WHO-AIMS

WHO-AIMS Report on

Mental Health System

in Paraguay

WHO-AIMS REPORT ON

MENTAL HEALTH SYSTEM

IN PARAGUAY

A report of the assessment of the mental health system in Paraguay using the World Health Organization - Assessment Instrument for Mental Health Systems (WHO-AIMS).

(Asuncion, Paraguay)

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Please refer to *WHO-AIMS* (WHO, 2005) for full information on the development of WHO-AIMS at the following website.
http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

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Executive Summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Paraguay. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Paraguay to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

Paraguay has a mental health policy and plan, but no mental health law. Financing is mainly oriented towards mental hospitals. There are no social insurance schemes and only a minority of the population has free access to psychotropic medication. Human rights were reviewed only in some facilities, and no review body exists. Only a fraction of mental health workers received training in human rights.

There is no mental health authority. Twenty-six outpatient facilities treat 263 users per 100,000 population. The rate of users is less than 1 per 100,000 population for both for day treatment facilities and community based psychiatric inpatient units. There are 1.1 beds in residential facilities per 100,000 population. Mental hospitals treat 53 patients per 100,000 population, and have occupancy rate above 110%. The majority of patients admitted have a diagnosis of schizophrenia. There has been an increase in the number of mental hospital beds in the last 5 years. All forensic beds are in prison mental health facilities. Involuntary admissions and restrain or seclusion are widely used, especially in the mental hospitals.

Primary health care staff has poor training in mental health and rare interaction with mental health services.

There are 35 human resources working in mental health for 100,000 population. Rates are particularly low for social workers and occupational therapists. Most psychiatrists work (exclusively or not) for government administered facilities. There is an uneven distribution of human resources in favor of mental hospitals and the main city. There are no consumer associations; some family associations have been involved in implementations of policies and plans, and interact with mental health facilities.

Public education and awareness campaigns are overseen by coordinating bodies. There are links with other relevant sectors, but no legislative or financial support for persons with mental disorders.

Data are collected and complied by facilities to a variable extent. No report is produced by the government based on these data. There is no research on mental health published on indexed journals. Some research on non-epidemiological clinical/questionnaires assessments of mental disorders and services has been conducted.

The mental health system has all types of facilities; however some need to be strengthened and developed. There is an imbalance in favor of mental hospital inpatient care. The vast majority of financial resources and an important part of human resources are destined to mental hospitals. At present mental hospitals are working beyond their capacity (in terms of number of beds), although the number of beds was increased in the last years. Few facilities are devoted to children and adolescents. Primary health care staff training on mental health is weak, as is interaction between primary health and mental health. Psychotropic medication is available, but only a minority of the population has free access to it. Access to mental health facilities is uneven across the country, favoring those living in or near Asuncion. There are family associations, but no consumer association. There are formal links of mental health sector with other sectors, but links of critical importance are weak or not developed, including welfare, housing, judicial, work provision, education. Mental health policy and plans exist, but financing is not considered in either. At present there is no mental health law. Some work has been done on human rights in training and inspection of facilities, but there is no review body and actions need to be extended to all facilities. The mental health information system does not cover all relevant information in all facilities.

As most countries in the world and the region of the Americas, Paraguay has a mental health policy. It was implemented comparatively recently. Community care for patients is present, but as seen in low and lower middle income countries, it is weak. Unlike the majority of countries in the world and the region, there is no mental health law. The country spends about 1% of the health budget in mental health, following the tendency of low and lower middle income countries. The poor involvement of primary health care services in mental health is also a feature shared with many low and lower middle income countries. The proportion of psychiatric beds located in psychiatric hospitals to the total psychiatric beds in the country is well above the average for the region. The number of psychiatrists per 100 000 population is similar to the majority of countries in the region of the Americas, and about the average for lower middle income countries in the world (Mental Health Atlas WHO, 2005).

In the last few years the number of outpatient facilities has grown significantly throughout the country: from 13 to 26 in the last 4 years. Efforts have been made to improve the quality of life and treatment of patients in mental hospitals. Some aspects of life in hospital have improved, but the number of patients has steadily grown. Human rights of patients in mental hospital is an issue in international human rights judicial bodies. The lack of human and financial resources is an important barrier for progress towards the treatment of patients in the community. No significant progress has been made in provision of affordable medication, housing or employment for patients in the community.

WHO-AIMS COUNTRY REPORT FOR PARAGUAY

Introduction

Paraguay is located in the centre of South America with an approximate geographical area of 407,000 square kilometres and a population of 5.2 million (2002 Census). The proportion of population under the age of 15 years is 37%, and the proportion of population above the age of 60 years is 7%. Forty-three percent of the population is rural.

The main languages used in the country are Guarani and Spanish, and the main ethnic group is "mestizo" with mixed Spanish and Indian origin. Religious groups include Catholics and other Christian confessions.

The country is a lower middle income group country based on World Bank 2004 criteria. The proportion of health budget to GDP is 8%. The per capita total expenditure on health is 332 international $, and the per capita government expenditure on health is 127 international $. The life expectancy at birth is 68.7 years for males and 74.7 years for females. The healthy life expectancy at birth is 60 years for males and 64 years for females. The literacy rate is 94% for men and 91.5% for women (Mental Health Atlas, WHO, 2005).

There are 133 hospital beds and 58 physicians per 100,000 population in public sector. In terms of primary care, there are 131 physician-based primary health care clinics and 677 non physician-based primary health care clinics. These data are available only for the public sector. Health resources are strongly centralized in spite of decentralization policy [e.g., 70% of physicians are based in the main city, Asuncion, and the surrounding Central region, both of which congregate 36% of the country population (2002 Census)].

The mental health system is hospital based. For the last 5 years efforts have been made to shift attention to the community, with limited success. In general, health system resources are scarce and centralized.

Data was collected in 2005 and is based on the year 2004.

Domain 1: Policy and Legislative Framework

Policy, plans, and legislation

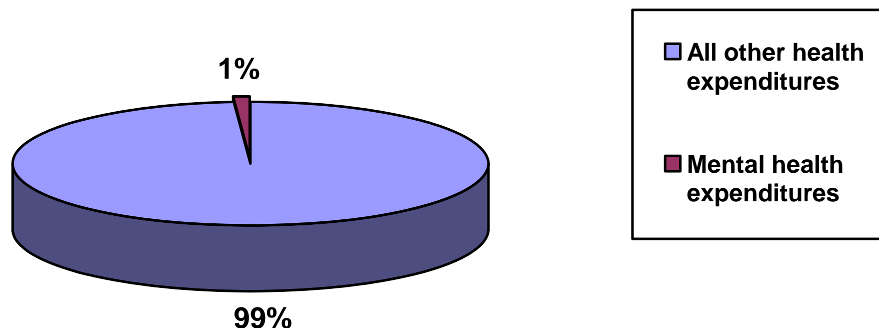
Paraguay's mental health policy was last revised in 2002 and includes the following components: (1) developing a mental health component in primary health care, (2) human resources, (3) involvement of users and families, (4) advocacy and promotion, (5) human rights protection of users, (6) equity and access to mental health services across different groups, (7) quality improvement, (8) monitoring system. No essential medicines list is present in the country.

The last revision of the mental health plans took place in 2003 when a psychiatric reform project was formulated as a complement to the 2002 mental health plan. Both documents include the same components as the mental health policy, but also include, regarding the organization of services: (1) developing community mental health services, (2) downsizing large mental hospitals, (3) reforming mental hospitals to provide more comprehensive care. In addition, a timeframe and specific goals are mentioned, some of which have been reached in the last year. There is no disaster/emergency preparedness plan for mental health. There is no current mental health legislation. A mental health law draft is expected be submitted to Congress before the end of 2005.

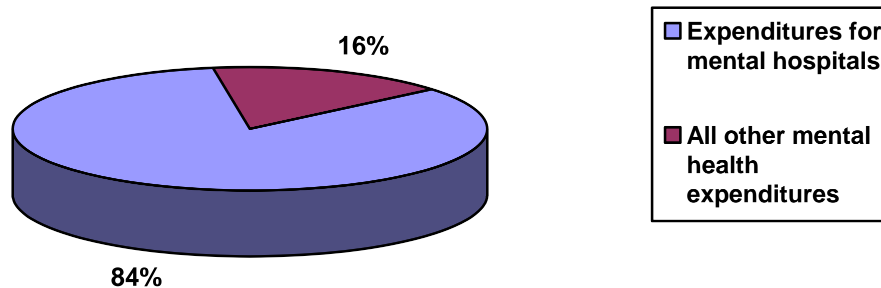
Financing of mental health services

One percent of health care expenditures by the government health department is directed towards mental health. Of all the expenditures spent on mental health, 84% is directed towards mental hospitals. Eleven percent of the population has free access (at least 80%) to essential psychotropic medicines. For those that pay out of pocket, the cost of antipsychotic medication is 2% and of antidepressant medication is 4% of the minimum daily wage (approximately 0.12 US$ per day for antipsychotic medication and 0.21 US$ per day for antidepressant medication). There are no social insurance schemes. Worker's insurance benefits 11% of the population and covers all mental disorders.

GRAPH 1.1 HEALTH EXPENDITURE TOWARDS MENTAL HEALTH



GRAPH 1.2 MENTAL HEALTH EXPENDITURE TOWARDS MENTAL HOSPITALS



Human rights policies

A national human rights review body doesn't exist. One out of the three mental hospitals had at least one review/inspection of human rights protection of patients the year of assessment, while none of community-based inpatient psychiatric units and community residential facilities had such a review. Thirty three percent of mental hospitals staff and no inpatient psychiatric units and community residential facilities staff have had at least one day training, meeting, or other type of working session on human rights protection of patients in that year.

During the year of assessment, cautionary measures issued by an international human rights court were applied to the country due to the condition of patients in a public mental hospital.

Domain 2: Mental Health Services

Organization of mental health services

There is no unique mental health authority in the country. The Director of the Mental Health Program and the Director of the Psychiatric Hospital are the main authorities. Mental health services are organized in terms of service areas, but the structure is strongly centralized.

Mental health outpatient facilities

There are 26 outpatient mental health facilities available in the country, of which 8% are for children and adolescents only. These facilities treat 263 users per 100,000 general population. Of all users treated in mental health outpatient facilities 53% are female. Forty percent of all contacts are with patients 20 years or younger. There are no data on the proportion of users that were children or adolescents.

The users treated in outpatient facilities are primarily diagnosed with schizophrenia and related disorders (21%) and mood disorders (20%). Information on diagnosis is based on

contacts not users. The average number of contacts per user is 2.8. Fifteen percent of outpatient facilities provide follow-up care in the community, while 12% have mental health mobile teams. In terms of available treatments, some (21-50%) of the outpatient facilities offer psychosocial treatments. All (100%) mental health outpatient facilities have at last one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility or a near-by pharmacy all year round.

Day treatment facilities

There is one day treatment facility available in the country. This facility treats 0.92 users per 100,000 general population. Of all users treated in day treatment facilities, 42% of them are female and 8% are children or adolescents. There are no day treatment facilities for children and adolescents only. On average, users spend 44 days per year in day treatment facilities.

Community-based psychiatric inpatient units

There are two community-based psychiatric inpatient units available in the country for a total of 0.27 beds per 100,000 population. None of these beds are reserved for children and adolescents only. Sixty-two percent of admissions to community-based psychiatric inpatient units are female. In one of the units (where data was available) 6% of admissions are children/adolescents. The diagnoses of admissions to community-based psychiatric inpatient are primarily from the following two diagnostic groups: mood disorders (30%) and schizophrenia and related disorders (21%). On average patients spend 6.3 days per discharge.

The majority (51-80%) of patients in community-based psychiatric inpatient units received one or more psychosocial interventions in the last year. All of the community-based psychiatric inpatient units have at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

Community residential facilities

There are five community residential facilities available in the country for a total of 1.1 beds/places per 100,000 population. None of these beds in community residential facilities are reserved for children and adolescents only. Four percent of users treated in community residential facilities are children. The number of users in community residential facilities is 55.

The community residential facilities are part of the Mennonite mental health service for population in Mennonite colonies. Data on gender and days spent in facilities are lacking. No other private or public residential facilities were available in the country the year of assessment.

Mental hospitals

There are three mental hospitals available in the country for a total of 7.8 beds per 100,000 population. All of these facilities are organizationally integrated with mental health outpatient facilities. Two percent of these beds in mental hospitals are reserved for children and adolescents only. The patients admitted to mental hospitals belong primarily to the following two diagnostic groups: schizophrenia and related disorders (58%) and mood disorders (8%). The number of patients in mental hospitals is 53 per 100,000 population.

The average number of days spent mental hospitals is 61. Sixty-eight percent of patients spend less than one year, 19% of patients spend 1-4 years, 8% of patients spend 5-10 years, and 4% of patients spend more than 10 years in mental hospitals. Few (1-20%) patients in mental hospitals received one or more psychosocial interventions in the last year. One hundred percent of mental hospitals have at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

The number of beds has increased by 8% in the last five years. The number of patients in hospital has increased even more, leading to an occupancy rate in excess of 110%.

Forensic and other residential facilities

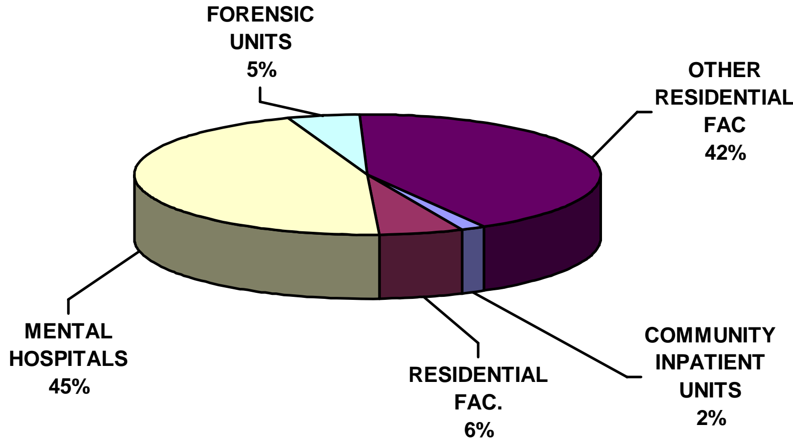
In addition to beds in mental health facilities, there are also 45 beds for persons with mental disorders in forensic inpatient units and 383 in other residential facilities such as homes for persons with mental retardation, detoxification inpatient facilities, homes for the destitute, etc. Forensic facilities offer 0.87 beds per 100,000 population. All forensic beds are in prison mental health treatment facilities. In these facilities 0% of patients spend less than one year, 54% of patients spend 1-4 years, 38% of patients spend 5-10 years, and 8% of patients spend more than 10 years.

Human rights and equity

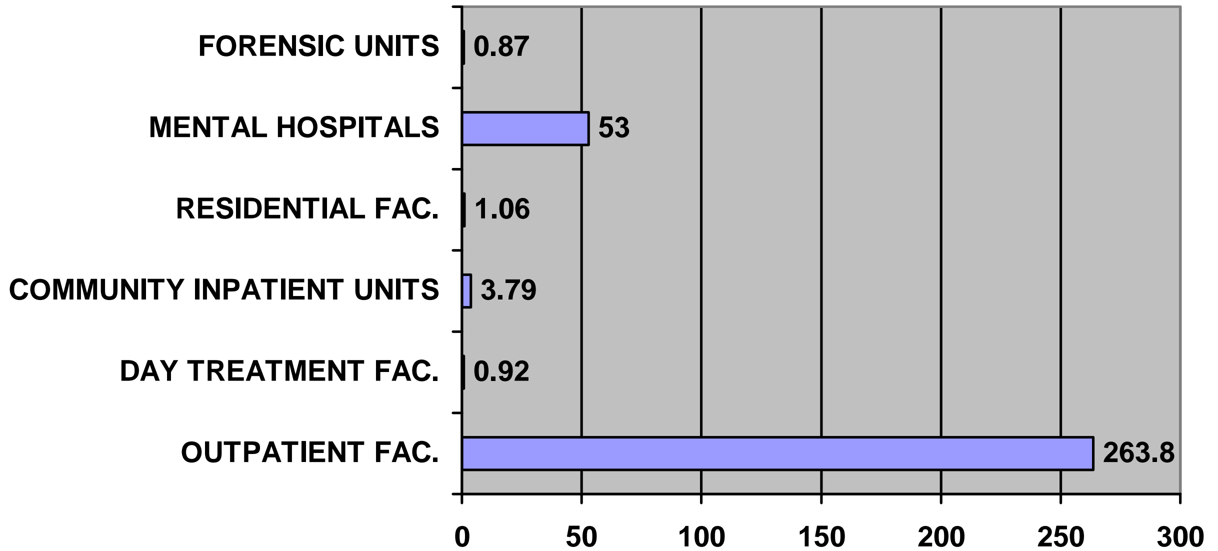
Six percent of all admissions to community-based inpatient psychiatric units are involuntary. The proportion of involuntary admissions to mental hospitals is unknown; the status of voluntary/involuntary admission to mental hospitals is in general not taken into account. It is estimated that the majority of admissions to mental hospitals are involuntary. One percent or less of patients were restrained or secluded at least once within the last year in community-based psychiatric inpatient units, in comparison to an estimated 11-20% of patients in mental hospitals.

Eighty-six percent of psychiatry beds in the country are located in or near Asuncion, the largest city. Such a distribution of beds prevents access of rural users. Inequity of access to mental health services for other minority users (e.g., linguistic, ethnic, religious minorities) is a moderate issue in the country.

Summary Charts



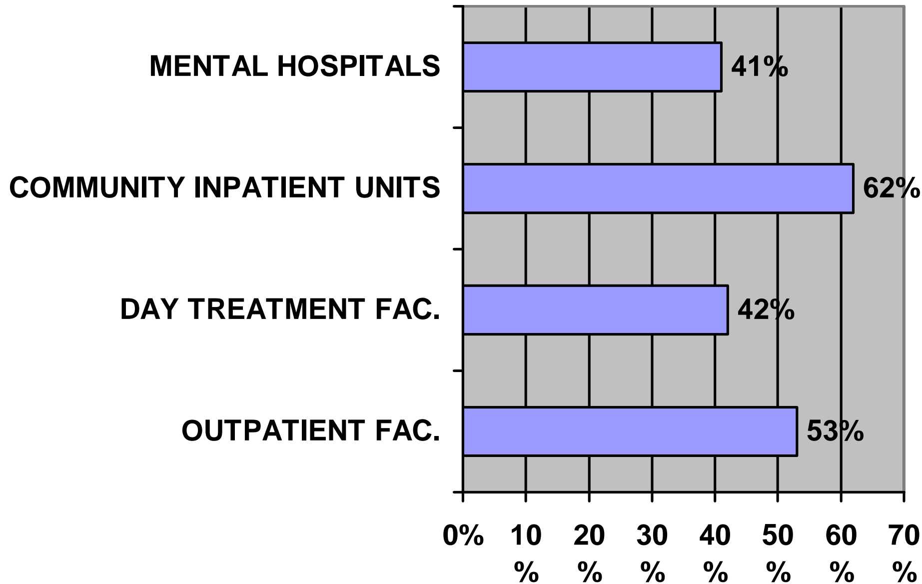
Summary for Graph 2.1
The majority of beds in the country are provided by mental hospitals, followed by other residential facilities (mainly outside the mental health system).



Summary for Graph 2.2

The majority of the users are treated in outpatient facilities and in mental hospitals, while the rate of users treated in inpatient units, day treatment facilities and residential facilities is lower.

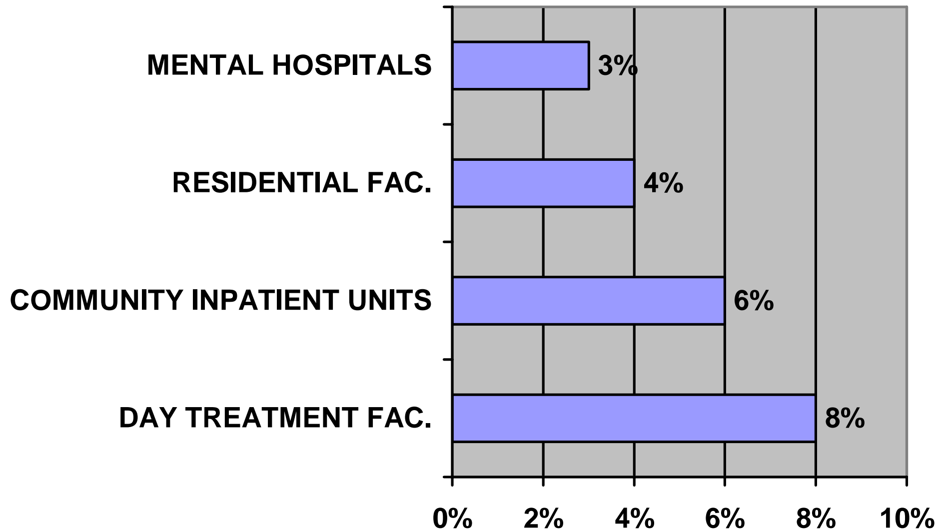
Note: In this graph the rate of admissions in inpatient units is used as proxy of the rate of users admitted in the units



Summary for Graph 2.3

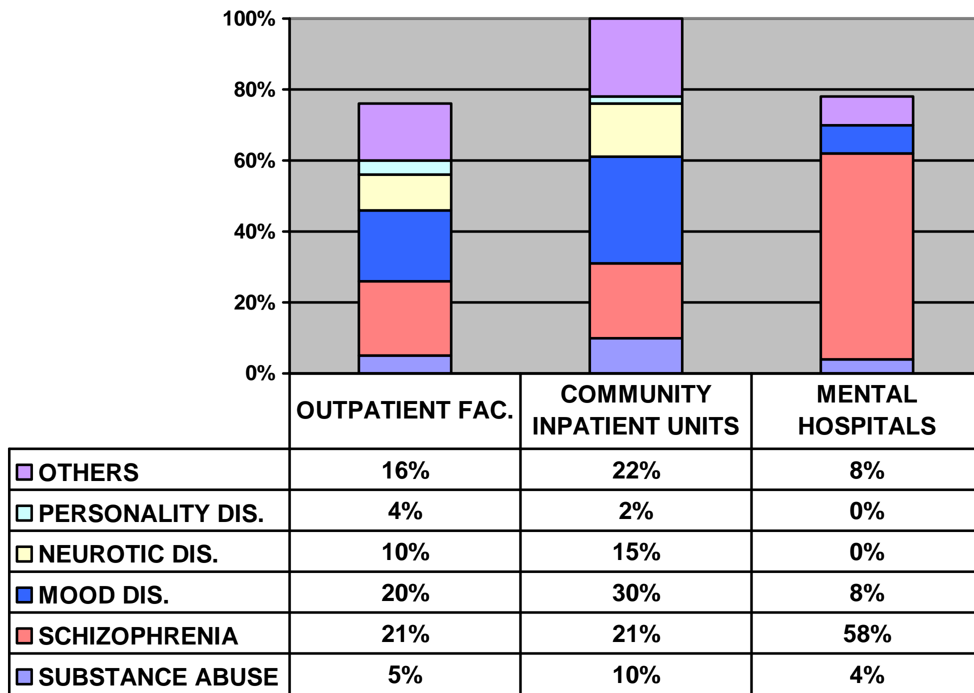
Female users make up over 50% in outpatient facilities and inpatient units. The proportion of female users is the lowest in mental hospitals. There is no data available on gender distribution in residential facilities.

Note: In this graph the percentage of female users' admissions in inpatient units is used as proxy of the percentage of women admitted in the units



Summary for Graph 2.4
The proportion of children users is highest in day treatment facilities and lowest in mental hospitals. There is no data available on the proportion of children users in outpatient facilities. It should be taken into consideration that the proportion of children and adolescents in general population is 44%
Note: In this graph the percentage of children and adolescents' admissions in inpatient units is used as proxy of the percentage of children and adolescents admitted in the units

GRAPH 2.5 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS

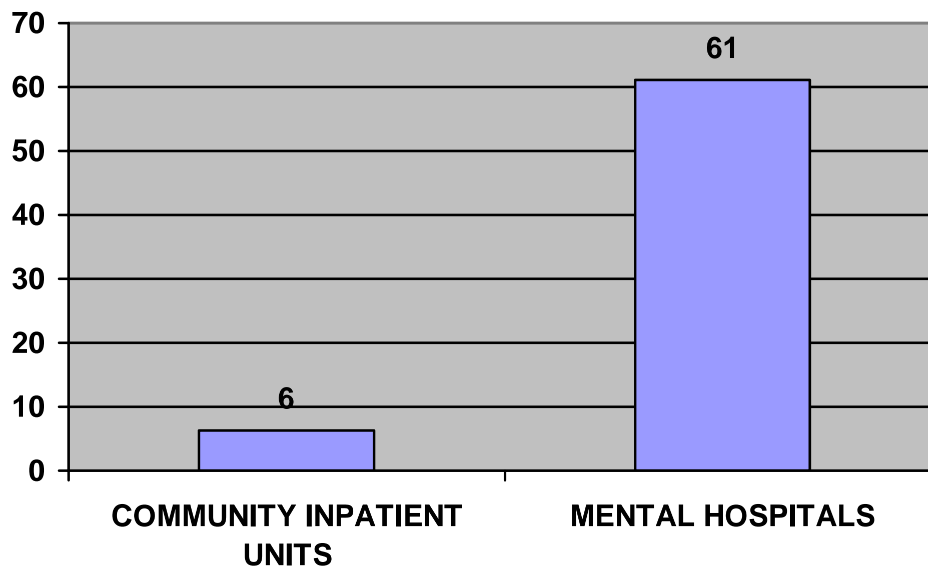


	OUTPATIENT FAC.	COMMUNITY INPATIENT UNITS	MENTAL HOSPITALS
OTHERS	16%	22%	8%
PERSONALITY DIS.	4%	2%	0%
NEUROTIC DIS.	10%	15%	0%
MOOD DIS.	20%	30%	8%
SCHIZOPHRENIA	21%	21%	58%
SUBSTANCE ABUSE	5%	10%	4%

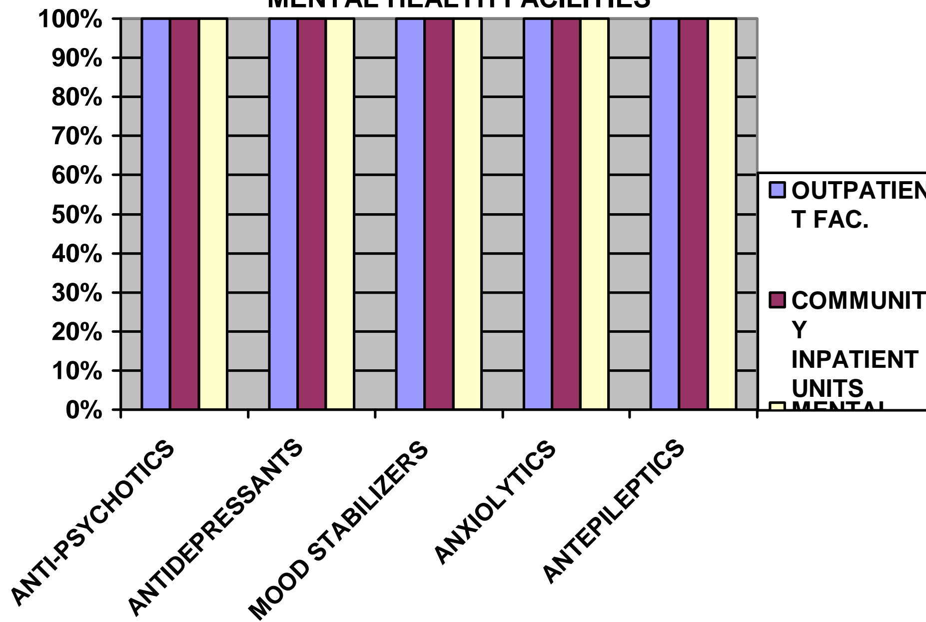
Summary for Graph 2.5

The distribution of diagnoses varies across facilities: in outpatients facilities mood disorders and schizophrenia have similar prevalence, within inpatient units affective disorders are most common, and in mental hospitals schizophrenia is by far the most frequent diagnosis.

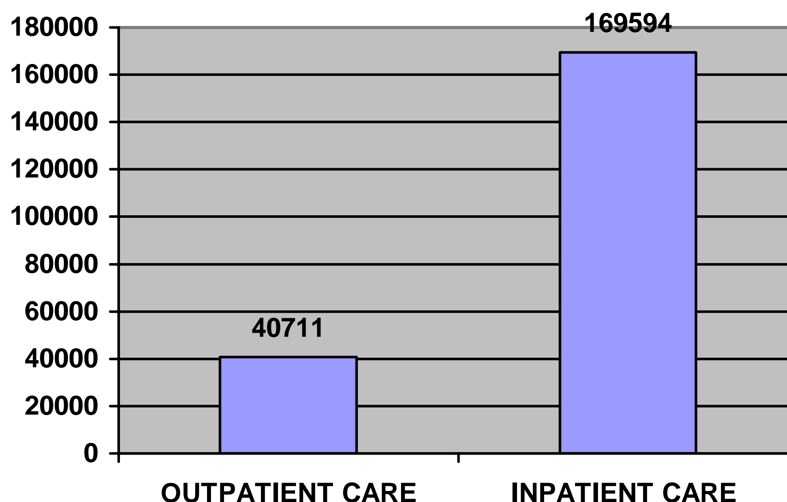
Note: In this graph the percentage of admissions in inpatient units by diagnosis is used as proxy of the percentage of users admitted in the units. The diagnosis for each contact is taken as estimation for users for each diagnosis in outpatient facilities. Percentages do not add up to 100% due to undiagnosed cases.



Summary for Graph 2.6
The longest length of stay for users is in mental hospitals. There is no data available on the length of stay in residential facilities.



Summary for Graph 2.7
Psychotropic drugs are widely available in all types of facilities.



Summary for Graph 2.8[1]
The ratio between outpatient/day care contacts and days spent in all the inpatient facilities (mental hospitals, residential facilities and general hospital units) is an indicator of extent of community care: in this country the ratio is 1:4.2
Note: residential facilities were not included because information was not available.

Domain 3: Mental Health in Primary Health Care

Training in mental health care for primary care staff

Two percent of the training for medical doctors is devoted to mental health, in comparison to 4% for nurses. In terms of refresher training, 0.03% of primary health care doctors have received at least two days of refresher training in mental health, while none of nurses and non-doctor/non-nurse primary health care workers have received such training.

Mental health in primary health care

Both physician based primary health care (PHC) and non-physician based PHC clinics are present in the country. In terms of physician-based primary health care clinics, few (<20%) have assessment and treatment protocols for key mental health conditions available, in comparison to 0% for non-physician-based primary health care clinics. None of physician-based primary health care clinics make on average at least one referral per month to a mental health professional. None of non-physician based primary health care clinics make at least a referral to a higher level of care per month. As for professional interaction between primary health care staff and other care providers, none of primary

[1] Graph based on methods derived from Lund C, Fisher AJ. Community hospital indicators in South African public sector mental health services. J Ment Health Policy Econ. 2003; 6(4); 181-7.

care doctors have interacted with a mental health professional at least monthly in the last year. None of physician-based PHC facilities, non-physician-based PHC clinics, or mental health facilities has had interaction with a complimentary/alternative/traditional practitioner.

Prescription in primary health care

Nurses and non doctor/non nurse primary health care workers are not allowed to prescribe psychotropic medications in any circumstance. Primary health care doctor are allowed to prescribe psychotropic medications without restrictions. As for availability of psychotropic medicines, almost all of physician-based PHC clinics and non physician-based PHC clinics have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available.

Domain 4: Human Resources

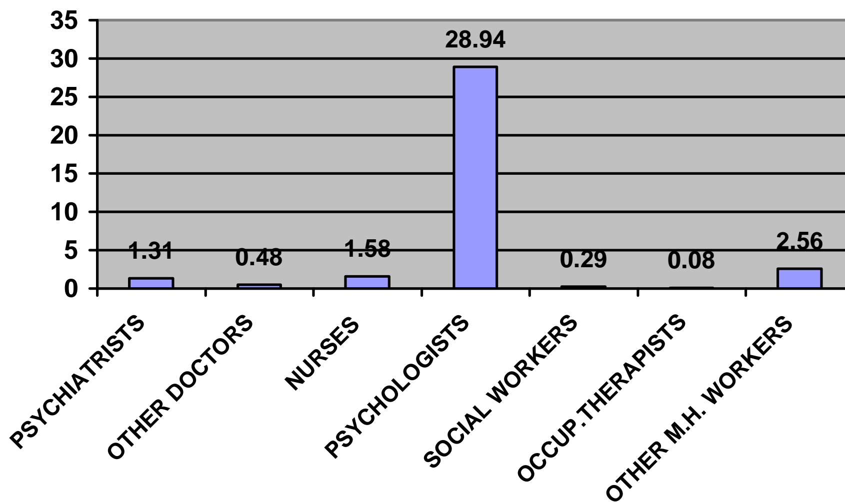
Number of human resources in mental health care

The total number of human resources working in mental health facilities or private practice per 100,000 population is 35.23. The breakdown according to profession is as follows: 1.31 psychiatrists, 0.48 other medical doctors (not specialized in psychiatry), 1.58 nurses, 28.94 psychologists, 0.29 social workers, 0.08 occupational therapists, 2.56 other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counselors). Twenty percent of psychiatrists work only for government administered mental health facilities, 28% work only for NGOs/for profit mental health facilities/private practice, while 52% work for both sectors. Five percent of psychologists, social workers, nurses and occupational therapists work for government administered mental health facilities, either exclusively or alongside with work in other sectors. Private practice is largely unregistered, especially in the case of psychologists. Figures provided are best estimates based on official registration and professional associations.

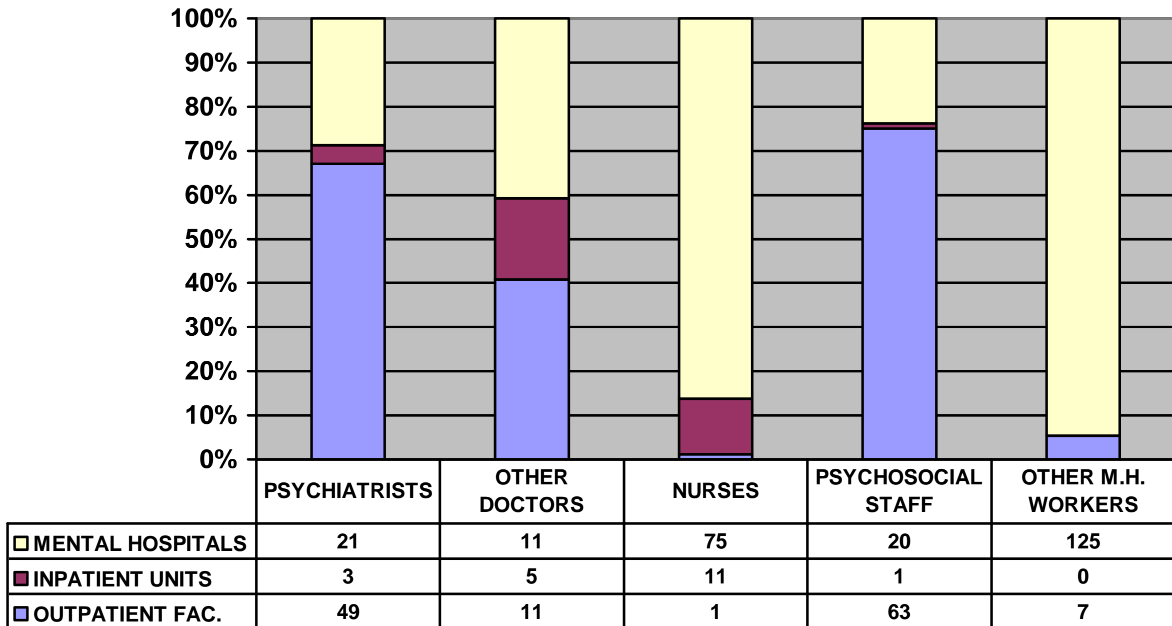
Regarding the workplace, 49 psychiatrists work in outpatient facilities, 3 in community-based psychiatric inpatient units and 21 in mental hospitals. Eleven other medical doctors, not specialized in mental health, work in outpatient facilities, 5 in community-based psychiatric inpatient units, and 11 in mental hospitals. As far as nurses are concerned, one works in outpatient facilities, 11 in community-based psychiatric inpatient units and 75 in mental hospitals. In terms of psychosocial staff (e.g., psychologists, social workers and occupational therapists), 63 work in outpatient facilities, 1 in a community-based psychiatric inpatient units and 20 in mental hospitals. As regards to other health or mental health workers, 7 work in outpatient facilities, none in community-based psychiatric inpatient units, and 125 in mental hospitals. These figures do no include private practice.

In terms of staffing in mental health facilities, there are 0.21 psychiatrists per bed in community-based psychiatric inpatient units, in comparison to 0.05 psychiatrists per bed in mental hospitals. As for nurses, there are 0.79 nurses per bed in community-based psychiatric inpatient units, in comparison to 0.18 per bed in mental hospitals. Finally, for other mental health care staff (e.g., psychologists, social workers, occupational therapists, other health or mental health workers), there are 0.07 per bed for community-based psychiatric inpatient units, and 0.36 per bed in mental hospitals. The distribution of human resources between urban and rural areas is disproportionate: the density of psychiatrists is 1.1 greater and the density of nurses is 1.4 greater in the largest city, Asuncion, than in the entire country. It should be taken into consideration that psychiatrists, psychologists and social workers work only 12 to 15 hours per week in government administered facilities. The number of professionals and professional per bed ratios may overestimate effective staffing of these facilities.

GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH (rate per 100.000 population)

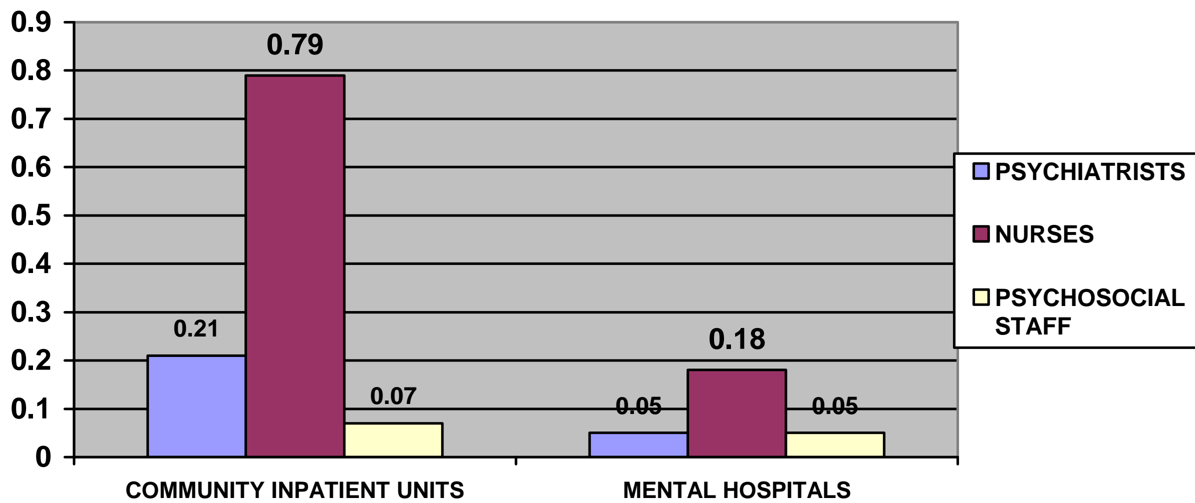


GRAPH 4.2 - STAFF WORKING IN MENTAL HEALTH FACILITIES
(percentage in the graph, number in the table)



	PSYCHIATRISTS	OTHER DOCTORS	NURSES	PSYCHOSOCIAL STAFF	OTHER M.H. WORKERS
MENTAL HOSPITALS	21	11	75	20	125
INPATIENT UNITS	3	5	11	1	0
OUTPATIENT FAC.	49	11	1	63	7

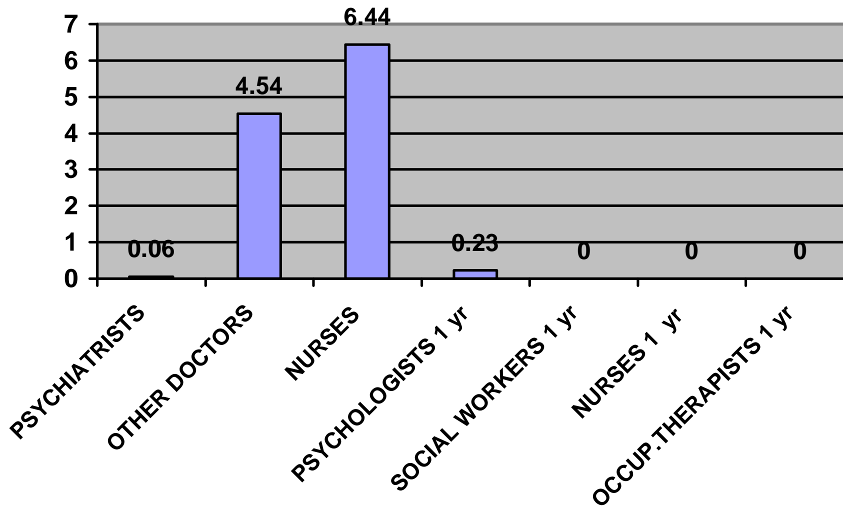
GRAPH 4.3 - RATIO HUMAN RESOURCES/BEDS



Training professionals in mental health

The number of professionals graduated last year in academic and educational institutions per 100,000 is as follows: 0.06 psychiatrists, 4.54 medical doctors, 6.44 nurses, 0.00 nurses with at least 1 year training in mental health care, 0.23 psychologists with at least 1 year training in mental health care, and 0.00 social workers with at least 1 year training in mental health care, 0.00 occupational therapists with at least 1 year training in mental health care. Few (<20%) psychiatrists emigrate from the country within five of the completion of their training. No mental health care staff attended at least two days of refresher training in the rational use of drugs, psychosocial interventions, and child/adolescent mental health issues.

GRAPH 4.4 - PROFESSIONALS GRADUATED IN MENTAL HEALTH (rate per 100.000 population)



Consumer and family associations

There are no consumer associations. One hundred and forty family members are members of family associations. Most family associations include family and friends of users. The government does not provide economic support for either consumer or family associations. Family associations have been involved in the formulation or implementation of mental health policies, plans, or legislation in the past two years. Few mental health facilities interact with these associations. In addition to family associations, there are five other NGOs in the country involved in individual assistance activities such as counselling, housing, or support groups.

Domain 5: Public Education and links with other sectors

Public education and awareness campaigns on mental health

There are coordinating bodies that oversee public education and awareness campaigns on mental health and mental disorders. Government agencies, NGOs, professional associations, private trusts and foundations, and international agencies have promoted public education and awareness campaigns in the last five years. These campaigns have targeted the following groups: general population, children, adolescents, women, and trauma survivors. In addition, there have been public education and awareness campaigns targeting professional groups including health care providers and teachers.

Legislative and financial provisions for persons with mental disorders

At the present time, there is no legislative or financial support for employment, provision against discrimination at work, provisions for housing, and provisions against discrimination in housing.

Links with other sectors

In addition to legislative and financial support, there are formal collaborations with the departments/agencies responsible for primary health care/community health, HIV/AIDS, child and adolescent health, substance abuse, child protection, education, and criminal justice. There is no information available on the proportion of primary and secondary schools that have either a part-time or full-time mental health professional. Few (1-20%) primary and secondary schools have school-based activities to promote mental health and prevent mental disorders. The proportion of prisoners with psychosis and mental retardation is estimated to be less than 2% for each diagnosis. Regarding mental health activities in the criminal justice system, less than 20% of prisons have at least one prisoner per month in treatment contact with a mental health professional. As for training, few (1-20%) police officers and no (0%) judges and lawyers have participated in educational activities on mental health in the last five years. In terms of financial support for users, none of mental health facilities have access to programs outside the mental health facility that provide outside employment for users with severe mental disorders. Finally, there are no social welfare benefits for disability.

Domain 6: Monitoring and Research

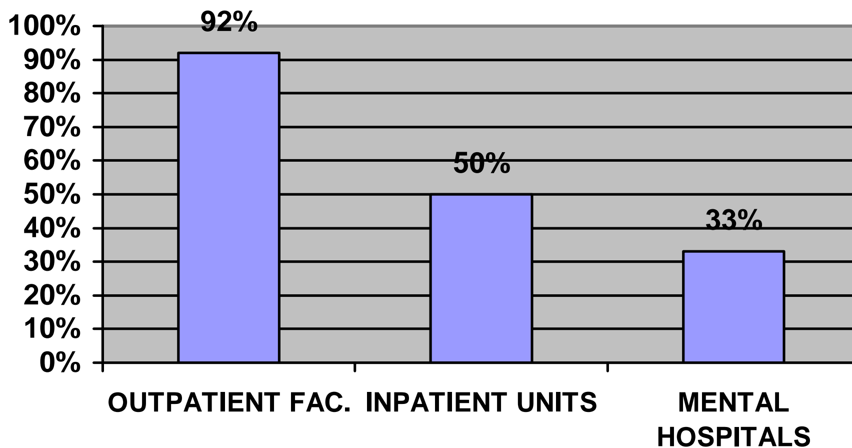
A formally defined list of individual data items that ought to be collected by all mental health facilities exists. The list includes number of beds, number of admissions, number of days spent in hospital and diagnoses. As shown in the table 6.1, the extent of data collection is variable among mental health facilities. The government health department received data from 33% mental hospitals, 50% community based psychiatric inpatient units, and 92% mental health outpatient facilities. However, no report was produced on the data transmitted to the government health department.

Research is focused on non-epidemiological clinical/questionnaires assessments of mental disorders and services research. It consists of monographs, theses and publications

in non indexed journals. There are no mental health research publications in indexed journals.

Table 6.1 - Percentage of mental health facilities collecting and compiling data by type of information

	MENTAL HOSPITALS	COMMUNITY INPATIENT UNITS	OUTPATIENT FAC.
N° of beds	33%	100%	------------------------
N° inpatient admissions/users treated in outpatient fac.	67%	100%	92%
N° of days spent/user contacts in outpatient fac.	33%	0%	100%
N° of involuntary admissions	0%	0%	------------------------ ------------------------
N° of users restrained	0%	0%	------------------------ ------------------------
Diagnoses	33%	0%	92%



Results for the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) applied to Paraguay for 2004 are reviewed. The mental health system has all types of facilities; however, some need to be strengthened and developed. There is an imbalance in favor of mental hospital inpatient care. The vast majority of financial resources and an important part of human resources are destined to mental hospitals. At present mental hospitals are working beyond their capacity (in terms of number of beds), although the number of beds was increased in the last years. Few facilities are devoted to children and adolescents. Primary health care staff training on mental health is weak, as is interaction between primary health and mental health. Psychotropic medication is available, but a minority has free access to it. Access to mental health facilities is uneven across the country, favoring those living in or near Asuncion. There are family associations, but no consumer association. There are formal links of mental health sector with other sectors, but links of critical importance are weak or not developed, including welfare, housing, judicial, work provision, education. Mental health policy and plans exist, but financing is not considered in either. At present there is no mental health law. Some work has been done on human rights in training and inspection of facilities, but there is no review body and actions need to be extended to all facilities. The mental health information system does not cover all relevant information in all facilities.