknown**	**Rating**	**If "yes" or "to some extent", please state how.** **If not, please state reason(s).**	**Action required (if any)**
PROCESS ISSUES			
1a. Was there a high-level mandate to develop the plan (e.g. from the Minister of Health)?			
1b. At what level has the plan been officially approved and adopted (e.g. the Department of Mental Health, Ministry of Health, Cabinet, Minister of Health)?			
2. Does the plan include strategies and activities that are consistent with an existing and up-to-date policy?			
3. If no policy is available, does the plan include strategies and activities that are consistent with another official document(s) stating the direction(s) for mental health? Please provide relevant document(s).			
4. Are strategies and activities written in a way that commits the governments (e.g. do they state "will" instead of "should")?			
5. Has the plan been informed by:			
– a situation analysis? and/or			
– a needs assessment?			
6. Have effective strategies that have been utilized within the country and in other countries with similar cultural and demographic patterns been examined and integrated where necessary?			
7. Has a thorough consultation process taken place with the following groups:			
– representatives from the health sector, for example, including planning, pharmaceutical, human resource development, child health, HIV/AIDS, epidemiology and surveillance, epidemic and disaster preparedness divisions?			
– representatives from the Finance Ministry?			
– representatives from the Social Welfare and Housing Ministry?			
– representatives from the criminal justice system?			
– consumers or their representatives?			
– family members or their representatives?			
– other nongovernmental organizations?			
– private sector?			
– any other key stakeholder groups? If so, please list them.			

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WHO CHECKLIST FOR EVALUATING A MENTAL HEALTH PLAN			
Please use the following rating scale to rate each item: **1 = yes/ to great degree 3 = no/not at all** **2 = to some extent 4 = unknown**	**Rating**	**If "yes" or "to some extent", please state how.** **If not, please state reason(s).**	**Action required (if any)**
OPERATIONAL ISSUES			
8. Have comprehensive strategies been identified for each priority area for action?			
Looking at strategies:			
9. *Time frames:*			
– are time frames provided for each strategy?			
– are the time frames reasonable and feasible?			
10. *Indicators:*			
– are there indicators for each strategy?			
– if so, are the indicators appropriate for measuring the particular strategy?			
11. *Targets:*			
– are there targets for each strategy?			
– if so, are the targets realistic?			
Looking at activities:			
12. Are clear activities defined for each strategy?			
13. Is the person/group/organization responsible for each activity identified?			
14. Is it clear when each activity will start and finish?			
15. Are the outputs for each activity outlined?			
16. Have potential obstacles been identified?			
17. Costs and funding:			
– have the costs for achieving each activity been calculated?			
– is the funding for each activity available and allocated?			
CONTENT ISSUES			
18. Does the plan include relevant strategies and activities for **coordination and management?**			
(a) Are the composition and functions clearly defined for:			
– the mental health coordinating body?			
– the mental health focal point?			

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WHO CHECKLIST FOR EVALUATING A MENTAL HEALTH PLAN			
Please use the following rating scale to rate each item: **1 = yes/ to great degree 3 = no/not at all** **2 = to some extent 4 = unknown**	**Rating**	**If "yes" or "to some extent", please state how.** **If not, please state reason(s).**	**Action required (if any)**
(b) Is an adequate infrastructure in place/planned (including computers, Internet access and administrative support)?			
(c) Are regular meetings of the coordinating body scheduled?			
(d) Has a system of reporting to a high-level ministry of health official been set up for the mental health coordinating body?			
(e) Are coordination and management strategies and associated activities:			
– relevant?			
– evidence-based?			
– realistic and possible to implement?			
– adequately funded?			
19. Does the plan include relevant strategies and activities for financing?			
(a) Is it clear how services will be funded?			
(b) Is the plan clear as to whether/how user charges will be made?			
(c) Are financing strategies and associated activities:			
– relevant?			
– evidence-based?			
– realistic and possible to implement?			
– adequately funded?			
20. Does the plan include relevant strategies and activities for legislation and/or regulations on human rights?			
(a) Where legislation and/or regulations are to be developed, have clear strategies/activities been specified for:			
– the process of drafting the law(s)/regulations?			
– defining the content of the law(s)/regulations?			
– implementing the law(s)/regulations?			
(b) Where a review body to protect human rights is to be established, are clear strategies/activities specified for its establishment?			
(c) Are there any other strategies to protect and promote the rights of people with mental disorders?			
(d) Are the strategies on human rights and legislation and associated activities:			
– relevant?			
– evidence-based?			
– realistic and possible to implement?			
– adequately funded?			

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WHO CHECKLIST FOR EVALUATING A MENTAL HEALTH PLAN			
Please use the following rating scale to rate each item: **1 = yes/ to great degree 3 = no/not at all** **2 = to some extent 4 = unknown**	**Rating**	**If "yes" or "to some extent", please state how. If not, please state reason(s).**	**Action required (if any)**
21. Does the plan include relevant strategies and activities for **organization of services?**			
(a) Are there strategies and associated activities for the provision of services at primary, secondary and tertiary levels, with continuity between them?			
(b) Are there strategies and associated activities for deinstitutionalization?			
(c) Are there strategies and associated activities for developing community mental health services?			
(d) Has provision been made for psychosocial rehabilitation services at all levels of the health system?			
(e) Are the strategies on organization of services and associated activities:			
– relevant?			
– evidence-based?			
– realistic and possible to implement?			
– adequately funded?			
22. Does the plan include relevant strategies and activities for **promotion, prevention, and rehabilitation?**			
(a) Are there clear strategies and associated activities for the promotion of mental health?			
(b) Are there clear strategies and associated activities for the prevention of mental disorders?			
(c) Are the strategies on prevention, promotion and rehabilitation and associated activities:			
– relevant?			
– evidence-based?			
– realistic and possible to implement?			
– adequately funded?			
23. Does the plan include relevant strategies and activities for the **procurement and distribution of essential medicines?**			
(a) If psychotropic medicines currently are not included on the Essential Drugs List, is there a strategy and associated activities to include them?			
(b) Does the plan incorporate strategies and associated activities to improve reliability of the supply and distribution system at relevant levels of health service where treatment is to be provided?			
(c) Are there strategies and relevant activities for monitoring the continuous provision and assessment of psychotropic medicines?			

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WHO CHECKLIST FOR EVALUATING A MENTAL HEALTH PLAN			
Please use the following rating scale to rate each item: **1 = yes/ to great degree 3 = no/not at all** **2 = to some extent 4 = unknown**	**Rating**	**If "yes" or "to some extent", please state how. If not, please state reason(s).**	**Action required (if any)**
(d) Are the strategies on the procurement and distribution of medicines and associated activities:			
– relevant?			
– evidence-based?			
– realistic and possible to implement?			
– adequately funded?			
24. Does the plan include relevant strategies and activities for advocacy?			
(a) Is there a strategy with associated activities to support (technically and/or in practical terms) consumer groups, family groups and nongovernmental organizations?			
(b) Is there a strategy and associated activities to involve consumers and family representatives in policy and service planning?			
(c) Are the advocacy strategy and associated activities:			
– relevant?			
– evidence-based?			
– realistic and possible to implement?			
– adequately funded?			
25. Does the plan include relevant strategies and activities for quality improvement?			
(a) Is there a strategy and associated activities for assessing quality?			
(b) Is there a strategy and associated activities for ongoing quality control of mental health facilities (e.g. standards)?			
(c) Is there a strategy and associated activities for accrediting facilities based on quality?			
(d) Are both hospital and community mental health facilities included in quality assessment?			
(e) Are the strategies on quality improvement and associated activities:			
– relevant?			
– evidence-based?			
– realistic and possible to implement?			
– adequately funded?			
26. Does the plan include relevant strategies and activities for information systems?			
(a) Have a strategy and linked activities been defined for:			
– reviewing the current mental health information system, and/or			
– improving the current mental health information system?			

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WHO CHECKLIST FOR EVALUATING A MENTAL HEALTH PLAN

Please use the following rating scale to rate each item: 1 = yes/ to great degree 3 = no/not at all 2 = to some extent 4 = unknown	Rating	If "yes" or "to some extent", please state how. If not, please state reason(s).	Action required (if any)
(b) Does the strategy or linked activities include the systematic collection of mental health data from a range of sources at different levels of the health system (e.g. general hospitals, primary health care, and community levels)?			
(c) Is it clear how the information will feedback into:			
– policy development, mental health planning and service delivery?			
– clinical practice?			
(d) Are the strategies on information systems and associated activities:			
– relevant?			
– evidence-based?			
– realistic and possible to implement?			
– adequately funded?			
27. Does the plan include relevant strategies and activities for human resources development and training?			
(a) Is there a well-defined strategy with associated activities for assessing available personnel and competencies at different service levels?			
(b) Is there a strategy to improve the number of providers for mental health?			
(c) Are there relevant management strategies and activities to address:			
– recruitment?			
– retention?			
– deployment of staff?			
(d) Has provision been made for ongoing education, training and skills development?			
(e) Is there a strategy/relevant defined activities to introduce changes to undergraduate and graduate curricula of health and allied health workers?			
(f) Is there a strategy for training health providers to develop the appropriate competencies at the levels of:			
– informal community services?			
– primary health care services?			
– general hospital care?			
– specialist care?			
(g) Are the strategies on human resources and associated activities:			
– relevant?			
– evidence-based?			
– realistic and possible to implement?			
– adequately funded?			

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WHO CHECKLIST FOR EVALUATING A MENTAL HEALTH PLAN			
Please use the following rating scale to rate each item: **1 = yes/ to great degree 3 = no/not at all** **2 = to some extent 4 = unknown**	**Rating**	**If "yes" or "to some extent", please state how.** **If not, please state reason(s).**	**Action required (if any)**
28. Does the plan include relevant strategies and activities for research and evaluation?			
(a) Are there strategies for improving capacity to conduct research and evaluation?			
(b) Will the research address practical issues for the country?			
(c) Has provision been made to evaluate the policy and plan?			
(d) Are research and evaluation strategies and defined activities:			
– relevant?			
– evidence-based?			
– realistic and possible to implement?			
– adequately funded?			
29. Does the plan include relevant strategies and activities for intrasectoral collaboration?			
(a) Is a structure planned/in place through which intrasectoral collaboration could take place?			
(b) Is collaboration with the following departments within the health sector included in the plan:			
–planning?			
–pharmaceuticals?			
–human resource development?			
–child health?			
–HIV/AIDS?			
–epidemiology and surveillance?			
–epidemic and disaster preparedness divisions?			
30. Does the plan include relevant strategies and activities for intersectoral collaboration?			
(a) Is a structure planned/in place through which intersectoral collaboration could take place?			
(b) Is collaboration with the following government departments included in the plan?			
– social services?			
– justice?			
– education?			
– housing?			
– corrections?			
– police?			

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WHO CHECKLIST FOR EVALUATING A MENTAL HEALTH PLAN

Please use the following rating scale to rate each item: 1 = yes/ to great degree 3 = no/not at all 2 = to some extent 4 = unknown	Rating	If "yes" or "to some extent", please state how. If not, please state reason(s).	Action required (if any)
(c) Is collaboration with the following included in the plan?			
– nongovernmental organizations?			
– consumer groups?			
– family groups?			
(d) Are the strategies on intersectoral collaboration and associated activities:			
– relevant?			
– evidence-based?			
– realistic and possible to implement?			
– adequately funded?			
31. To what degree have the key mental health strategies been integrated into the country's existing strategic plans for:			
– improving patients' rights?			
– improving rights of people living with disabilities?			
– overall health?			
– social welfare?			
– poverty reduction?			
– development?			
Taking into account the financial and human resources available in the country, please comment on the general feasibility for implementation of the plan.			

ANNEX 2: WHO Checklist on Mental Health Legislation

Introduction and how to use this checklist

This checklist is a companion to the WHO *Resource Book on Mental Health, Human Rights and Legislation.* Its objectives are to: a) assist countries in reviewing the comprehensiveness and adequacy of existing mental health legislation; and b) help them in the process of drafting new law. This checklist can help countries assess whether key components are included in legislation, and ensure that the broad recommendations contained in the Resource Book are carefully examined and considered.

A *committee* to work through the checklist is recommended. While an individual in, for example, the ministry of health, may be able to complete the checklist, this has certain limitations. First, no single person is likely to have all the relevant information that a well selected team would have. Secondly, different individuals or representatives of different groups are likely to have differing views on various issues. An evaluation committee that allows critical debate and the development of a consensus is invaluable. Although countries should decide for themselves on the composition of the committee, it is advisable to include a legal practitioner familiar with the various national laws, the governmental mental health focal point, representatives of service user and family groups, and representatives of mental health professionals, NGOs and different government departments. It is recommended that the process be led and mediated by an independent human rights and/or legal expert.

This checklist should generally not be *utilized without thoroughly studying the Resource Book itself*. A number of important items included in the checklist are explained in the Resource Book, and the rationale and different options for legislation are discussed. The Resource Book emphasizes that countries should make their own decisions about various alternatives and ways of drafting legislation as well as about a number of content issues. The format of this checklist allows for such flexibility, and aims to encourage internal debate; it thus permits countries to make decisions based on their own unique situations.

The checklist covers issues from a broad perspective, and many of the provisions will need to be fleshed out or elaborated upon with respect to details and country specifications. Moreover, not all provisions will be equally relevant to all countries due to different social, economic, cultural and political factors. For example, not all countries will choose to have community treatment orders; not all countries have provision for "non-protesting patients"; and in most countries, sterilization of people with mental disorders will not be relevant. However, while each country in its evaluative process may determine that a particular provision is not relevant, this determination should be made part of the checklist exercise. All provisions in the checklist should be considered and discussed carefully before it is decided that one (or more) of the provisions is not relevant to a country's particular context.

The Resource Book points out that countries may have laws that affect mental health in a single statute or in numerous different statutory laws relating to areas such as general health, employment, housing, discrimination and criminal justice. Moreover, some countries utilize regulations, orders and other mechanisms to complement a statutory act. It is therefore essential, when conducting this audit, to collect and collate all legal provisions pertaining to mental health, and to make decisions based on comprehensive information.

The Resource Book makes it clear that drawing up or changing mental health legislation is a "process". Establishing what needs to be included in the legislation is an important element of that process, and this checklist can be a useful aid to achieving this goal. Nonetheless, the objective of drafting a law that can be implemented in a country must never be separated from the "content", and must always be a central consideration.

WHO checklist on mental health legislation

For each component included in the checklist, three questions need to be addressed:

a) Has the issue been adequately covered in the legislation?
b) Has it beencovered, but not fully and comprehensively?
c) Has it not been covered at all?

If the response is either (b) or (c), the committee conducting the assessment mustdecide on the feasibility and local relevance of including the issue, leading to the drafting of locally appropriate legislation.

This checklist does not cover each and every issue that could or should be included in legislation. This does not mean that other items are unimportant and thatcountries should not pursue them; however, for the sake of simplicity and ease of use, the scope of this checklist has been limited.

Legislative issue	**Extent to which covered in legislation (tick one)** **a) Adequately covered** **b) Covered to some extent** **c) Not covered at all**	**If (b), explain:** **• Why it is not adequately covered** **• What is missing or problematic about the existing provision** **If (c), explain why it is not covered incurrent legislation (Additional information may be added to new pages if required)**	**If (b) or (c), explain how/whether it is to be included in new legislation (Additional information may be added to new pages if required)**
A. Preamble and objectives			
1) Does the legislation have a preamble which emphasizes:			
a) the human rights of people with mental disorders?	a) b) c)		
b) the importance of accessible mental health services for all?	a) b) c)		

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Legislative issue	Extent to which covered in legislation (tick one)
	a) Adequately covered
	b) Covered to some extent
	c) Not covered at all
		If (b), explain:
		• Why it is not adequately covered
		• What is missing or problematic about the existing provision
		If (c), explain why it is not covered incurrent legislation
		(Additional information may be added to new pages if required)
			If (b) or (c), explain how/whether it is to be included in new legislation (Additional information may be added to new pages if required)

2) Does the legislation specify that the purpose and objectives to be achieved include:			
a) non-discrimination against people with mental disorders?	a) b) c)		
b) promotion and protection of the rights of people with mental disorders?	a) b) c)		
c) improved access to mental health services?	a) b) c)		
d) a community-based approach?	a) b) c)		
B. Definitions			
1) Is there a clear definition of mental disorder/ mental illness/mental disability/mental incapacity?	a) b) c)		
2) Is it evident from the legislation why the particular term (above) has been chosen?	a) b) c)		

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Legislative issue	Extent to which covered in legislation (tick one)
	a) Adequately covered
	b) Covered to some extent
	c) Not covered at all
		If (b), explain:
		• Why it is not adequately covered
		• What is missing or problematic about the existing provision
		If (c), explain why it is not covered incurrent legislation
		(Additional information may be added to new pages if required)
			If (b) or (c), explain how/whether it is to be included in new legislation (Additional information may be added to new pages if required)

3) Is the legislation clear on whether or not mental retardation/intellectual disability, personality disorders and substance abuse are being covered in the legislation?	a) b) c)		
4) Are all key terms in the legislation clearly defined?	a) b) c)		
5) Are all the key terms used consistently throughout the legislation (i.e. not interchanged with other terms with similar meanings)?	a) b) c)		
6) Are all "interpretable" terms (i.e. terms that may have several possible interpretations or meanings or may be ambiguous in terms of their meaning) in the legislation defined?	a) b) c)		
C. Access to mental health care			
1) Does the legislation make provision for the financing of mental health services?	a) b) c)		
2) Does the legislation state that mental health services should be provided on an equal basis with physical health care?	a) b) c)		

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Legislative issue	Extent to which covered in legislation (tick one)
	a) Adequately covered
	b) Covered to some extent
	c) Not covered at all
		If (b), explain:
		• Why it is not adequately covered
		• What is missing or problematic about the existing provision
		If (c), explain why it is not covered incurrent legislation
		(Additional information may be added to new pages if required)
			If (b) or (c), explain how/whether it is to be included in new legislation (Additional information may be added to new pages if required)

3) Does the legislation ensure allocation of resources to underserved populations and specify that these services should be culturally appropriate?	a) b) c)		
4) Does the legislation promote mental health within primary health care?	a) b) c)		
5) Does the legislation promote access to psychotropic drugs?	a) b) c)		
6) Does the legislation promote a psychosocial, rehabilitative approach?	a) b) c)		
7) Does the legislation promote access to health insurance in the private and publichealth sector for people with mental disorders?	a) b) c)		
8) Does the legislation promote community care and deinstitutionalization?	a) b) c)		
D. Rights of users of mental health services			
1) Does the legislation include the rights to respect, dignity and to be treated in a humane way?	a) b) c)		

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Legislative issue	Extent to which covered in legislation (tick one)
	a) Adequately covered
	b) Covered to some extent
	c) Not covered at all
		If (b), explain:
		• Why it is not adequately covered
		• What is missing or problematic about the existing provision
		If (c), explain why it is not covered incurrent legislation
		(Additional information may be added to new pages if required)
			If (b) or (c), explain how/whether it is to be included in new legislation (Additional information may be added to new pages if required)

2) Is the right to patients' confidentiality regarding information about themselves, their illness and treatment included?	a) b) c)		
a) Are there sanctions and penalties for people who contravene patients' confidentiality?	a) b) c)		
b) Does the legislation lay down exceptional circumstances when confidentiality may be legally breached?	a) b) c)		
c) Does the legislation allow patients and their personal representatives the right to ask for judicial review of, or appeal against, decisions to release information?	a) b) c)		
3) Does the legislation provide patients free and full access to information about themselves (including access to their clinical records)?	a) b) c)		
a) Are circumstances in which such access can be denied outlined?	a) b) c)		
b) Does the legislation allow patients and their personal representatives the right to ask for judicial review of, or appeal against, decisions to withhold information?	a) b) c)		

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Legislative issue	Extent to which covered in legislation (tick one)
	a) Adequately covered
	b) Covered to some extent
	c) Not covered at all
		If (b), explain:
		• Why it is not adequately covered
		• What is missing or problematic about the existing provision
		If (c), explain why it is not covered incurrent legislation
		(Additional information may be added to new pages if required)
			If (b) or (c), explain how/whether it is to be included in new legislation (Additional information may be added to new pages if required)

4) Does the law specify the right to be protected from cruel, inhuman and degrading treatment?	a) b) c)		
5) Does the legislation set out the minimal conditions to be maintained in mental health facilities for a safe, the rapeutic and hygienic environment?	a) b) c)		
6) Does the law insist on the privacy of people with mental disorders? a) Is the law clear on minimal levels of privacy to be respected?	a) b) c) a) b) c)		
7) Does the legislation outlaw forced or in adequately remunerated labour within mental health institutions?	a) b) c)		
8) Does the law make provision for: • educational activities, • vocational training, • leisure and recreational activities,and • religious or cultural needs of people with mental disorders?	a) b) c)		
9) Are the health authorities compelled by the law to inform patients of their rights?	a) b) c)		

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Legislative issue	Extent to which covered in legislation (tick one)
	a) Adequately covered
	b) Covered to some extent
	c) Not covered at all
		If (b), explain:
		• Why it is not adequately covered
		• What is missing or problematic about the existing provision
		If (c), explain why it is not covered incurrent legislation
		(Additional information may be added to new pages if required)
			If (b) or (c), explain how/whether it is to be included in new legislation (Additional information may be added to new pages if required)

10) Does legislation ensure that users of mental health services are involved in mental health policy, legislation development and service planning?	a) b) c)		
E. Rights of families or other carers			
1) Does the law entitle families or other primary carers to information about the person with a mental disorder (unless the patient refuses the divulging of such information)?	a) b) c)		
2) Are family members or other primary carers encouraged to become involved in the formulation and implementation of the patient's individualized treatment plan?	a) b) c)		
3) Do families or other primary carers have the right to appeal involuntary admission and treatment decisions?	a) b) c)		
4) Do families or other primary carers have the right to apply for the dischargeof mentally ill offenders?	a) b) c)		
5) Does legislation ensure that family members or other carers are involved inthe development of mental health policy, legislation and service planning?	a) b) c)		

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Legislative issue	Extent to which covered in legislation (tick one)
	a) Adequately covered
	b) Covered to some extent
	c) Not covered at all
		If (b), explain:
		• Why it is not adequately covered
		• What is missing or problematic about the existing provision
		If (c), explain why it is not covered incurrent legislation
		(Additional information may be added to new pages if required)
			If (b) or (c), explain how/whether it is to be included in new legislation (Additional information may be added to new pages if required)

F. Competence, capacity and guardianship			
1) Does legislation make provision for the management of the affairs of people with mental disorders if they are unable to do so?	a) b) c)		
2) Does the law define "competence" and "capacity"?	a) b) c)		
3) Does the law lay down a procedure and criteria for determining a person's incapacity/ incompetence with respect to issues such as treatment decisions, selection of a substitute decision-maker, making financial decisions?	a) b) c)		
4) Are procedures laid down for appeals against decisions of incapacity/ incompetence, and for periodic reviews of decisions?	a) b) c)		
5) Does the law lay down procedures for the appointment, duration, duties and responsibilities of a guardian to act on behalf of a patient?	a) b) c)		
6) Does the law determine a process for establishing in which areas a guardian may take decisions on behalf of apatient?	a) b) c)		
7) Does the law make provision for a systematic review of the need for a guardian?	a) b) c)		

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8) Does the law make provision for a patient to appeal against the appointment of a guardian?	a) b) c)		
G. Voluntary admission and treatment			
1) Does the law promote voluntary admission and treatment as a preferred alternative to involuntary admission and treatment?	a) b) c)		
2) Does the law state that all voluntary patients can only be treated after obtaining informed consent?	a) b) c)		
3) Does the law state that people admitted as voluntary mental health users should be cared for in a way that is equitable with patients with physical health problems?	a) b) c)		
4) Does the law state that voluntary admission and treatment also implies the right to voluntary discharge/ refusal of treatment?	a) b) c)		
5) Does the law state that voluntary patients should be informed at the time of admission that they may only be denied the right to leave if they meet the conditions for involuntary care?	a) b) c)		

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H. Non-protesting patients			
1) Does the law make provision for patients who are incapable of making informed decisions about admission or treatment, but who do not refuse admission or treatment?	a) b) c)		
2) Are the conditions under which a non-protesting patient may be admitted and treated specified?	a) b) c)		
3) Does the law state that if users admitted or treated under this provision object to their admission or treatment they must be discharged or treatment stopped unless the criteria for involuntary admission are met?	a) b) c)		
I. Involuntary admission(when separate from treatment) and involuntary treatment (where admission and treatment are combined)			
1) Does the law state that involuntary admission may only be allowed if:			
a) there is evidence of mental disorder of specified severity? and;	a) b) c)		
b) there is serious likelihood of harm to self or others and/or substantial likelihood of serious deterioration in the patient's condition if treatment is not given?and;	a) b) c)		

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c) admission is for a therapeutic purpose?	a) b) c)		
2) Does the law state that two accredited mental health care practitioners must certify that the criteria for involuntary admission have been met?	a) b) c)		
3) Does the law insist on accreditation of a facility before it can admit involuntary patients?	a) b) c)		
4) Is the principle of the least restrictive environment applied to involuntary admissions?	a) b) c)		
5) Does the law make provision for an independent authority (e.g. review body or tribunal) to authorize all involuntary admissions?	a) b) c)		
6) Are speedy time frames laid down within which the independent authority must make a decision?	a) b) c)		
7) Does the law insist that patients, families and legal representatives be informed of the reasons for admission and of their rights of appeal?	a) b) c)		

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8) Does the law provide for a right to appeal an involuntary admission?	a) b) c)		
9) Does the law include a provision for time-bound periodic reviews of involuntary (and long-term "voluntary") admission by an independent authority?	a) b) c)		
10) Does the law specify that patients must be discharged from involuntary admission as soon as they no longer fulfil the criteria for involuntary admission?	a) b) c)		
J. Involuntary treatment (when separate from involuntary admission)			
1) Does the law set out the criteria that must be met for involuntary treatment, including:			
• Patient suffers from a mental disorder?	a) b) c)		
• Patient lacks the capacity to make informed treatment decisions?	a) b) c)		
• Treatment is necessary to bring about an improvement in the patient's condition, and/or restore the capacity to make treatment decisions, and/or prevent serious deterioration, and/or prevent injury or harm to self or others?	a) b) c)		

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2) Does the law ensure that a treatment plan is proposed by an accredited practitioner with expertise and knowledge to provide the treatment?	a) b) c)		
3) Does the law make provision for a second practitioner to agree on the treatment plan?	a) b) c)		
4) Has an independent body been set up to authorize involuntary treatment?	a) b) c)		
5) Does the law ensure that treatment is for a limited time period only?	a) b) c)		
6) Does the law provide for a right to appeal involuntary treatment?	a) b) c)		
7) Are there speedy, time-bound, periodic reviews of involuntary treatment in the legislation?	a) b) c)		
K. Proxy consent for treatment			
1) Does the law provide for a person to consent to treatment on a patient's behalf if that patient has been found incapable of consenting?	a) b) c)		
2) Is the patient given the right to appeal a treatment decision to which a proxy consent has been given ?	a) b) c)		

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3) Does the law provide for use of "advance directives" and, if so, is the term clearly defined?	a) b) c)		
L. Involuntary treatment in community settings			
1) Does the law provide for involuntary treatment in the community as a "less restrictive" alternative to an inpatient mental health facility?	a) b) c)		
2) Are all the criteria and safe guards required for involuntary inpatient treatment also included for involuntary community-based treatment?	a) b) c)		
M. Emergency situations			
1) Are the criteria for emergency admission/ treatment limited to situations where there is a high probability of immediate and imminent danger or harm to self and/or others?	a) b) c)		
2) Is there a clear procedure in the law for admission and treatment in emergency situations?	a) b) c)		
3) Does the law allow any qualified and accredited medical or mental health practitioner to admit and treat emergency cases?	a) b) c)		

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4) Does the law specify a time limit for emergency admission (usually no longer than 72 hours)?	a) b) c)		
5) Does the law specify the need to initiate procedures for involuntary admission and treatment, if needed, assoon as possible after the emergency situation has ended?	a) b) c)		
6) Are treatments such as ECT, psychosurgery and sterilization, as well as participation in clinical or experimental trials out lawed for people held as emergency cases?	a) b) c)		
7) Do patients, family members and personal representatives have the right to appeal against emergency admission/treatment?	a) b) c)		
N. Determinations of mental disorder			
1) Does the legislation: a) Define the level of skills required to determine mental disorder?	a) b) c)		
b) Specify the categories of professionals who may assess a person to determine the existence of a mental disorder?	a) b) c)		

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2) Is the accreditation of practitioners codified in law and does this ensure that accreditation is operated by an independent body?	a) b) c)		
0. Special treatments			
1) Does the law prohibit sterilization as a treatment for mental disorder?	a) b) c)		
a) Does the law specify that the mere fact of having a mental disorder should not be a reason for sterilization or abortion without informed consent?	a) b) c)		
2) Does the law require informed consent for major medical and surgical procedureson persons with a mental disorder?	a) b) c)		
a) Does the law allow medical and surgical procedures without informed consent, if waiting for informed consent would put the patient's life at risk?	a) b) c)		
b) In cases where inability to consent is likely to be long term, does the law allow authorization for medical and surgical procedures from an independent review body or by proxy consent of a guardian?	a) b) c)		

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3) Are psychosurgery and other irreversible treatments outlawed on involuntary patients? a) Is there an independent body that makes sure there is indeed informed consent for psychosurgery or other irreversible treatments on involuntary patients?	a) b) c) a) b) c)		
4) Does the law specify the need for informed consent when using ECT?	a) b) c)		
5) Does the law prohibit the use of unmodified ECT?	a) b) c)		
6) Does the law prohibit the use of ECT in minors?	a) b) c)		
P. Seclusion and restraint			
1) Does the law state that seclusion and restraint should only be utilized in exceptional cases to prevent immediate or imminent harm to self or others?	a) b) c)		
2) Does the law state that seclusion and restraint should never be used as ameans of punishment or for the convenience of staff?	a) b) c)		

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3) Does the law specify a restricted maximum time period for which seclusion and restraints can be used?	a) b) c)		
4) Does the law ensure that one period of seclusion and restraint is not followed immediately by another?	a) b) c)		
5) Does the law encourage the development of appropriate structural and human resource requirements that minimize the need to use seclusion and restraints in mental health facilities?	a) b) c)		
6) Does the law lay down adequate procedures for the use of seclusion and restraints, including: • who should authorize it, • that the facility should beaccredited, • that the reasons and duration of each incident be recorded in a database and made available to a review board, and • that family members/carers and personal representatives be immediately informed when the patient is subject to seclusionand/ or restraint?	a) b) c)		

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Q. Clinical and experimental research			
1) Does the law state that informed consent must be obtained for participation in clinical or experimental research from both voluntary and involuntary patients who have the abilityto consent?	a) b) c)		
2) Where a person is unable to give informed consent (and where a decision has been made that research can be conducted): a) Does the law ensure that proxy consent is obtained from either the legally appointed guardian or family member, or from an independent authority constituted for this purpose? b) Does the law state that there search cannot be conducted if the same research could be conducted on people capable of consenting, and that the research is necessary to promote the health of the individual and that of the population represented?	a) b) c) a) b) c) a) b) c)		
R. Oversight and review mechanisms			
1) Does the law set up a judicial or quasi-judicial body to review processes related to involuntary admission or treatment and other restrictions of rights?	a) b) c)		

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a) Does the above body:			
(i) Assess each involuntary admission/ treatment?	a) b) c)		
(ii) Entertain appeals against involuntary admission and/orinvoluntary treatment?	a) b) c)		
(iii) Review the cases of patients admitted on an involuntary basis (and long-term voluntary patients)?	a) b) c)		
(iv) Regularly monitor patients receiving treatment against their will?	a) b) c)		
(v) Authorize or prohibit intrusive and irreversible treatments (such as psychosurgery and ECT)?	a) b) c)		
b) Does the composition of this body include an experienced legal practitioner and an experienced health care practitioner, and a "wise person" reflecting the "community" perspective?	a) b) c)		
c) Does the law allow for appealof this body's decisions to a higher court?	a) b) c)		

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2) Does the law set up a regulatory and oversight body to protect the rights of people with mental disorders within and outside mental health facilities?	a) b) c)		
a) Does the above body:			
(i) Conduct regular inspections of mental health facilities?	a) b) c)		
(ii) Provide guidance on minimizing intrusive treatments?	a) b) c)		
(iii) Maintain statistics; on, for example, the use of intrusiveand irreversible treatments, seclusion and restraints?	a) b) c)		
(iv) Maintain registers of accredited facilities and professionals?	a) b) c)		
(v) Report and make recommendations directly to the appropriate government minister?	a) b) c)		
(vi) Publish findings on a regular basis?	a) b) c)		

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b) Does the composition of the body include professionals (in mental health, legal, socialwork), representatives of users of mental health facilities, members representing families of people with mental disorders, advocates and lay persons?	a) b) c)		
c) Is this body's authority clearly stated in the legislation?	a) b) c)		
3)			
a) Does the legislation outline procedures for submissions, investigations and resolutions of complaints?	a) b) c)		
b) Does the law stipulate:			
• the time period from the occurrence of the incident within which the complaint should be made?	a) b) c)		
• a maximum time period within which the complaint should be responded to, by whom and how?	a) b) c)		
• the right of patients to choose and appoint a personal representative and/or legal counsel to represent them in any appeals or complaints procedures?	a) b) c)		

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• the right of patients to aninterpreter during the proceedings, if necessary?	a) b) c)		
• the right of patients and their counsel to access copies of their medical records and any other relevant reports and documents during the complaints or appeals procedures?	a) b) c)		
• the right of patients and their counsel to attend and participate in complaints and appeals procedures?	a) b) c)		
S. Police responsibilities			
1) Does the law place restrictions on the activities of the police to ensure that persons with mental disorders are protected against unlawful arrest and detention, and are directed towards the appropriate health care services?	a) b) c)		
2) Does the legislation allow family members, carers or health professionals to obtain police assistance in situations where a patient is highly aggressive or is showing out-of-control behaviour?	a) b) c)		
3) Does the law allow for persons arrested for criminal acts, and in police custody, to be promptly assessed for mental disorder if there is suspicion of mental disorder?	a) b) c)		

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4) Does the law make provision for the police to assist in taking a person to a mental health facility who has been involuntarily admitted to the facility?	a) b) c)		
5) Does the legislation make provision for the police to find an involuntarily committed person who has absconded and return him/her to the mental health facility?	a) b) c)		
T. Mentally ill offenders			
1) Does the legislation allow for diverting an alleged offender with a mental disorder to the mental health system in lieu of prosecuting him/her, taking into account the gravity of the offence, the person's psychiatric history, mental health state at the time of the offence, the likelihood of detriment to the person's health and the community's interest in prosecution?	a) b) c)		
2) Does the law make adequate provision for people who are not fit to stand trial to be assessed, and for charges to be dropped or stayed while they undergo treatment? a) Are people undergoing such treatment given the same rights in the law as other involuntarily admitted persons, including the right to judicial review by an independent body?	a) b) c) a) b) c)		

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3) Does the law allow for people who are found by the courts to be "not responsible due to mental disability" to be treated in a mental health facility and to be discharged once their mental disorder sufficiently improves?	a) b) c)		
4) Does the law allow, at the sentencing stage, for persons with mental disorders to be given probation or hospital orders, rather than being sentenced to prison?	a) b) c)		
5) Does the law allow for the transfer of a convicted prisoner to a mental health facility if he/she becomes mentally ill while serving a sentence? a) Does the law prohibit keeping a prisoner in the mental health facility for longer than the sentence, unless involuntary admission procedures are followed?	a) b) c) a) b) c)		
6) Does the legislation provide for securemental health facilities for mentally illoffenders?	a) b) c)		
U. Discrimination			
1) Does the law include provisions aimed at stopping discrimination against people with mental disorders?	a) b) c)		

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V. Housing			
1) Does the law ensure non-discrimination of people with mental disorders in the allocation of housing?	a) b) c)		
2) Does the law make provision for housing of people with mental disorders in state housing schemes or through subsidized housing?	a) b) c)		
3) Does the legislation make provision for housing in halfway homes and long-stay, supported homes for people with mental disorders?	a) b) c)		
W. Employment			
1) Does the law make provision for the protection of persons with mental disorders from discrimination and exploitation in the work place?	a) b) c)		
2) Does the law provide for "reasonable accommodation" for employees with mental disorders, for example by providing for a degree of flexibility in working hours to enable those employees to seek mental health treatment?	a) b) c)		
3) Does the law provide for equal employment opportunities for people with mental disorders?	a) b) c)		

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4) Does the law make provision for thee stablishment of vocational rehabilitation programmes and other programmes that provide jobs and employment in the community for people with mental discorders?	a) b) c)		
X. Social security			
1) Does legislation provide for disability grants and pensions for people with mental disabilities?	a) b) c)		
2) Does the law provide for disability grants and pensions for people with mental disorders at similar rates as those for people with physical disabilities?	a) b) c)		
Y. Civil issues			
1) Does the law uphold the rights of people with mental disorders to the full range of civil, political, economic, social and cultural rights to which all people are entitled?	a) b) c)		
Z. Protection of vulnerable groups *Protection of minors*			
1) Does the law limit the involuntary placement of minors in mental health facilities to instances where all feasible community alternatives have been tried?	a) b) c)		

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2) If minors are placed in mental health facilities, does the legislation stipulate that	a) b) c)		
a) they should have a separate living area from adults?	a) b) c)		
b) that the environment is age-appropriate and takes into consideration the developmental needs of minors?	a) b) c)		
3) Does the law ensure that all minors have an adult to represent them in all matters affecting them, including consenting to treatment?	a) b) c)		
4) Does the law stipulate the need to take the opinions of minors into consideration on all issues affecting them (including consent to treatment), depending on their age and maturity?	a) b) c)		
5) Does legislation ban all irreversible treatments for children?	a) b) c)		

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Protection of women			
1) Does legislation allow women with mental disorders equal rights with men in all matters relating to civil, political, economic, social and cultural rights?	a) b) c)		
2) Does the law ensure that women in mental health facilities: a) have adequate privacy?	a) b) c)		
b) are provided with separate sleeping facilities from men?	a) b) c)		
3) Does legislation state that women with mental disorders should receive equal mental health treatment and care as men, including access to mental health services and care in the community, and in relation to voluntary and involuntary admission and treatment?	a) b) c)		
Protection of minorities			
1) Does legislation specifically state that persons with mental disorders should not be discriminated against on the grounds of race, colour, language, religion, political or other opinions, national, ethnic or social origin, legal or social status?	a) b) c)		

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		If (c), explain why it is not covered incurrent legislation
		(Additional information may be added to new pages if required)
			If (b) or (c), explain how/whether it is to be included in new legislation (Additional information may be added to new pages if required)

2) Does the legislation provide for a review body to monitor involuntary admission and treatment of minorities and ensure non-discrimination on all matters?	a) b) c)		
3) Does the law stipulate that refugees and asylum seekers are entitled to the same mental health treatment as other citizens of the host country?	a) b) c)		
AZ. Offences and penalties			
1) Does the law have a section dealing with offences and appropriate penalties?	a) b) c)		
2) Does the law provide appropriate sanctions against individuals who violate any of the rights of patients as established in the law?	a) b) c)		

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