WHO-AIMS

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World Health Organization

Assessment Instrument for Mental Health Systems

WHO-AIMS
Version 2.2

WORLD HEALTH ORGANIZATION

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WORLD HEALTH ORGANIZATION ASSESSMENT INSTRUMENT FOR MENTAL HEALTH SYSTEMS

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INTRODUCTION

The *World Health Organization Assessment Instrument for Mental health Systems* (WHO-AIMS) is a new WHO tool for collecting essential information on the mental health system of a country or region. The goal of collecting this information is to improve mental health systems. For the purpose of WHO-AIMS, a mental health system is defined as all the activities whose primary purpose is to promote, restore or maintain mental health. The mental health system includes all organizations and resources focused on improving mental health.

The mission of WHO in the area of mental health is to reduce the burden associated with mental and neurological disorders, including substance use disorders, and to promote mental health of the population worldwide. *The World Health Report 2001: Mental Health: New Understanding, New Hope* provides scientific evidence on the huge burden of disease associated with mental illness. This report also outlines the need and rationale for building community-based mental health systems and services. The report's 10 recommendations address key components of mental health system development:

1. Provide treatment for mental disorders in primary care
2. Ensure wider accessibility to essential psychotropic drugs
3. Provide care in the community
4. Educate the public
5. Involve communities, families and consumers
6. Establish national policies, programmes and legislation on mental health
7. Develop human resources
8. Link with other sectors
9. Monitor community mental health
10. Support relevant research.

The WHO Atlas study reports that in 2005 more than 24% of countries do not have any system for collecting and reporting mental health information. Many other countries have information systems but these systems often are of limited scope and quality. This lack of good information impedes the development of mental health policies, plans and services.

WHO-AIMS was developed to assess key components of a mental health system and thereby provide essential information to strengthen mental health systems. WHO-AIMS is based on the WHO strategy to provide information-based mental health assistance to countries within the *WHO Mental Health Global Action Plan (mhGAP)*, as endorsed by WHO's governing bodies. 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.

How was WHO-AIMS developed? The 10 recommendations of the *World Health Report 2001*, described above, serve as the foundation for WHO-AIMS. These recommendations address essential aspects of mental health system development in resource-poor settings. For each recommendation (domain of interest), items were generated and grouped together in a number of facets (subdomains). Experts and key focal point people from resource-poor countries provided inputs to ensure the clarity, validity and feasibility of the items. In December 2003, WHO-AIMS 1.1 (pilot version) of the instrument was released. WHO-AIMS 1.1 consisted of 10 domains covering each of the 10 recommendations. During the spring of 2004, the pilot instrument was tested in Albania, Barbados, Ecuador, India, Kenya, Latvia, Moldova, Pakistan, Senegal, Sri Lanka, Tunisia and Viet Nam. The main conclusion from the pilot test was that the instrument is highly useful because it is comprehensive and collects key information that is relevant for action. The majority of countries were able to collect meaningful information for the majority of items. However, the length of the pilot instrument was a barrier to its use. Consequently, the pilot instrument was substantially revised and shortened.

The revision and shortening process used the following information: (a) the number of countries that were able to collect data for each item in the pilot study; (b) the number of countries reporting the presence of some mental health activity for each item in the pilot study; (c) expert rankings on the importance of having data on a particular item or facet to plan public mental health action in low and middle-income countries; and (d) ratings (*low*, *medium*, *high*) for each of the items of the instrument on the extent to which they are meaningful, feasible and actionable.

A revision was presented at a WHO meeting in Milan, Italy in December 2004 to country representatives from Albania, China, India, Iran, Iraq, Latvia, Nigeria, Macedonia, Moldova, Pakistan, Palestine, Paraguay, Sir Lanka, Viet Nam, as well as key resource people from a number of countries. Overall, meeting participants felt that the instrument was a valuable tool that may be effectively used to assess and strengthen the mental health systems in countries. Nevertheless, several additions and revisions were recommended. All feedback from meeting participants was seriously considered and the vast majority of the recommendations were incorporated into WHO-AIMS 2.1, which was released in February of 2005. Several small revisions in wording were made to WHO-AIMS 2.1 resulting in the current version WHO-AIMS 2.2. There is complete compatibility between version 2.1 and 2.2 on item numbers.

WHO-AIMS 2.2 consists of six domains (covering the 10 *World Health Report 2001* recommendations through 28 facets and 156 items). The six domains are interdependent, conceptually interlinked, and somewhat overlapping. All six domains need to be assessed to form a relatively complete picture of a mental health system.

WHO-AIMS 2.2 also contains a list of items which comprise a brief version of the instrument. WHO-AIMS-Brief is a set of items that may be used for a more rapid assessment of a mental health system. However, the use of the full instrument is strongly recommended for obtaining a comprehensive assessment and for planning for relevant mental health action. Brief version items for WHO-AIMS-Brief 2.2 appear in Appendix A. WHO-AIMS is primarily intended for assessing mental health systems in low- and middle-income countries. It can be used for an entire country, or for a region (state, province, district) within a large country, such as India, Brazil or China. In addition, most items of the instrument are relevant and applicable to resource-poor settings within high-income countries.

The implementation of WHO-AIMS can generate awareness and facilitate improvement in mental health services. WHO-AIMS data should assist countries in developing information-based mental health plans with clear baseline information and targets. Countries will also be 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 WHO-AIMS, countries will have a clearer and more comprehensive picture of the main weaknesses in their mental health system, and this knowledge should facilitate improvements over time.

WHO-AIMS is one of the essential technical documents recently developed by WHO in the area of mental health systems and should be used along with other WHO resources. The most relevant of these recent documents are the interrelated modules of the WHO *Mental Health Policy and Services Guidance Package* (http://www.who.int/mental_health/policy/en/).A complete list of WHO documents on mental health can be viewed and downloaded from the WHO website (http://www.who.int/mental_health/en/)-

For information and feedback on WHO-AIMS, please contact Dr Shekhar Saxena, Mental Health: Evidence and Research Team, Department of Mental Health and Substance Abuse, World Health Organization, Geneva. (saxenas@who.int).

ANSWERS TO FREQUENTLY ASKED QUESTIONS

➲ How should I get started?

The first step is to identify a person who will serve as the focal point for your country in completing WHO-AIMS (if it is not you). This person should become familiar with the WHO-AIMS instrument and the supporting materials. Please read the entire instrument carefully. This will help in efficient data collection and save time. The second step is to develop a data collection plan. This plan should describe how you will collect the data for each item, identify which institutions/agencies/facilities/people you will contact to obtain the data, and specify the time frame for contacting data sources and compiling the data.

➲ Should I use the full version or the brief version?

Use of the full instrument is essential for obtaining a comprehensive assessment and for planning for relevant mental health action. Appropriate uses of the brief version include:

1. For research that is limited to only part of the mental health system
2. For an initial assessment to be followed by the full version
3. If the mental health resources in your country are extremely limited
4. If you are using the instrument along with another WHO-AIMS module such as WHO-AIMS-E (under development).

➲ Which data sources should I contact?

During data collection you need to be pro-active, actively involving and interacting with key persons in different institutions/agencies/facilities.

On page 10 there is a list of possible data sources for each domain. These sources are only recommendations, as some of them may not be relevant in your country. Also, other relevant data sources may exist in your country that have not been listed. Use all relevant data sources.

Data may be available at national (central) level, at provincial/state/district level and at facility level. It is advised to list all available sources at the different levels. First, contact institutions at the national level. If good data for a particular item exist at the national level, then there is no need to contact sources at the provincial/state/district level or at the facility level. However, very often data are not available at the national level. If so, consider contacting institutions at the provincial/state/district level. If good data for a particular item exist at the provincial/state/district level, then there is no need to contact sources at the facility level. If adequate data are not available at the provincial/state/district level, then you will need to contact the facilities. You may want to consider sending a survey to the facilities to get data directly from them.

Finally, it should also be noted that some data may be already compiled, while data for other items may require aggregation from a variety of sources.

➲ What type of information do I need to record and where?

We ask you to record various types of information in different places: (1) **Data**: enter all collected data into the WHO-AIMS Excel Data Entry Programme and also keep a hard copy of this information. (2) **Item level comments**: each item in the Excel data sheet has a column for comments. Please record in this space any comments regarding the item, including whether you encountered any problems in collecting data, or if the definitions differ from that used in your county. (3) **Instrument**

feedback/other information: at the end of the WHO-AIMS Excel Data Entry Programme there is a sheet to record any feedback you have on different facets, domains, or the instrument as a whole and to provide data that are not specifically requested in WHO-AIMS but which are relevant to the mental health system in your country/region. (4) **Data collection log:** please keep a data collection log. In this log you can record the data sources that you used to obtain information for each item, keep facility level data, and keep ongoing notes as it pertains to the data collection process.

➲ Do I need to list all data sources?

We have only asked you to report your data sources for certain questions. However, it is helpful for you to keep in your **data log** detailed notes on all data sources, as this will make data collection in the future faster and comparable over time.

➲ What if my country is too large to collect all of the data?

WHO-AIMS can be used to assess the mental health system of a country or a region (state, province, district). If your country has a very large population (e.g. your country is China or India) or has a vast number of mental health facilities (e.g. your country is rich), then you may want to consider using the instrument at the regional level. It is important that you decide at what level you want to collect the data, clearly specify the region, and answer all questions for this regional level.

➲ Do I need to keep the data collected from the individual mental health facilities?

Most WHO-AIMS items involve aggregated data. However, disaggregated data (e.g. data from individual mental health facilities) will be important when developing and planning an action plan for improving the mental health system in your country. Thus, although only aggregated data are reported, it is essential to keep the data in disaggregated format in your **data collection log**.

➲ Why are some words italicized?

Any word that is italicized in the instrument appears in the "frequently used terms" section at the beginning of the instrument. This section provides definitions and descriptions of terms used in WHO-AIMS. The terms defined are strictly for use within the context of the WHO-AIMS project and are not to be construed as official WHO definitions. All definitions of terms are tailored to use of the terms for mental health system assessment.

➲ What if the definition in the "frequently used terms" section differs from that commonly used in my country?

Please use the definition provided in the "frequently used terms" section even if it differs from the definition used in your country. If the two definitions differ, please record this as an item level comment in the "**comments**" column of the Excel programme.

➲ What does the # mean?

A # indicates that relevant data have been collected for a previous item and thus do not need to be collected again. The WHO-AIMS Excel Data Entry Programme ensures that data are consistent across items marked with a # symbol.

➲ For some WHO-AIMS multiple-choice items (ranging from A to E), I am asked to provide a 'data source' or a 'best estimate.' Could you please explain?

When precise data are not readily available to complete a multiple-choice item (e.g. items with response options ranging from A to E), complete the item to the best of your ability. Data sources that could aid you in making a best estimate include using focus groups, consulting experts in the area, consulting secondary data sources, sending out surveys, or forming a committee of key informants. Please indicate the data source you used in the specific space provided in the data entry programme. If you do not have a data source, please provide your best estimate and check the relevant box in the data entry programme.

➲ Can I add information about services or programmes that aren't included in the instrument?

Yes. You are encouraged to write descriptive accounts or provide related data that are not specifically requested in WHO-AIMS. Such descriptive accounts are an opportunity to describe aspects of your mental health system that are not covered by WHO-AIMS. Write such information in the **instrument feedback/other information** section contained at the end of the Excel data entry programme.

➲ Can I interpret the information contained in the items as official WHO standards for mental health systems?

No. This instrument is designed to assess weaknesses and strengths of mental health systems and the information is for use primarily by the country for improving their mental health system. The instrument should not be interpreted as setting or reflecting official WHO standards for mental health systems.

➲ Is WHO willing to assist in obtaining the necessary cooperation from national and regional agencies?

A collaborative relationship with national and regional bodies (e.g. Ministry of Health) is helpful in collecting data. We are willing to contact the necessary national or regional agencies to facilitate such collaboration. National agencies, such as the Ministry of Health, will be instrumental in facilitating contacts and collaboration with regional agencies and mental health facilities.

➲ What if my question isn't answered here or in any of the other supporting materials?

If you can't find the answer to your question in this document or any of the other supporting materials, don't hesitate to contact the WHO-AIMS team in Geneva.

GUIDANCE ON DATA COLLECTION IN WHO-AIMS

This document provides guidance on data collection for WHO-AIMS. Although it is written from the perspective of someone filling it out for an entire country, the general strategies outlined are also relevant to those specific situations where data are to be collected at the regional level (state, provincial, district), because data collection for the entire country is not feasible (e.g. for high population countries such as China or India, or high resource countries such as Canada).

1. Preliminary phase.

During the preliminary phase, the country focal point person gets familiar with the WHO-AIMS instrument and the content of the items. It is important that before starting data collection, the entire WHO - AIMS instrument is carefully read. This will help in efficient data collection and save time, as it serves to:

- Form an impression of the types of data to be collected
- Help identify possible institutions/organizations where the information can be collected.
- Stimulate thinking about the availability of information in different institutions/ organizations, as well as the development of a general data collection plan.
- Help the focal point person to think of other solutions/ other sources for data collection if the information for mental health situation in the country is not available in central institutions such as ministries, national institutions, etc.

An important component of the preliminary stage is the development of a data collection plan. This plan should describe how you will collect data for each item. It should describe for each item which institutions/agencies/facilities/people you will contact to get the data. It should describe for different items potential methods of data collection (direct contacts, phone contacts, official letters, questionnaires, etc.) and it should describe a time table for the work.

The timetable in the action plan needs to consider:

- Time for organizing data collection
- Time to collect data from national and regional (state, provincial, district) level agencies
- Time to collect necessary data from facilities
- Time for possible re-confirmations / re-clarification of data
- Putting all the data in the WHO-AIMS Excel Data Entry Programme
- Developing a descriptive report

It is crucial to be flexible while implementing your data collection plan, because problems and delays may arise during the process of data collection. For example, it may take more effort than expected to obtain the data. Nevertheless, an action plan with a timetable is helpful, as it creates a frame for systematic data collection. The pilot study, using an earlier version of WHO-AIMS, suggested that in most settings the steps outlined above could be undertaken within two to four months time.

2. Data collection phase

The information collected through WHO-AIMS represents the overall country situation in the mental health system for one specific year. To collect the information for the country situation, sources of different levels (not only at country, but also at regional and facility levels) may need to be contacted. A list of possible data sources for each domain is contained in the following table.

Domain 1	Domain 2	Domain 3	Domain 4	Domain 5	Domain 6
• Consumer associations • Family associations • Finance Department in Ministry of Health • Human rights associations • International organizations • Legal Office in Ministry of Health • Library/ archives of Parliament • Mental health authority • Mental health services • Ministry of Finance • National or regional government agencies (e.g. Ministry of Health, Department of Mental Health Services) • Non-governmental organizations (NGOs) • Parliament publications • Private health insurance • Social health insurance	• Community Care Department in Ministry of Health • Health insurance • Hospital Department in Ministry of Health • Mental health authority • Mental health services • *Mental hospitals* • Ministry of Health • National Institute of Mental Health • Non-governmental organizations (NGOs) • Pharmaceutical Department in Ministry of Health • Pharmaceutical industries • Pharmacists' associations	• Associations of *alternative health system practitioners* • Department of Family Medicine, Faculty of Medicine • Health insurance • International agencies • Medical and *nurses*' associations • Mental health services • National Mental Health Institute • Non-governmental organizations (NGOs) • Nursing schools • Pharmaceutical Department in Ministry of Health • Pharmaceutical industries • Pharmacists' associations • Primary Health Care Department in Ministry of Health • Primary health care districts	• Consumer associations • Family associations • Hospital Department in Ministry of Health • Human Resources Department in Ministry of Health • Human rights associations • International agencies • International organizations • Mental health authority • Mental health services • National government agencies (e.g. Ministry of Health, Department of Mental Health Services) • National register for NGOs • Non-governmental organizations (NGOs) • Nursing schools • Personnel Department in Ministry of Health • Professional associations • Professional schools for different professions • Training centres in mental health • universities	• Courts • Department of Prisons in Ministry of Justice • Employers' associations • International organizations active in mental health • Local authorities • Mental health services • Ministry of Education • Ministry of Health • Ministry of Justice • Ministry of Labour • Ministry of Public Works and Housing • Ministry of Social Welfare • National social services • Non-governmental organizations (NGOs) • Police departments • Press associations • Professional associations • Regional employment offices • School districts/boards • Social insurance	• Electronic databases, including PubMed • Institute of Public Health • International organizations • Mental health services • Ministry of Education • Ministry of Health • National Institute of Statistics • National scientific journals • Non-governmental organizations (NGOs) • Nursing schools and professional schools • Other university departments • Private and public mental health providers • Professional associations • Regional health authorities • Research councils (e.g. National Medical Research Council) • University departments of medicine and social science (e.g. departments of psychiatry, public health, psychology)

2.1 Data sources at the country level

First, contact the central institutions (e.g. ministries, national organizations/institutions) that are supposed to have information for the whole country. Ask the following type of questions:

- What kind of mental health information do they regularly collect?
- What kind of mental health information do they report?

- How often do they report the information?
- What kind of other information do they keep records on (but do not routinely report)?

These central institutions often have only a small amount of the information necessary to complete WHO-AIMS. When data are not available at the national level, consider contacting institutions at the regional (state, provincial, district) level and then aggregating the data.

2.2 Data Sources at the Regional (State, Provincial, District) Level

To check the availability of information in regional/district/provincial institutions one may directly contact (e.g. phone) representatives of regional (state, provincial, district) institutions. Again, ask the following type of questions:

- What kind of mental health information do they regularly collect?
- What kind of mental health information do they report?
- How often do they report the information?
- What kind of other information do they keep records on (but do not routinely report)?
- To whom do they report the information?

Of note, it may be necessary to contact those central institutions to which regional, provincial or district institutions report. It can be difficult to directly contact all regional (state, provincial, district) institutions in the country. So the national (central) institutions may need to be contacted to facilitate cooperative, smooth and fast data collection. This will help in getting the information back in a timely manner.

It may also be helpful to have joint meetings – where representatives of different regional (state, provincial, district) levels are invited to a meeting – to give necessary explanations. Alternatively, national institutions may draft a letter in support of the data collection process from regions (states, provinces, districts).

2.3 Data Sources at Facility Level

Often central or regional institutions have little data available. Fortunately, mental health facilities often have considerable information available. However, they may not keep the data in a systematic or easily accessible manner. The challenge here is how to find the most effective and efficient way to get in contact with all the facilities and to access these data.

Steps to be considered

1. Make a list of all the existing mental health facilities in the country that need to be contacted.
2. Obtain contact details of key persons in each facility.
3. Develop a survey to send to the respective mental health facilities. It is important to design the survey so that it can be easily understood by people in the facilities who are to complete it. Clear definitions of items need to be provided. By sending a survey with all of the facility-specific WHO-AIMS items, you should only have to collect data from each facility once. To help you develop a survey, consult the following table that shows which WHO-AIMS items pertain to which facilities.
4. It can be helpful to pilot test your survey in one facility. The piloting serves to improve and adapt the questionnaire so that it is congruent with the way that facilities record and document information.
5. It can be helpful to use a fax machine to send and receive survey questionnaires.
6. It can be extremely helpful to phone or meet the key persons in each facility in order to discuss how to best collect the information (e.g. how to frame the survey questions so that they are consistent with the way that data are recorded). This will result in a questionnaire that is more understandable and will avoid unnecessary mistakes.

7. In certain circumstances, it may be more efficient to collect the data through an interview with the director and/or staff working in facilities.
8. Informal individual or group trainings may be helpful to avoid confusion over the definitions of terms (e.g. sometimes " number of patients treated" is confused with "number of patient contacts" because often mental health facilities are only required to report the number of contacts).
9. It is important to be available (e.g. by phone or email) to assist key persons at the facilities for any questions that they might have and to follow up on the data collection process.
10. After reviewing the collected information from the facility, it may be necessary to re-contact key persons at the facilities to confirm or clarify the contents of the data.

Summary Table: WHO-AIMS items pertaining to different facilities

	Mental hospitals	Community-based psychiatric inpatient units	Mental health outpatient facilities	Community residential facilities	Mental health day treatment facilities
WHO-AIMS Item Number	1.4.2 1.4.4	1.4.3 1.4.5		1.4.3 1.4.5	
	2.1.3 2.6.1 - 2.6.12 2.7.2 2.9.1 2.10.1 2.11.1 2.11.5	 2.4.1 - 2.4.9 2.9.2 2.10.2 2.11.1	2.1.3 2.2.1- 2.2.9 2.9.3 2.10.3 2.11.2-2.11.4 2.11.6	2.5.1-2.5.7	2.3.1-2.3.6
	4.1.1 4.1.4	4.1.1 4.1.3	4.1.1 4.1.2	4.1.1	4.1.1
	6.1.2 6.1.5	6.1.3 6.1.5	6.1.4 6.1.5		

How to use this table: Under each mental health facility heading is a list of WHO-AIMS items that pertain to that facility. For example, a strategy for developing a survey to send to *mental hospitals* would include the following: (1) Use the table above to identify all items that pertain to *mental hospitals*. (2) Develop survey questions for each of these items (e.g. for item 1.4.2, you might develop the following question: "Does your facility have at least one yearly review/inspection of *human rights protection of patients*?"). (3) Provide all the relevant definitions and notes that will be needed to answer the questions (e.g. for item 1.4.2, you will need to provide the definition for *human rights protection of patients*).

When contacting facilities/organizations/institutions the general procedure should include:

- Informing the head of the institution about WHO-AIMS.
- Identifying a key person within the facility (usually key persons are people that work with data collection in the respective facility).
- Directly instructing the key person about what information needs to be collected. It can be important to give instructions directly to the key persons of the facility, rather than to the head of the institutions.
- Representatives of institutions may present their institution in an overly positive light. If this happens it may be necessary to assure them that the aim of WHO-AIMS is not to evaluate, but to understand the current situation in the mental health system and to plan further developments.
- Whenever possible, try to be physically present in the facility/institution along with the key person identified so that you may compile the data together.

There are two different kinds of data in WHO-AIMS – quantitative items and multiple-choice items. To calculate country-level data on the basis of data collected at the facility level for each of these two types of data, please consider the following:

QUANTITATIVE ITEMS, where the measure is a number, a rate or a proportion. At the country level, the total value is calculated by adding up the values obtained from all the different mental health facilities. For example, the country-level value of *"number of users treated in mental health outpatient facilities"* is found by adding up the number of users treated in each mental health facility. Another example is the country-level value of "number of *community-based psychiatric inpatient units* in which at least one psychotropic medicine for each therapeutic category is available" which is found by adding up the number of *community-based psychiatric inpatient units* that report having at least one psychotropic medicine for each therapeutic category available.

MULTIPLE-CHOICE ITEMS, where the categories represent a numerical range (generally a percentage: A=0%, B=1%-20%, C=21%-50%, etc.). The total country-level figure is calculated by taking a weighted average. For example, the "Percentage of *patients* in *mental hospitals* who were restrained or secluded at least once within the last year" is found by adding the number of *patients* secluded in each *mental hospital* and dividing by the total *number of patients treated in mental hospitals* at the country level.

WHO-AIMS also contains several items that have a list of sub-items (e.g. see item 1.1.2 which has 11 sub-items). Data need to be provided for each subitem.

3.0 Post-data collection

After data are collected, it should be entered into the WHO-AIMS Excel Data Entry Programme. This programme, as well as instructions on data entry, is available upon request. You should also plan to develop a descriptive report based on the data and disseminate it to relevant stakeholders.

DEFINITIONS FOR SOME FREQUENTLY USED TERMS

The terms defined below are strictly for use within the context of the WHO-AIMS project; the definitions and descriptions are not to be construed as official WHO definitions. All definitions of terms are tailored for mental health system assessment.

Bed: A bed that is continuously available for use by people with mental disorders for round the clock (day and night) care.

Community-based facility: A mental health facility outside of a *mental hospital*.

Community-based psychiatric inpatient unit: A psychiatric unit that provides inpatient care for the management of mental disorders within a *community-based facility*. These units are usually located within general hospitals, they provide care to *users* with acute problems, and the period of stay is usually short (weeks to months).

- **Includes:** Both public and private non-profit and for-profit facilities; *community-based psychiatric inpatient units* for children and adolescents only; *community-based psychiatric inpatient units* for other specific groups (e.g. elderly).
- **Excludes**: *Mental hospitals*; *community residential facilities*; facilities that treat only people with alcohol and substance abuse disorder or mental retardation.

Community residential facility: A non-hospital, community-based mental health facility that provides overnight residence for people with mental disorders. Usually these facilities serve *users* with relatively stable mental disorders not requiring intensive medical interventions.

- **Includes:** Supervised housing; un-staffed group homes; group homes with some residential or visiting staff; hostels with day staff; hostels with day and night staff; hostels and homes with 24-hour nursing staff; halfway houses; therapeutic communities. Both public and private non-profit and for-profit facilities are included. *Community residential facilities for children and adolescents only* and *community residential facilities* for other specifics groups (e.g. elderly) are also included.
- **Excludes:** Facilities that treat only people with a diagnosis of alcohol and substance abuse disorder or mental retardation; residential facilities in *mental hospitals*; generic facilities that are important for people with mental disorders, but that are not planned with their specific needs in mind (e.g. nursing homes and rest homes for elderly people, institutions treating mainly neurological disorders, or physical disability problems).

Community residential facility for children and adolescents only: A facility that meets the definition for *community residential facility* and exclusively serves children or adolescents.

- **Excludes:** Facilities for children with social problems (e.g. orphans, children from disrupted families) but without necessarily a mental disorder.

Complementary/alternative/traditional practitioner: A practitioner who primarily practices traditional or complementary/alternative medicine rather than allopathic/modern medicine.

Forensic inpatient unit: An inpatient unit that is exclusively maintained for the evaluation or treatment of people with mental disorders who are involved with the criminal justice system. These units can be located in *mental hospitals,* general hospitals, or elsewhere.

Human rights protection of users/patients: Action related to the following issues to ensure the protection of *users*' human rights: least restrictive care, informed consent to treatment, confidentiality, avoidance of restraint and seclusion when possible, voluntary and involuntary admission and treatment procedures, discharge procedures, complaints and appeals processes, protection from abuse by staff, and

protection of *user* property.

Medical doctor: A health professional with a degree in modern medicine who is authorized/licensed to practice medicine under the rules of the country.

Mental health day treatment facility: A facility that typically provides care for *users* during the day. The facilities are generally: (1) available to groups of *users* at the same time (rather than delivering services to individuals one at a time), (2) expect *users* to stay at the facilities beyond the periods during which they have face-to-face contact with staff (i.e. the service is not simply based on *users* coming for appointments with staff and then leaving immediately after the appointment) and (3) involve attendances that last half or one full day.

- **Includes:** day centres; day care centres; sheltered workshops; club houses; drop-in centres; employment/rehabilitation workshops; social firms. Both public and private non-profit and for-profit facilities are included. *Mental health day treatment facilities for children and adolescents only* and *mental health day treatment facilities* for other specifics groups (e.g. elderly) are also included.
- **Excludes:** Facilities that treat only people with a diagnosis of alcohol and substance abuse disorder or mental retardation without an accompanying mental disorder diagnosis; generic facilities that are important for people with mental disorders, but that are not planned with their specific needs in mind; day treatment facilities for inpatients are excluded.

Mental health day treatment facility for children and adolescents only: A facility that meets the definition for *mental health day treatment facility* and exclusively serves children or adolescents.

Mental health legislation: Legal provisions related to mental health. These provisions typically focus on issues such as: civil and human rights protection of people with mental disorders, treatment facilities, personnel, professional training, and service structure.

Mental health outpatient facility: A facility that focuses on the management of mental disorders and the clinical and social problems related to it on an outpatient basis.

- **Includes:** Community mental health centres; mental health ambulatories; outpatient services for specific mental disorders or for specialized treatments; mental health outpatient departments in general hospitals; mental health policlinics; specialized NGO clinics that have mental health staff and provide mental health outpatient care (e.g. for rape survivors or homeless people). Both public and private non-profit and for-profit facilities are included. *Mental health outpatient facilities for children and adolescents only* and *mental health outpatient facilities* for other specifics groups (e.g. elderly) are also included.
- **Excludes:** Private practice; facilities that treat only people with alcohol and substance abuse disorder or mental retardation without an accompanying mental disorder diagnosis.

Mental health outpatient facility for children and adolescents only: A facility that meets the definition for *mental health outpatient facility* and exclusively serves children or adolescents.

Mental hospital: A specialized hospital-based facility that provides inpatient care and long-stay residential services for people with mental disorders. Usually these facilities are independent and stand-alone, although they may have some links with the rest of the health care system. The level of specialization varies considerably: in some cases only long-stay custodial services are offered, in others specialized and short-term services are also available (rehabilitation services, specialist units for children and elderly, etc.)

- **Includes:** Both public and private non-profit and for-profit facilities; *mental hospitals* for children and adolescents only and *mental hospitals* for other specifics groups (e.g., elderly) are also included**.**
- **Excludes:** *Community-based psychiatric inpatient units*; *forensic inpatient units* and forensic

hospitals. Facilities that treat only people with alcohol and substance abuse disorder or mental retardation without an accompanying mental disorder diagnosis.

Non-doctor/non-nurse primary health care worker: A *primary health care clinic* staff member who provides basic health services and links with other aspects of the health care system. These staff members include medical assistants, aide-level workers, multi-purpose health workers, health assistants, community health workers, among others. The training and functions of these workers vary across countries, but are usually less than those for doctors and *nurses*. Doctors, *nurses* and other health professionals may supervise their work.

Non-physician based primary health care clinic: A *primary health care clinic* without a *primary health care doctor* as part of their regular staff.

Number of admissions: The *number of admissions* in one year is the sum of all admissions to the facility within that year. In WHO-AIMS, this number is a duplicated count. In other words, if one user is admitted twice, it is counted as two admissions.

Number of patients treated in a *mental hospital*: (a) the *number of patients* in the *mental hospital* at the beginning of the year plus (b) the *number of admissions* during the year.

Number of *users* treated in a *community residential facility*: (a) the number of *users* in the facility at the beginning of the year plus (b) the *number of admissions* to the facility during the year.

Number of *users* treated through a *mental health day treatment facility*: The number of *users* with at least one attendance for treatment at the facility within the year.

Number of *users* treated in a *mental health outpatient facility*: The number of *users* with at least one outpatient contact with the facility. A contact refers to a mental health intervention provided by a staff member of a *mental health outpatient facility*, whether the intervention occurs within the facility or elsewhere.

Nurse: A health professional having completed a formal training in nursing at a recognized, university-level school for a diploma or degree in nursing.

Occupational therapist: A health professional having completed a formal training in occupational therapy at a recognized, university-level school for a diploma or degree in occupational therapy.

Other health or mental health worker: A health or mental health worker that possesses some training in health care or mental health care but does not fit into any of the defined professional categories (e.g. *medical doctors*, *nurses*, *psychologists*, *social workers*, *occupational therapists*).

- **Includes:** *Non-doctor/non-nurse primary care workers*, professional and paraprofessional psychosocial counsellors, special mental health educators, and auxiliary staff
- **Excludes:** This group does not include general staff for support services within health or mental health care settings (e.g. cooking, cleaning, security).

Other residential facility: A residential facility that houses people with mental disorders but does not meet the definition for *community residential facility* or any other mental health facility defined for this instrument (*community-based psychiatric inpatient unit*, *community residential facility*, *forensic inpatient unit*, *mental hospital*).

- **Includes:** Residential facilities specifically for people with mental retardation, for people with substance abuse problems, or for people with dementia. Included are also residential facilities that formally are not mental health facilities but where, nevertheless, the majority of the people residing in the facilities have diagnosable mental disorders.

Physician-based primary health care clinic: A *primary health care clinic* with *primary health care*

doctors as part of their regular staff.

Primary health care clinic: A clinic that often offers the first point of entry into the health care system. *Primary health care clinics* usually provide the initial assessment and treatment for common health conditions and refer those requiring more specialized diagnosis and treatment to facilities with staff with a higher level of training.

Primary health care doctor: A general practitioner, family doctor, or other non-specialized medical doctor working in a *primary health care clinic*.

Primary health care nurse: A nurse working in a *primary health care clinic*.

Psychiatrist: A *medical doctor* who has had at least two years of post-graduate training in psychiatry at a recognized teaching institution. This period may include training in any sub-specialty of psychiatry.

Psychologist: A professional having completed a formal training in psychology at a recognized, university-level school for a diploma or degree in psychology. WHO-AIMS asks for information only on *psychologists* working in mental health care.

Psychosocial intervention: An intervention using primarily psychological or social methods for the treatment and/or rehabilitation of a mental disorder or substantial reduction of psychosocial distress.

- **Includes**: psychotherapy; counselling; activities with families; psycho-educational treatments; the provision of social support; rehabilitation activities (e.g. leisure and socializing activities, interpersonal and social skills training, occupational activities, vocational training, sheltered employment activities).
- **Excludes**: Do not include intake interviews; assessment; follow-up psychopharmacology appointments as psychosocial interventions.

Public education and awareness campaign: An organized, coordinated effort to educate the public and raise their awareness about issues related to mental health using a variety of tools (e.g. media, brochures, face-to-face initiatives).

- **Excludes:** Commercial advertisements (e.g. by pharmaceutical companies); advertisements for research studies.

Refresher training in psychiatry/mental health: The provision of essential knowledge and skills in the identification, treatment, and referral of people with mental disorders. *Refresher training* occurs after university (or vocational school) degree training. Eight hours of training is equivalent to one day of training.

- **Includes:** In-service training.
- **Excludes:** Training exclusively in neurology.

Social worker: A professional having completed a formal training in social work at a recognized, university-level school for a diploma or degree in social work. WHO-AIMS asks for information only on *social workers* working in mental health care.

User/Consumer/Patient: A person receiving mental health care. These terms are used in different places and by different groups of practitioners and people with mental disorders, and are used synonymously in WHO-AIMS.

TERMS USED IN WHO-AIMS WERE PRIMARILY DRAWN FROM THE FOLLOWING SOURCES

Johnson S, Kuhlmann R; EPCAT Group. European Psychiatric Assessment Team. The European Service Mapping Schedule (ESMS): Development of an instrument for the description and classification of mental health services. *Acta Psychiatrica Scandinavica*, 2000, 405:14-23.

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World Health Organization (2003). *Mental Health Financing. Mental Health Policy and Service Package.* Geneva. World Health Organization.

World Health Organization (2003). *Advocacy for Mental Health Mental Health Legislation and Human Rights. Mental Health Policy and Service Package.* Geneva, World Health Organization.

DOMAIN 1
POLICY AND LEGISLATIVE FRAMEWORK

1.1	**Mental health policy**
1.2	**Mental health plan**
1.3	**Mental health legislation**
1.4	**Monitoring and training on human rights**
1.5	**Financing of mental health services**

FACET 1.1	**Mental health policy**
DEFINITION	Date and components included in mental health policy and essential medicines list

ITEM 1.1.1	**Last version of mental health policy**
DEFINITION	Year of the last version of the mental health policy document (either as a separate mental health policy document or incorporated within a general health policy document)
MEASURE	Number; UN = unknown; NA= not applicable (e.g. no mental health policy exists)
NOTES	Mental health policy refers to an organized set of values, principles, and objectives to improve mental health and reduce the burden of mental disorders in a population.

ITEM 1.1.2	**Contents of the mental health policy**
DEFINITION	Components included in the mental health policy
MEASURE	1. Organization of services: developing community mental health services 2. Organization of services: downsizing large mental hospitals 3. Organization of services: developing a mental health component in primary health care 4. Human resources 5. Involvement of *users* and families 6. Advocacy and promotion *7. Human rights protection of users* 8. Equity of access to mental health services across different groups 9. Financing 10. Quality improvement 11. Monitoring system Y/N; UN = unknown; NA= not applicable

ITEM 1.1.3	**Psychotropic medicines included on the essential medicines list**
DEFINITION	Categories of psychotropic medicines included on the essential medicines list
MEASURE	1. Antipsychotics (Y/N; NA = not applicable) 2. Anxiolytics (Y/N; NA = not applicable) 3. Antidepressants (Y/N; NA = not applicable) 4. Mood stabilizers (Y/N; NA = not applicable) 5. Antiepileptic drugs (Y/N; NA = not applicable)
NOTES	• Antipsychotics include chlorpromazine, fluphenazine, haloperidol; antidepressants include amitriptyline, clomipramine; mood stabilizers include carbamazepine, lithium carbonate, valproic acid; anxiolytics include diazepam; antiepileptic drugs include phenobarbital, carbamazepine, valproic acid. • Rate Y if at least one medicine for category is present on the essential medicines list. • Code N if there are no medicines within that category on the essential medicines list. • Code NA if there is no essential medicines list. • Essential medicines refer to the medicines that the region or country has adopted - often an adaptation of the WHO Model List of Essential Medicines.

Reminders: - All questions are for the previous, full calendar year, unless otherwise specified.
- *Italicized* terms are defined in the 'frequently used terms' section (pages 11-14).

FACET 1.2	Mental health plan
DEFINITION	Date, components included, and specification of strategies in the mental health plan

ITEM 1.2.1	Last version of the mental health plan
DEFINITION	Year of the last version of the mental health plan
MEASURE	Number; UN = unknown; NA = not applicable (e.g. no mental health plan exists)
NOTES	A mental health plan is a detailed scheme for action on mental health which usually includes setting priorities for strategies and establishing timelines and resource requirements. A mental health plan usually includes action for promoting mental health, preventing mental disorders and treating people with mental illnesses.

ITEM 1.2.2	Content of the mental health plan(s)
DEFINITION	Components included in the mental health plan(s)
MEASURE	1. Organization of services: developing community mental health services 2. Organization of services: downsizing large mental hospitals 3. Organization of services: reforming mental hospitals to provide more comprehensive care 4. Organization of services: developing a mental health component in primary health care 5. Human resources 6. Involvement of *users* and families 7. Advocacy and promotion *8. Human rights protection of users* 9. Equity of access to mental health services across different groups 10. Financing 11. Quality improvement 12. Monitoring system Y/N; UN = unknown; NA = not applicable
NOTES	Describe the components of all mental health plans that are valid for the last year, independent of when the plan was made (e.g. if plans were made in 1995 and in 2000 and both are still in operation, please describe the components of both plans).

ITEM 1.2.3	Strategies in the last mental health plan
DEFINITION	Identification of strategies in the last mental health plan
MEASURE	1. Budget is mentioned in the last mental health plan. 2. A timeframe is mentioned in the last mental health plan. 3. Specific goals are mentioned in the last mental health plan. 4. Have any of the goals identified in the last mental health plan been reached within the last calendar year? Y/N; UN = unknown; NA = not applicable

ITEM 1.2.4	Last version of a disaster/emergency preparedness plan for mental health
DEFINITION	Year of the last version of a disaster/emergency preparedness plan for mental health in emergencies
MEASURE	Number; UN = unknown; NA = not applicable (e.g. no disaster/emergency plan for mental health exists)
NOTES	• A disaster/emergency preparedness plan for mental health is a detailed scheme for preparing for action on mental health in the context of a disaster/emergency. It usually sets priorities for strategies, establishes timelines and resource requirements. • The plan may be part of the mental health plan, the health plan, a disaster plan, or a separate document.

FACET 1.3	Mental health legislation
DEFINITION	Date, components included, and implementation of *mental health legislation*

ITEM 1.3.1	Last version of mental health legislation
DEFINITION	Year of the last version of *mental health legislation*
MEASURE	Number; UN = unknown; NA = not applicable (e.g. no *mental health legislation* exists)
NOTES	*Mental health legislation* refers to specific legal provisions that are primarily related to mental health. These provisions typically focus on issues such as: civil and *human rights protection* of people with mental disorders, treatment facilities, personnel, professional training and service structure.

ITEM 1.3.2	Contents of legislation on mental health
DEFINITION	Components included in legislation on mental health
MEASURE	1. Access to mental health care including access to the least restrictive care 2. Rights of mental health service consumers, family members, and other care givers 3. Competency, capacity, and guardianship issues for people with mental illness 4. Voluntary and involuntary treatment 5. Accreditation of professionals and facilities 6. Law enforcement and other judicial system issues for people with mental illness 7. Mechanisms to oversee involuntary admission and treatment practices 8. Mechanisms to implement the provisions of *mental health legislation* Y/N; UN = unknown; NA = not applicable
NOTES	Describe all relevant legislation on mental health, which may be found in diverse areas of law. It may be found in specific mental health legislation (defined in previous item) but it may also be found in legislation that is primarily on health or other issues (e.g. violence, suicide).

ITEM 1.3.3	Procedures and standardized documentation for implementing legislation
DEFINITION	Standardized documentation and procedures for implementing *mental health legislation*
MEASURE	**Procedures and standardized documentation exist in:** A = no components of the *mental health legislation* B = a few components of the *mental health legislation* C = some components of the *mental health legislation* D = the majority of the components of the *mental health legislation* E = all or almost all components of the *mental health legislation* UN = unknown; NA = not applicable
NOTES	• These may include guidance on procedures, instruments, or forms for use. • In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

FACET 1.4	Monitoring and training on human rights
DEFINITION	Monitoring and training on *human rights protection* in mental health services

ITEM 1.4.1	Functions of national-level or regional-level review bodies on human rights
DEFINITION	Functions of national-level or regional-level review bodies assessing the *human rights protection of users* in mental health services
MEASURE	National-level or regional-level review bodies exist that have the authority to: 1. Oversee regular inspections in mental health facilities 2. Review involuntary admission and discharge procedures 3. Review complaints investigation processes 4. The review body has the authority to impose sanctions (e.g. withdraw accreditation, impose penalties, or close facilities that persistently violate human rights). Y/N; UN = unknown; NA = not applicable
NOTES	If you are filling out WHO-AIMS for your country, please answer the question for national review bodies; if for a state, province, or designated administrative area please answer the question for regional-level review bodies.

ITEM 1.4.2	Inspecting human rights in mental hospitals
DEFINITION	Proportion of *mental hospitals* with at least one yearly external review/inspection of *human rights protection of patients*
MEASURE	Proportion; UN = unknown
NUMERATOR	Number of *mental hospitals* with at least one yearly external review/inspection of *human rights protection of patients*
DENOMINATOR	Total number of *mental hospitals*
NOTES	An external review/inspection refers to a review that is conducted by an external body that is independent from the mental health facility.

ITEM 1.4.3	Inspecting human rights in community-based inpatient psychiatric units and in community residential facilities
DEFINITION	Proportion of *community-based inpatient psychiatric units* and *community residential facilities* with at least one yearly external review/inspection of *human rights protection of patients*
MEASURE	Proportion; UN = unknown
NUMERATOR	Number of *community-based inpatient psychiatric units* and *community residential facilities* with at least one yearly external review/inspection of *human rights protection of patients*
DENOMINATOR	Total number of *community-based inpatient psychiatric units* and *community residential facilities*
NOTES	An external review/inspection refers to a review that is conducted by an external body that is independent from the mental health facility.

ITEM 1.4.4	Training staff in mental hospitals on human rights protection of patients
DEFINITION	Proportion of *mental hospitals* with at least one-day training, meeting or other type of working session on *human rights protection of patients* in the last two years
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of *mental hospitals* with at least one-day training, meeting, or other type of working session on *human rights protection of patients* in the last two years
DENOMINATOR	Total number of *mental hospitals* **(#)**

ITEM 1.4.5	Training staff in community-based inpatient psychiatric units and community residential facilities on human rights protection of patients
DEFINITION	Proportion of *community-based inpatient psychiatric units* and *community residential facilities* with at least one-day training, meeting, or other type of working session on *human rights protection of patients* in the last two years
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of *community-based inpatient psychiatric units* and *community residential facilities* with at least one-day training, meeting, or other type of working session on *human rights protection of patients* in the last two years
DENOMINATOR	Total number of *community-based inpatient psychiatric units* and *community residential facilities* **(#)**

FACET 1.5	Financing of mental health services
DEFINITION	Expenditures and financial sources in mental health services

ITEM 1.5.1	Mental health expenditures by the government health department
DEFINITION	Proportion of mental health expenditures from the total health expenditures by the government health department
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	Amount of money spent for mental health services by the government health department (in local currency)
DENOMINATOR	Total amount of money spent for health services by the government health department (in local currency)
NOTES	This item covers expenditures on mental health services (i.e. money spent). It does not cover budget allocation. Budget allocation and expenditures may be different because allocated monies are often spent on other services.

ITEM 1.5.2	Expenditures on mental hospitals
DEFINITION	Proportion of mental health expenditures spent on *mental hospitals*
MEASURE	Proportion ; UN = unknown; NA = not applicable
NUMERATOR	Amount of money spent on *mental hospitals* by the government health department (in local currency)
DENOMINATOR	Total amount of money spent for mental health services by the government health department (in local currency) **(#)**

ITEM 1.5.3	Mental disorders in social insurance schemes
DEFINITION	Coverage of mental disorders by social insurance schemes
MEASURE	A = no mental disorder is covered by social insurance schemes B = only (some) severe mental disorders are covered by social insurance schemes C = all severe and some mild mental disorders are covered D = all mental disorders are covered E = all mental disorders and all mental health problems of clinical concern are covered UN = unknown; NA = not applicable
NOTES	• Social insurance schemes are a source of funding for mental health care. Everyone above a certain income level is required to transfer a fixed percentage of the income to the government–administered health insurance fund. In return, the government pays for a part or all mental health care. • In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

Reminders: - All questions are for the previous, full calendar year, unless otherwise specified.
- *Italicized* terms are defined in the 'frequently used terms' section (pages 11-14).

ITEM 1.5.4	Free access to essential psychotropic medicines
DEFINITION	Proportion of the population with free access (at 80% least covered) to essential psychotropic medicines
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of people with free access (at 80% least covered) to essential psychotropic medicines
DENOMINATOR	Number of people in the general population
NOTES	• This item is specific for psychotropic drugs (in many countries psychotropic drugs are not covered by government or insurance schemes). • Free access to essential psychotropic medicines means that essential psychotropic medicines – once prescribed – are provided to people with mental disorders free of cost or with reimbursement equal or more than 80% of the retail price. The funding sources for free access/reimbursement may be the government or insurance schemes (employment, social, or private).

IF THE RESPONSE TO THE PREVIOUS ITEM WAS LESS THAN 100%, PROCEED TO THE NEXT ITEM. IF NOT, PROCEED TO DOMAIN 2.

ITEM 1.5.5	Affordability of antipsychotic medication
DEFINITION	Proportion of the daily minimum wage needed to pay for one day of antipsychotic medication by a user without any reimbursement, using the cheapest available antipsychotic drug
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	Cost of one day of antipsychotic medication, using the cheapest available antipsychotic drug in local currency
DENOMINATOR	One day minimum wage in local currency
NOTES	• Daily minimum wage**:** A minimum level of payment established by law for work performed. It is a time-based wage that usually applies to unskilled adults entering work for the first time. If the minimum wage is specified in hours, the daily minimum wage may be calculated by assuming an 8-hours work day and accordingly multiplying the hourly wage by eight hours. • For source of country minimum wage, consult Ministry of Labour or Ministry of Welfare or Bureau of Statistics or the ILO (stat@ilo.org). If minimum wage data are available only on a year basis, divide the yearly minimum income by 250 working days. Use the daily wage of a 'day labour' worker if no minimum wage exists. (A 'day labour' worker is an unskilled labour worker who is contracted and paid on a day-by-day basis.) • The cost of the medicine is based on the retail price, paid by the user assuming no reimbursement from insurance or government schemes. • To determine the one day cost, use the medicine dosage recommended by Defined Daily Dose (DDD) system. The DDD is the assumed average maintenance dose per day for a drug used for its main indication in adults. The DDDs of the antipsychotic medicines in the WHO Model List of Essential Medicines (2003) are: 1. chlorpromazine (DDD 300 mg oral) 2. fluphenazine (DDD 1 mg depot) 3. haloperidol (DDD 8 mg oral) 4. other antipsychotic drugs (specify the medicine and used DDD) (see, ATC Index 2004, www.whocc.no/atcddd/). • An example: the DDD of the antipsychotic chlorpromazine is 300 mg. In Albania using the local currency (lek) the unit cost for each 100 mg tablet of chlorpromazine is 2.8 lek. Thus, the DDD cost is 3 x 2.8 = 8.4 lek per day.

ITEM 1.5.6	Affordability of antidepressant medication
DEFINITION	Proportion of the daily minimum wage needed to pay for one day of antidepressant medication by a user without any reimbursement, using the cheapest available antidepressant drug
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	Cost of one day of antidepressant medication using the cheapest antidepressant drug in local currency
DENOMINATOR	One day minimum wage in the local currency **(#)**
NOTES	• Daily minimum wage: A minimum level of payment established by law for work performed. It is a time-based wage that usually applies to unskilled adults entering work for the first time. If the minimum wage is specified in hours, the daily minimum wage may be calculated by assuming an 8-hours work day and accordingly multiplying the hourly wage by eight hours. • For source of country minimum wage, consult Ministry of Labour or Ministry of Welfare or Bureau of Statistics or the ILO (stat@ilo.org). If minimum wage data are available only on a year basis, divide the yearly minimum income by 250 working days. Use the daily wage of a 'day labour' worker if no minimum wage exists. (A 'day labour' worker is an unskilled labour worker who is contracted and paid on a day-by-day basis.) • The cost of the medicine is based on the retail price, paid by the user assuming no reimbursement from insurance or government schemes. • To determine the one day cost, use the medicine dosage recommended by Defined Daily Dose (DDD) system. The DDD is the assumed average maintenance dose per day for a drug used for its main indication in adults. The DDDs of the antidepressant medicines in the WHO Model List of Essential Medicines (2003) are: 1. amitriptyline (DDD 75 mg oral) 2. clomipramine (DDD 100 mg oral) 3. other antidepressant drugs (specify the medicine and used DDD) (see, ATC Index 2004, www.whocc.no/atcddd/).

DOMAIN 2
MENTAL HEALTH SERVICES

2.1.	**Organizational integration of mental health services**
2.2.	**Mental health outpatient facilities**
2.3.	**Day treatment facilities**
2.4.	**Community-based psychiatric inpatient units**
2.5.	**Community residential facilities**
2.6.	**Mental hospitals**
2.7.	**Forensic inpatient units**
2.8.	**Other residential facilities**
2.9.	**Availability of psychosocial treatment in mental health facilities**
2.10.	**Availability of essential psychotropic medicines**
2.11.	**Equity of access to mental health services**

FACET 2.1	**Organizational integration of services**
DEFINITION	Organizational integration of mental health services across facilities

ITEM 2.1.1	**Existence and functions of a national or regional 'mental health authority'**
DEFINITION	Existence and the specification of roles of a national or regional 'mental health authority'
MEASURE	1. A national or regional mental health authority exists. 2. The mental health authority provides advice to the government on mental health policies and legislation. 3. The mental health authority is involved in service planning. 4. The mental health authority is involved in service management. 5. The mental health authority is involved in monitoring and quality assessment of mental health services. Y/N; NA = not applicable
NOTES	• The 'mental health authority' is an organizational entity responsible for mental health care within a region or country. The Department of Mental Health or the Mental Health Office in the Ministry of Health may be considered to be a 'mental health authority'. • Rate NA = not applicable if there is no 'mental health authority'.

ITEM 2.1.2	**Organization of mental health services by catchment areas/service areas**
DEFINITION	Catchment areas/service areas exist as a way to organize mental health services to communities
MEASURE	Y/N; UN = unknown
NOTES	A catchment area/service area is a defined geographical area whose residents have access to basic mental health services from assigned facilities, which typically are located in (or near) the geographical area. All residents of a catchment area are expected to avail all basic services from assigned facilities.

ITEM 2.1.3	Mental hospitals organizationally integrated with mental health outpatient facilities
DEFINITION	Proportion of *mental hospitals* organizationally integrated with *mental health outpatient facilities*
MEASURE	Proportion; NA = not applicable ; UN = unknown
NUMERATOR	Number of *mental hospitals* organizationally integrated with *mental health outpatient facilities*
DENOMINATOR	Total number of *mental hospitals* **(#)**
NOTES	• Rate NA, if *mental hospitals* do not exist • The two facilities are organizationally integrated if both of the following two conditions exist: a. A referral system between the two types of facilities is utilized to facilitate continuity of care; b. *Mental hospitals* and *mental health outpatient* facilities work in a coordinated manner.

FACET 2.2	Mental health outpatient facilities
DEFINITION	*Users* and services provided through *mental health outpatient facilities*

ITEM 2.2.1	Availability of mental health outpatient facilities
DEFINITION	Number of *mental health outpatient facilities*
MEASURE	Number; UN = unknown

ITEM 2.2.2	Users treated through mental health outpatient facilities
DEFINITION	*Number of users treated through mental health outpatient facilities*, per 100 000 general population
MEASURE	Rate per 100 000 general population; UN = unknown; NA = not applicable
NUMERATOR	*Number of users treated through mental health outpatient facilities*
DENOMINATOR	Number of people in the general population divided by 100 000

ITEM 2.2.3	Gender distribution of users treated through mental health outpatient facilities
DEFINITION	Proportion of female *users* treated through *mental health outpatient facilities*
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of female *users* treated through *mental health outpatient facilities*
DENOMINATOR	*Number of users treated through mental health outpatient facilities* **(#)**

ITEM 2.2.4	Diagnosis of users treated through mental health outpatient facilities
DEFINITION	Proportion of *users* treated through *mental health outpatient facilities* by ICD-10 diagnosis
MEASURE	1. Mental and behavioural disorders due to psychoactive substance use (F10-F19) 2. Schizophrenia, schizotypal and delusional disorders (F20-F29) 3. Mood [affective] disorders (F30-F39) 4. Neurotic, stress-related and somatoform disorders (F40-F48) 5. Disorders of adult personality and behaviour (F60-F69) 6. Other (e.g. epilepsy, organic mental disorders, mental retardation, behavioural and emotional disorder with onset usually occurring in childhood and adolescence, disorders of psychological development) (UN = unknown; NA = not applicable)
NUMERATOR	*Number of users treated through mental health outpatient facilities* for each diagnosis
DENOMINATOR	*Number of users treated through mental health outpatient facilities* **(#)**
NOTES	ICD-10 refers to the International Statistical Classification of Diseases and Related Health Problems 10th Revision Version (http://www3.who.int/icd/vol1htm2003/fr-icd.htm).

ITEM 2.2.5	Mental health outpatient contacts
DEFINITION	Average number of contacts per *user* treated through *mental health outpatient facilities*
MEASURE	Number; UN = unknown; NA = not applicable
NUMERATOR	Cumulative number of outpatient contacts provided in the previous year through *mental health outpatient facilities* (total of all users)
DENOMINATOR	*Number of users treated through mental health outpatient facilities* **(#)**
NOTES	An outpatient contact is an interaction (e.g. an intake interview, a treatment session, a follow-up visit) involving a *user* and a staff member on an outpatient basis. The cumulative number of outpatient contacts is the sum of contacts across all *users* across all outpatient facilities. Includes: contacts provided by a staff member of the facility whether or not the contact occurs within the facility or at another location (e.g. at home).

ITEM 2.2.6	Children and adolescents treated through mental health outpatient facilities
DEFINITION	Proportion of children and adolescents among *users* treated through *mental health outpatient facilities*
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of *users* 17 years of age or younger treated through *mental health outpatient facilities*
DENOMINATOR	*Number of users treated through mental health outpatient facilities* **(#)**
NOTES	Count *users* aged 17 years and younger (i.e. those younger than 18 years old) treated in both adult and specialized child and adolescents facilities

ITEM 2.2.7	Availability of mental health outpatient facilities that are for children and adolescents only
DEFINITION	Proportion of *mental health outpatient facilities for children and adolescents only*
MEASURE	Proportion; UN = unknown
NUMERATOR	Number of *mental health outpatient facilities for children and adolescents only*
DENOMINATOR	Number of *mental health outpatient facilities* **(#)**

ITEM 2.2.8	Provision of follow-up community care
DEFINITION	Proportion of *mental health outpatient facilities* that provide routine follow-up community care
MEASURE	Proportion; UN = unknown
NUMERATOR	Number of *mental health outpatient facilities* that provide routine follow-up community care
DENOMINATOR	Number of *mental health outpatient facilities* (#)
NOTES	Routine follow-up community care means follow-up care provided outside the premises of the facility (e.g. follow-up home visits to check medication adherence, to ensure proper care for the user, to identify early signs of relapse, to assist with rehabilitation)

ITEM 2.2.9	Mental health mobile clinic teams
DEFINITION	Proportion of *mental health outpatient facilities* that have mental health mobile clinic teams that provide regular mental health care outside of the mental health facility
MEASURE	Proportion; UN = unknown
NUMERATOR	Number of *mental health outpatient facilities* that have mental health mobile clinic teams that provide regular mental health care outside of the mental health facility
DENOMINATOR	Number of *mental health outpatient facilities* (#)
NOTES	Mental health mobile clinic teams provide regular outpatient clinics in different places to address inadequate physical access to mental health facilities. Includes extension clinics.

FACET 2.3	Day treatment facilities
DEFINITION	*Users* and use of *mental health day treatment facilities*

ITEM 2.3.1	Availability of mental health day treatment facilities
DEFINITION	Number of *mental health day treatment facilities*
MEASURE	Number; UN = unknown

ITEM 2.3.2	Users treated in day treatment facilities
DEFINITION	*Number of users treated in mental health day treatment facilities*, per 100 000 general population
MEASURE	Rate per 100 000 general population ; UN = unknown; NA = not applicable
NUMERATOR	*Number of users treated in mental health day treatment facilities*
DENOMINATOR	Number of people in the general population divided by 100 000 **(#)**

ITEM 2.3.3	Gender distribution of users treated in mental health day treatment facilities
DEFINITION	Proportion of female *users* treated in *mental health day treatment facilities*
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of female *users* treated in *mental health day treatment facilities*
DENOMINATOR	*Number of users treated in mental health day treatment facilities* **(#)**

ITEM 2.3.4	Time spent at day treatment facilities
DEFINITION	Average number of days on which *users* are present at *mental health day treatment facilities*
MEASURE	Number; UN = unknown; NA = not applicable
NUMERATOR	Cumulative number of days on which *users* were present in *mental health day treatment facilities* in the previous year (total of all *users*)
DENOMINATOR	*Number of users treated in mental health day treatment facilities* **(#)**
NOTES	The cumulative number of days on which *users* were present in *mental health day treatment facilities* is the sum of the number of days across all users and across all day treatment facilities.

ITEM 2.3.5	Children and adolescents treated in day treatment facilities
DEFINITION	Proportion of children and adolescents among *users* treated in *mental health day treatment facilities*
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of *users* 17 years of age or younger treated in *mental health day treatment facilities*
DENOMINATOR	*Number of users treated in mental health day treatment facilities* **(#)**
NOTES	Count *users* aged 17 years and younger treated in both adult and specialized child and adolescents facilities

ITEM 2.3.6	Availability of day treatment facilities that are for children and adolescents only
DEFINITION	Proportion of *mental health day treatment facilities for children and adolescents only*
MEASURE	Proportion; UN = unknown
NUMERATOR	Number of *mental health day treatment facilities for children and adolescents only*
DENOMINATOR	Number of *mental health day treatment facilities**(#)***

FACET 2.4	Community-based psychiatric inpatient units
DEFINITION	*Beds*, *patients*, and use of *community-based psychiatric inpatient units*

ITEM 2.4.1	Availability of community-based psychiatric inpatient units
DEFINITION	Number of *community-based psychiatric inpatient units*
MEASURE	Number; UN = unknown

ITEM 2.4.2	Beds in community-based psychiatric inpatient units
DEFINITION	Number of *beds* in *community-based psychiatric inpatient units*, per 100 000 general population
MEASURE	Rate per 100 000 general population; UN = unknown; NA = not applicable
NUMERATOR	Number of *beds* in *community-based psychiatric inpatient units*
DENOMINATOR	Number of people in the general population divided by 100 000 **(#)**

ITEM 2.4.3	Gender distribution of admissions to community-based psychiatric inpatient units
DEFINITION	Proportion of female admissions to *community-based psychiatric inpatient units*
MEASURE	Proportion; UN = unknown
NUMERATOR	Number of female admissions to *community-based psychiatric inpatient units*
DENOMINATOR	*Number of admissions* to *community-based psychiatric inpatient units*

ITEM 2.4.4	Diagnosis of admissions to community-based psychiatric inpatient units
DEFINITION	Proportion of admissions to *community-based psychiatric inpatient units* by ICD 10 diagnosis
MEASURE	1. Mental and behavioural disorders due to psychoactive substance use (F10-F19) 2. Schizophrenia, schizotypal and delusional disorders (F20-F29) 3. Mood [affective] disorders (F30-F39) 4. Neurotic, stress-related and somatoform disorders (F40-F48) 5. Disorders of adult personality and behaviour (F60-F69) 6. Other (e.g. epilepsy, organic mental disorders, mental retardation, behavioural and emotional disorder with onset usually occurring in childhood and adolescence, disorders of psychological development) UN = unknown; NA = not applicable
NUMERATOR	*Number of admissions* to *community-based psychiatric inpatient units* for each diagnosis
DENOMINATOR	*Number of admissions* to *community-based psychiatric inpatient units* **(#)**
NOTES	The ICD 10 refers to the International Statistical Classification of Diseases and Related Health Problems 10th Revision Version (http://www3.who.int/icd/vol1htm2003/fr-icd.htm).

ITEM 2.4.5	Involuntary admissions to community-based psychiatric inpatient units
DEFINITION	Proportion of involuntary admissions to *community-based psychiatric inpatient units*
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of involuntary admissions to *community-based psychiatric inpatient units*
DENOMINATOR	*Number of admissions* to *community-based psychiatric inpatient units* **(#)**
NOTES	Involuntary admissions refer to admissions to mental health facilities that occur without the voluntary consent of the individual. Involuntary admissions are typically permitted in situations where a person with a mental disorder is likely to cause self-harm or harm to others or suffer deterioration in condition if treatment is not given. Involuntary admissions are typically ruled by mental health legislation.

ITEM 2.4.6	Time spent in community-based psychiatric inpatient units per discharge
DEFINITION	Average number of days spent in *community-based psychiatric inpatient units* per discharge
MEASURE	Number; UN = unknown; NA = not applicable
NUMERATOR	Cumulative number of days that discharged patients spent in *community-based psychiatric inpatient units* in the previous year (total across all discharges)
DENOMINATOR	Number of discharges from *community-based psychiatric inpatient units*
NOTES	The cumulative number of days that discharged patients spent in *community-based psychiatric inpatient units* is the sum of the number of days across all users and across all *community-based psychiatric inpatient units*.

Reminders: - All questions are for the previous, full calendar year, unless otherwise specified.
- *Italicized* terms are defined in the 'frequently used terms' section (pages 11-14).

ITEM 2.4.7	Physical restraint and seclusion in community-based psychiatric inpatient units
DEFINITION	Percentage of *patients* who were physically restrained or secluded at least once in the past year in *community-based psychiatric inpatient units*
MEASURE	A = over 20% of *patients* were restrained or secluded B = 11-20% of *patients* were restrained or secluded C = 6-10% of *patients* were restrained or secluded D = 2-5% of *patients* were restrained or secluded E = 0-1% of *patients* were restrained or secluded UN = unknown
NOTES	• A physical restraint is any manual method, physical or mechanical device, material, or equipment attached or adjacent to the patient's body, which he or she cannot easily remove. Using force to hold a patient and restrict movement constitutes restraint. Seclusion refers to the practice of placing a patient in a confined space alone (e.g. in a locked room). • Include all the patients who were physically restrained or secluded, irrespective of the duration of the restraint or seclusion. • In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 2.4.8	Child and adolescent admissions to community-based psychiatric inpatient units
DEFINITION	Proportion of children and adolescent admissions to *community-based psychiatric inpatient units*
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	*Number of admissions* of patients 17 years of age or younger to *community-based psychiatric inpatient units*
DENOMINATOR	*Number of admissions* to *community-based psychiatric inpatient units* **(#)**
NOTES	Count patients aged 17 years and younger treated in both adult and specialized child and adolescents units

ITEM 2.4.9	Community-based psychiatric inpatient beds that are for children and adolescents only
DEFINITION	Proportion of community-based psychiatric inpatient *beds* for children and adolescents only
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of community-based psychiatric inpatient *beds* for children and adolescents only
DENOMINATOR	Number of community-based psychiatric inpatient *beds* **(#)**
NOTES	Psychiatric inpatient *beds* for children and adolescents may be found in different units including paediatric units as well as adult psychiatric units (however, the *beds* must be specifically reserved for child and adolescent patients).

FACET 2.5	**Community residential facilities**
DEFINITION	*Beds*/places, *users*, and use of *community residential facilities*

ITEM 2.5.1	Availability of community residential facilities
DEFINITION	Number of *community residential facilities*
MEASURE	Number; UN = unknown

ITEM 2.5.2	Beds/places in community residential facilities
DEFINITION	Number of *beds*/places in *community residential facilities*, per 100 000 general population
MEASURE	Rate per 100 000 general population; UN = unknown; NA = not applicable
NUMERATOR	Number of *beds*/places in *community residential facilities*
DENOMINATOR	Number of people in the general population divided by 100 000 **(#)**

Reminders: - All questions are for the previous, full calendar year, unless otherwise specified.
- *Italicized* terms are defined in the 'frequently used terms' section (pages 11-14).

ITEM 2.5.3	Users treated in community residential facilities
DEFINITION	*Number of users treated in community residential facilities*, per 100 000 general population
MEASURE	Rate per 100 000 general population; UN = unknown; NA = not applicable
NUMERATOR	*Number of users treated in community residential facilities*
DENOMINATOR	Number of people in the general population divided by 100 000 **(#)**

ITEM 2.5.4	Gender distribution of users treated in community residential facilities
DEFINITION	Proportion of female *users* treated in *community residential facilities*
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of female *users* treated in *community residential facilities*
DENOMINATOR	*Number of users treated in community residential facilities* **(#)**

ITEM 2.5.5	Average time spent in community residential facilities
DEFINITION	Average number of days spent in *community residential facilities*
MEASURE	Number; UN = unknown; NA = not applicable
NUMERATOR	Cumulative number of days spent in *community residential facilities* in the previous year (total of all users)
DENOMINATOR	*Number of users treated in community residential facilities* **(#)**
NOTES	The cumulative number of days spent in *community residential facilities* is the sum of the number of days across all users and across all *community residential facilities*

ITEM 2.5.6	Children and adolescents treated in community residential facilities
DEFINITION	Proportion of children and adolescents among *users* treated in *community residential facilities*
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of *users* 17 years of age or younger treated in *community residential facilities*
DENOMINATOR	*Number of users treated in community residential facilities* **(#)**
NOTES	Count *users* aged 17 years and younger treated in both adult and specialized child and adolescents facilities

ITEM 2.5.7	Beds/places in community residential facilities that are for children and adolescents only
DEFINITION	Proportion of the *beds/*places in *community residential facilities for children and adolescents only*
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of *beds/*places in *community residential facilities for children and adolescents only*
DENOMINATOR	Number of *beds*/places in *community residential facilities* **(#)**

FACET 2.6	Mental hospitals
DEFINITION	*Beds*, *patients*, and use of *mental hospitals*

ITEM 2.6.1	Availability of mental hospitals
DEFINITION	Number of *mental hospitals* **(#)**
MEASURE	Number; UN = unknown

ITEM 2.6.2	Availability of mental hospital beds
DEFINITION	Number of *beds* in *mental hospitals* per 100 000 population
MEASURE	Rate per 100 000 general population; UN = unknown; NA = not applicable
NUMERATOR	Number of *beds* in *mental hospitals*
DENOMINATOR	Number of people in the general population divided by 100 000 **(#)**

ITEM 2.6.3	Change in beds in mental hospitals
DEFINITION	Decrease/increase of the number of *beds* in *mental hospitals* in the last five years
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	[Number of *beds* in *mental hospitals* in the year of assessment **(#)**] - [Number of *beds* in *mental hospitals* five years before]
DENOMINATOR	Number of *beds* in *mental hospitals* five years before
NOTES	E.g. if the year of assessment is 2004, then one should compare with the number of beds in 1999.

ITEM 2.6.4	Gender distribution of patients treated in mental hospitals
DEFINITION	Proportion of female *patients* treated in *mental hospitals*
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of female *patients* treated in *mental hospitals*
DENOMINATOR	*Number of patients treated in mental hospitals*

ITEM 2.6.5	Diagnosis of patients in mental hospitals
DEFINITION	Proportion of *patients* treated in *mental hospitals* the last year by ICD-10 diagnosis
MEASURE	1. Mental and behavioural disorders due to psychoactive substance use (F10-F19) 2. Schizophrenia, schizotypal and delusional disorders (F20-F29) 3. Mood [affective] disorders (F30-F39) 4. Neurotic, stress-related and somatoform disorders (F40-F48) 5. Disorders of adult personality and behaviour (F60-F69) 6. Other (e.g., epilepsy, organic mental disorders, mental retardation, behavioural and emotional disorder with onset usually occurring in childhood and adolescence, disorders of psychological development) UN = unknown; NA = not applicable
NUMERATOR	*Number of patients treated in mental hospitals* for each diagnostic group
DENOMINATOR	*Number of patients treated in mental hospitals* **(#)**

ITEM 2.6.6	Involuntary admissions to mental hospitals
DEFINITION	Proportion of involuntary admissions to *mental hospitals*
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of involuntary admissions to *mental hospitals*
DENOMINATOR	*Number of admissions* to *mental hospitals*
NOTES	Involuntary admissions refer to admissions to mental health facilities that occur without the voluntary consent of the individual. Involuntary admissions are typically permitted in situations where a person with a mental disorder is likely to cause self-harm or harm to others or suffer deterioration in condition if treatment is not given. Involuntary admissions are typically ruled by mental health legislation.

ITEM 2.6.7	Long-stay patients in mental hospitals
DEFINITION	Proportion of long-stay patients by length of stay on 31 December of the last year in *mental hospitals*
MEASURE	Length of stay: 1. more than 10 years 2. 5-10 years 3. 1-4 years 4. less than 1 year Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of *patients* for each grouping of length of stay
DENOMINATOR	Number of *patients* staying in *mental hospitals* on 31 December of the last year

Reminders: - All questions are for the previous, full calendar year, unless otherwise specified.
- *Italicized* terms are defined in the 'frequently used terms' section (pages 11-14).

ITEM 2.6.8	Time spent in mental hospitals
DEFINITION	Average number of days spent in *mental hospitals*
MEASURE	Number; UN = unknown; NA = not applicable
NUMERATOR	Cumulative number of days spent in *mental hospitals* (total of all *patients*)
DENOMINATOR	*Number of patients treated in mental hospitals* **(#)**
NOTES	The cumulative number of days spent in *mental hospitals* is the sum of the number of days across all *patients* and across all *mental hospitals*

ITEM 2.6.9	Occupancy of mental hospitals
DEFINITION	Occupancy rate in *mental hospitals*
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	Cumulative number of days spent in *mental hospitals* (total of all *patients*) **(#)**
DENOMINATOR	Number of *beds* in *mental hospitals* times 365 **(#)**

ITEM 2.6.10	Physical restraint and seclusion in mental hospitals
DEFINITION	Percentage of *patients* who were physically restrained or secluded at least once in the last year in *mental hospitals*
MEASURE	A = over 20% of *patients* were restrained or secluded B = 11-20% of *patients* were restrained or secluded C = 6-10% of *patients* were restrained or secluded D = 2-5% of *patients* were restrained or secluded E = 0-1% of *patients* were restrained or secluded UN = unknown
NOTES	• A physical restraint is any manual method, physical or mechanical device, material, or equipment attached or adjacent to the user's body, which he or she cannot easily remove. Using force to hold a user and restrict movement constitutes restraint. Seclusion refers to the practice of placing a user in a confined space alone (e.g. in a locked room). • Include all the users who are physically restrained or secluded, irrespective of the duration of the restraint or seclusion. • In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 2.6.11	Children and adolescents treated in mental hospitals
DEFINITION	Proportion of children and adolescents among *patients* treated in *mental hospitals*
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of patients 17 years of age or younger treated in *mental hospitals*
DENOMINATOR	*Number of patients treated* in *mental hospitals* **(#)**
NOTES	Count *patients* aged 17 years and younger treated in both adult and specialized child and adolescents facilities**.**

ITEM 2.6.12	Availability of mental hospital beds that are for children and adolescents only
DEFINITION	Proportion of *mental hospital beds* that are for children and adolescents only
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of *mental hospital beds* that are for children and adolescents only
DENOMINATOR	Number of *mental hospitals beds* (#)

FACET 2.7	Forensic inpatient units
DEFINITION	*Beds* and *patients* in *forensic inpatient units*

ITEM 2.7.1	Availability of beds in forensic inpatient units
DEFINITION	Number of *beds* in *forensic inpatient units*, per 100 000 general population
MEASURE	Rate per 100 000 general population; UN = unknown; NA = not applicable
NUMERATOR	Number of *beds* in *forensic inpatient units*
DENOMINATOR	Number of people in the general population divided by 100 000 **(#)**

ITEM 2.7.2	Beds in forensic inpatient units by type of facility
DEFINITION	Proportion of *beds* in *forensic inpatient units* by type of facility
MEASURE	Type of facility: 1) *Mental hospitals* 2) Forensic units in *mental hospitals* 3) Forensic units in general hospitals 4) Prison mental health treatment facilities Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of *beds* in *forensic inpatient units* by type of facility
DENOMINATOR	Number of *beds* in *forensic inpatient units* **(#)**
NOTES	Prison mental health treatment facilities are mental health treatment facilities that are located within prisons.

ITEM 2.7.3	Long-stay patients in forensic units
DEFINITION	Proportion of long-stay patients by length of stay on 31 December of the last year in forensic units
MEASURE	Length of stay: 1. more than 10 years 2. 5-10 years 3. 1-4 years 4. less than 1 year Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of *patients* for each grouping of length of stay
DENOMINATOR	Number of *patients* staying in forensic units on 31 December of the last year

FACET 2.8	Other residential facilities
DEFINITION	Availability of *beds*/places in *other residential facilities* that provide care for people with mental disorders

ITEM 2.8.1	Availability of other residential facilities
DEFINITION	Number of *other residential facilities* within or outside the health system that provide care for people with mental disorders by type of facility
MEASURE	Number of residential facilities: 1. specifically for people (of any age) with mental retardation 2. specifically for youth aged 17 years and younger with mental retardation 3. specifically for people with substance abuse (including alcohol) problems (e.g. detoxification inpatient facilities) 4. specifically for people with dementia that are not mental health facilities but where, nevertheless, the majority of the people residing in the facilities have diagnosable mental disorders (e.g. mental retardation, substance abuse, dementia, epilepsy, psychosis) Number; UN = unknown
NOTES	Examples of residential facilities in the last category (#5) include facilities for the homeless or destitute, detoxification facilities run by social services, homes for widows, etc. that de facto are being used to house people with diagnosable ICD-10 mental disorders.

ITEM 2.8.2	Number of places/beds in other residential facilities
DEFINITION	Number of places/*beds* in *other residential facilities* within or outside the health system that provide care for people with mental disorders by type of facility
MEASURE	1. Places/*beds* in residential facilities specifically for people (of any age) with mental retardation 2. Places/*beds* in residential facilities specifically for youth aged 17 years and younger with mental retardation 3. Places/*beds* in residential facilities specifically for people with substance abuse (including alcohol) problems (e.g. detoxification inpatient facilities) 4. Places/*beds* in residential facilities specifically for people with dementia 5. Places/*beds* in residential facilities that formally are not mental health facilities but where, nevertheless, the majority of the people residing in the facilities have diagnosable mental disorders (e.g. mental retardation, substance abuse, dementia, epilepsy, psychosis) Number; UN = unknown; NA= not applicable
NOTES	Examples of residential facilities in the last category (#5) include facilities for the homeless or destitute, detoxification facilities run by social services, homes for widows, etc. that de facto are being used to house people with diagnosable ICD-10 mental disorders

FACET 2.9	Availability of psychosocial treatment in mental health facilities
DEFINITION	Percentage of *users* who receive psychosocial treatments

ITEM 2.9.1	Availability of psychosocial interventions in mental hospitals
DEFINITION	Percentage of *patients* who received one or more *psychosocial interventions* in mental hospitals in the last year
MEASURE	A = none (0%) B = a few (1 - 20%) C = some (21 - 50%) D = the majority (51 - 80%) E = all or almost all (81 - 100%) UN = unknown; NA = not applicable
NOTES	*Psychosocial intervention* sessions should last a minimum of 20 minutes to be counted for this item. Examples of psychosocial treatments include psychotherapy, provision of social support, counselling, rehabilitation activities, interpersonal and social skills training, and psycho-educational treatments. Do not include intake interviews, assessment, and follow-up psychopharmacology appointments as psychosocial interventions.

ITEM 2.9.2	Availability of psychosocial interventions in community-based psychiatric inpatient units
DEFINITION	Percentage of *patients* who received one or more *psychosocial intervention* in *community-based psychiatric inpatient units* in the last year
MEASURE	A = none (0%) B = a few (1 - 20%) C = some (21 - 50%) D = the majority (51 - 80%) E = all or almost all (81 - 100%) UN = unknown; NA = not applicable
NOTES	*Psychosocial intervention* sessions should last a minimum of 20 minutes to be counted for this item. Examples of psychosocial treatments include psychotherapy, provision of social support, counselling, rehabilitation activities, interpersonal and social skills training, and psycho-educational treatments. Do not include intake interviews, assessment, and follow-up psychopharmacology appointments as psychosocial interventions.

ITEM 2.9.3	Availability of psychosocial interventions in mental health outpatient facilities
DEFINITION	Percentage of *users* who received one or more *psychosocial intervention* in *mental health outpatient facilities* in the last year
MEASURE	A = none (0%) B = a few (1 - 20%) C = some (21 - 50%) D = the majority (51 - 80%) E = all or almost all (81 - 100%) UN = unknown; NA = not applicable
NOTES	*Psychosocial intervention* sessions should last a minimum of 20 minutes to be counted for this item. Examples of psychosocial treatments include psychotherapy, provision of social support, counselling, rehabilitation activities, interpersonal and social skills training, and psycho-educational treatments. Do not include intake interviews, assessment, and follow-up psychopharmacology appointments as psychosocial interventions.

FACET 2.10	Availability of psychotropic medicines
DEFINITION	Effective availability of medicines at mental health facilities at all times
NOTES	This facet covers physical availability of medicines, but not the affordability of medicines (see the facet on financing in the first domain).

ITEM 2.10.1	Availability of medicines in mental hospitals
DEFINITION	Proportion of *mental hospitals* in which at least one psychotropic medicine of each therapeutic category (antipsychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic medicines) is available in the facility all year long
MEASURE	Proportion; UN = unknown; NA= not applicable
NUMERATOR	Number of *mental hospitals* in which at least one psychotropic medicine of each therapeutic category is available
DENOMINATOR	Total number of *mental hospitals (#)*

ITEM 2.10.2	Availability of medicines in community-based psychiatric inpatient units
DEFINITION	Proportion of *community-based psychiatric inpatient units* in which at least one psychotropic medicine of each therapeutic category (antipsychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic medicines) is available in the facility all year long.
MEASURE	Proportion; UN = unknown; NA= not applicable
NUMERATOR	Number of *community-based psychiatric inpatient units* in which at least one psychotropic medicine for each therapeutic category is available
DENOMINATOR	Total number of *community-based psychiatric inpatient units* (#)

ITEM 2.10.3	Availability of medicines in mental health outpatient facilities
DEFINITION	Proportion of *mental health outpatient facilities* in which at least one psychotropic medicine of each therapeutic category (antipsychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic medicines) is available in the facility or in a nearby pharmacy all year long.
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of *mental health outpatient facilities* in which at least one psychotropic medicine of each therapeutic category is available in the facility or in a nearby pharmacy
DENOMINATOR	Total number of *mental health outpatient facilities* (#)

FACET 2.11	Equity of access to mental health services
DEFINITION	Equity of access to mental health services across different population groups

ITEM 2.11.1	Psychiatry beds located in or near the largest city
DEFINITION	Per capita ratio of the number of psychiatric *beds* in or near the largest city to the total number of psychiatric *beds* in the country (or region)
MEASURE	Ratio; UN = unknown; NA = not applicable
NUMERATOR	Number of psychiatry *beds* in *community-based psychiatric inpatient units* and the number of *mental hospital beds* in or near the largest city per 100 000 city population
DENOMINATOR	Number of psychiatric *beds* in *community-based psychiatric inpatient units* and *mental hospitals* in the entire country (or region) per 100 000 country population **(#)**
NOTES	Choose the largest city in terms of population. Include the greater metropolitan area (agglomeration) of the city to determine the largest city.

ITEM 2.11.2	Use of mental health outpatient services by rural users
DEFINITION	Proportionate use of mental health outpatient services by rural *users* in comparison to their relative population size
MEASURE	In proportion to their relative population size, rural *users* are: A = Substantially under-represented in their use of outpatient services B = Roughly equally represented in their use of outpatient services C = Substantially over-represented in their use of outpatient services UN = unknown; NA = not applicable
NOTES	• Use your own countries' definition for rural population. • In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 2.11.3	Access to mental health services for potential linguistic minority users
DEFINITION	Percentage of *mental health outpatient facilities* that employ a specific strategy to ensure that linguistic minorities can access mental health services in a language in which they are fluent
MEASURE	A = none (0%) B = a few (1 - 20%) C = some (21 - 50%) D = the majority (51 - 80%) E = all or almost all (81 - 100%) UN = unknown; NA = not applicable
NOTES	• Strategies may be formal or informal and may include: (a) provision of translation/interpreter services, (b) scheduling staff to ensure that at any given time at least one staff is present who is fluent in the relevant minority languages, or (c) providing language training for staff in minority languages, etc. • Exclude facilities where there are no or few linguistic minority people in the population (i.e. facilities for which language is not an issue). • In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 2.11.4	Use of mental health outpatient services by ethnic and religious minority groups
DEFINITION	Proportionate use of mental health outpatient services by ethnic and religious minority groups in comparison to their relative population size
MEASURE	In proportion to their relative population size, ethnic and religious minority *users* are: A = Substantially under-represented in their use of outpatient services B = Roughly equally represented in their use of outpatient services C = Substantially over-represented in their use of outpatient services UN = unknown; NA = not applicable

ITEM 2.11.5	Ethnic and religious minority group admissions to mental hospitals
DEFINITION	Proportionate number of ethnic and religious minority group admissions to *mental hospitals* in comparison to their relative population size
MEASURE	In comparison to their relative population size, ethnic and religious minority groups make up: A = Substantially larger proportion of admissions to *mental hospitals* B = Roughly equal proportion of admissions to *mental hospitals* C = Substantially smaller proportion of admissions to *mental hospitals* UN = unknown; NA = not applicable
NOTES	In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 2.11.6	Differences between government-administered and for-profit mental health care facilities
DEFINITION	On average a substantial difference (i.e.. greater than 50%) between government-administered and for-profit mental health care facilities on selected indicators of care
MEASURE	On average a substantial difference (i.e.. greater than 50%) on 1. Average duration of the waiting list for an initial non-emergency psychiatric outpatient appointment 2. Average number of minutes of an outpatient consultation with a psychiatrist 3. Average number of beds per nurse in psychiatric inpatient facilities Y/N; UN = unknown; NA = not applicable
NOTES	In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

Domain 3
MENTAL HEALTH IN PRIMARY HEALTH CARE

3.1	**Physician-based primary health care**
3.2	**Non-physician-based primary health care**
3.3	**Interaction with complementary/alternative/traditional practitioners**

FACET 3.1	**Physician-based primary health care**
DEFINITION	Training of primary health care physicians in mental health, linkage with the mental health system, and psychotropic medicines in physician-based primary health care

ITEM 3.1.1	**Undergraduate training for medical doctors**
DEFINITION	Proportion of undergraduate (first degree) training hours devoted to psychiatry and mental health-related subjects for *medical doctors*
MEASURE	Proportion; UN = unknown
NUMERATOR	Number of undergraduate (first degree) training hours devoted to psychiatry and mental health-related subjects for *medical doctors*
DENOMINATOR	Total number of undergraduate (first degree) training hours for *medical doctors* in university
NOTES	• For total number of undergraduate training hours count both theoretical lessons and practical training. • If there is more than one medical school/university, use the average across schools/universities.

ITEM 3.1.2	**Refresher training programmes for primary health care doctors**
DEFINITION	Proportion of *primary health care doctors* with at least two days of *refresher training* in psychiatry/mental health in the last year
MEASURE	Proportion; UN= not known; NA = not applicable
NUMERATOR	Number of *primary health care doctors* with at least two days of *refresher training* in psychiatry/mental health in the last year
DENOMINATOR	Total number of *primary health care doctors* working in *primary health care clinics* in the last year

ITEM 3.1.3	**Assessment and treatment protocols in physician-based primary health care**
DEFINITION	Availability of assessment and treatment protocols for key mental health conditions in *physician-based primary health care clinics*
MEASURE	Protocols are available in: A = no *physician-based primary health care clinics* (0%) B = a few *physician-based primary health care clinics* (1 - 20%) C = some *physician-based primary health care clinics* (21 - 50%) D = the majority of *physician-based primary health care clinics* (51 - 80%) E = all or almost all *physician-based primary health care clinics* (81 - 100%) UN = unknown; NA = not applicable
NOTES	• Assessment and treatment protocols include clinical guidelines, manuals, or videos on mental health for primary health care staff. They also include referral and back-referral procedures between *primary health care clinics* and mental health services. General mental health textbooks **are not** considered treatment protocols. • In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 3.1.4	Referrals between primary health care doctors and mental health professionals
DEFINITION	Full-time *primary health care doctors* who make on average at least one referral per month to a mental health professional
MEASURE	A = none (0%) B = a few (1 - 20%) C = some (21 - 50%) D = the majority (51 - 80%) E = all or almost all (81 - 100%) UN = unknown; NA = not applicable
NOTES	In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 3.1.5	Interaction of primary health care doctors with mental health services
DEFINITION	*Primary health care doctors* interacting with a mental health professional at least monthly in the last year
MEASURE	A = none (0%) B = a few (1 - 20%) C = some (21 - 50%) D = the majority (51 - 80%) E = all or almost all (81 - 100%) UN = unknown; NA = not applicable
NOTES	• Interaction includes (face-to face or telephone) meetings, review of individual cases, co-ordination of activities and of referral issues, as well as mental health training sessions. • In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 3.1.6	Prescription by primary health care doctors
DEFINITION	Health regulations authorize *primary health care doctors* to prescribe and/or to continue prescription of psychotropic medicines
MEASURE	A = not allowed B = *primary health care doctors* are allowed to prescribe but with restrictions (e.g. they are not allowed to initiate prescription but are allowed to continue prescription, or they are allowed to prescribe in emergencies only) C = *primary health care doctors* are allowed to prescribe without restrictions NA = not applicable

ITEM 3.1.7	Availability of medicines to primary health care patients in physician-based primary health care
DEFINITION	*Physician-based primary health care clinics* in which at least one psychotropic medicine of each therapeutic category (antipsychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic medicines) is available in the facility or in a nearby pharmacy all year long
MEASURE	A = none of the clinics (0%) B = a few of the clinics (1 - 20%) C = some of the clinics (21 - 50%) D = a majority of the clinics (51 - 80%) E = all or almost all of the clinics (81 - 100%) UN = unknown; NA = not applicable
NOTES	In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

FACET 3.2	Non-physician-based primary health care
DEFINITION	Training of non-physician primary health care staff in mental health, linkage with the mental health system, and psychotropic medicines in non-physician based primary health care

ITEM 3.2.1	Undergraduate training for nurses
DEFINITION	Proportion of undergraduate (first degree) training hours devoted to psychiatry and mental health-related subjects in nursing schools
MEASURE	Proportion; UN = unknown
NUMERATOR	Number of undergraduate (first degree) training hours devoted to psychiatry and mental health-related subjects in nursing schools
DENOMINATOR	Total number of undergraduate (first degree) training hours for nurses in nursing schools
NOTES	• For total number of undergraduate training hours count both theoretical lessons and practical training. • If there is more than one nursing school, use the average across nursing schools

ITEM 3.2.2	Training for non-doctor/non-nurse primary health care workers in vocational schools
DEFINITION	Proportion of training hours devoted to psychiatry and mental health-related subjects for *non-doctor/non-nurse primary health care workers* in colleges/vocational schools
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of training hours devoted to psychiatry and mental health-related subjects for *non-doctor/non-nurse primary health care workers* in colleges/vocational schools
DENOMINATOR	Number of training hours for *non-doctor/non-nurse primary health care workers* in colleges/vocational schools
NOTES	• For total number of training hours count both theoretical lessons and practical training. • If there is more than one vocational school, use the average across colleges/schools

ITEM 3.2.3	Refresher training programmes for primary health care nurses
DEFINITION	Proportion of *primary health care nurses* with at least two days of *refresher training in psychiatry/mental* health in the last year
MEASURE	Proportion; UN = not known; NA = not applicable
NUMERATOR	Number of *primary health care nurses* with at least two days of *refresher training in psychiatry/mental* health in the last year
DENOMINATOR	Total number of *primary health care nurses* working in *primary health care clinics* in the last year

ITEM 3.2.4	Refresher training programmes for non-doctor/non-nurse primary health care workers
DEFINITION	Proportion of *non- doctor /non-nurse primary health care workers* with at least two days of *refresher training in psychiatry/mental* health in the last year
MEASURE	Proportion; UN = not known; NA = not applicable
NUMERATOR	Number of *non- doctor /non-nurse primary health care workers* with at least two days of *refresher training in psychiatry/mental* health in the last year
DENOMINATOR	Total number of *non- doctor /non-nurse primary health care workers* working in *primary health care clinics* in the last year

ITEM 3.2.5	Assessment and treatment protocols in non-physician-based primary health care
DEFINITION	Availability of assessment and treatment protocols for key mental health conditions in *non-physician-based primary health care*
MEASURE	Protocols are available in: A = no *non-physician-based primary health care clinics* (0%) B = a few *non-physician-based primary health care clinics* (1 - 20%) C = some *non-physician-based primary health care clinics* (21 - 50%) D = the majority of *non-physician-based primary health care clinics* (51 - 80%) E = all or almost all *non-physician-based primary health care clinics* (81 - 100%) UN = unknown
NOTES	• Assessment and treatment protocols include clinical guidelines, manuals, or videos on mental health for primary health care staff. They also include referral and back-referral procedures between *primary health care clinics* and mental health services. General mental health textbooks **are not** considered treatment protocols. • In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 3.2.6	Mental health referrals between non-physician based primary health care to a higher level of care
DEFINITION	Full-time primary care providers in *non physician-based primary health care clinics* who make on average at least one mental health referral to a higher level of care per month
MEASURE	A = none (0%) B = a few (1 - 20%) C = some (21 - 50%) D = the majority (51 - 80%) E = all or almost all (81 - 100%) UN = unknown; NA = not applicable
NOTES	In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 3.2.7	Availability of medicines to primary health care patients in non-physician-based primary health care clinics
DEFINITION	*Non-physician-based primary health care clinics* in which at least one psychotropic medicine of each therapeutic category (antipsychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic medicines) is available in the facility or in a nearby pharmacy all year long
MEASURE	A = none of the clinics (0%) B = a few of the clinics (1 - 20%) C = some of the clinics (21 - 50%) D = a majority of the clinics (51 - 80%) E = all or almost all of the clinics (81 - 100%) UN = unknown; NA = not applicable
NOTES	In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 3.2.8	Prescription by nurses
DEFINITION	Health regulations authorize *primary health care nurses* to prescribe and/or to continue prescription of psychotropic medicines
MEASURE	A = not allowed B = *primary health care nurses* are allowed to prescribe but with restrictions (e.g. they are not allowed to initiate prescription but are allowed to continue prescription, or they are allowed to prescribe in emergencies only; they are allowed to hand-out medicines but are formally not allowed to prescribe) C = *primary health care nurses* are allowed to prescribe without restrictions NA = not applicable

ITEM 3.2.9	Prescription by non-doctor/non-nurse primary health care workers
DEFINITION	Health regulations authorize *non-doctor/ non-nurse primary health care workers* to prescribe and/or to continue prescription of psychotropic medicines
MEASURE	A = not allowed B = *non-doctor/non-nurse primary health care workers* are allowed to prescribe but with restrictions (e.g. they are not allowed to initiate prescription but are allowed to continue prescription, or they are allowed to prescribe in emergencies only; they are allowed to hand-out medicines but are formally not allowed to prescribe) C = *non-doctor/non-nurse primary health care workers* are allowed to prescribe without restrictions NA = not applicable

FACET 3.3	Interaction with complementary/alternative/traditional practitioners
DEFINITION	Interaction of primary health care and mental health facilities with complementary/ alternative/traditional practitioners

ITEM 3.3.1	Interaction of physician-based primary health care clinics with complementary/ alternative/traditional practitioners
DEFINITION	*Physician-based primary health care clinics* interacting with *complementary/ alternative/traditional practitioners* at least once in the last year
MEASURE	A = none (0%) B = a few (1 - 20%) C = some (21 - 50%) D = the majority (51 - 80%) E = all or almost all (81 - 100%) UN = unknown; NA = not applicable
NOTES	• Interaction includes meetings, review of individual cases, coordination of activities and of referral issues, as well as training complementary/alternative/traditional practitioners in relevant aspects of mental health. • In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 3.3.2	Interaction of non-physician-based primary health care clinics with complementary/alternative/traditional practitioners
DEFINITION	*Non-physician-based primary health care clinics* interacting with *complementary/ alternative/traditional practitioners* at least once in the last year
MEASURE	A = none (0%) B = a few (1 - 20%) C = some (21 - 50%) D = the majority (51 - 80%) E = all or almost all (81 - 100%) UN = unknown; NA = not applicable
NOTES	• Interaction includes meetings, review of individual cases, coordination of activities and of referral issues, as well as training complementary/alternative/traditional practitioners in relevant aspects of mental health. • In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 3.3.3	Interaction of mental health facilities with complementary/alternative/ traditional practitioners
DEFINITION	Mental health facilities interacting with *complementary alternative/traditional practitioners* at least once in the last year
MEASURE	A = none (0%) B = a few (1 - 20%) C = some (21 - 50%) D = the majority (51 - 80%) E = all or almost all (81 - 100%) UN = unknown; NA = not applicable
NOTES	• Interaction includes meetings, review of individual cases, coordination of activities and of referral issues, as well as training complementary/alternative/traditional practitioners in relevant aspects of mental health. • In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

DOMAIN 4
HUMAN RESOURCES

4.1	**Number of human resources**
4.2	**Training professionals in mental health**
4.3	**User/consumer and family associations**
4.4	**Activities of consumer associations, family associations and other NGOs**

FACET 4.1	**Number of human resources**
DEFINITION	Number of staff working in or for mental health facilities

ITEM 4.1.1	**Human resources in mental health facilities per capita**
DEFINITION	Number of human resources working in or for mental health facilities or private practice per 100 000 population by profession
MEASURE	Number of human resources working for mental health facilities or private practice: 1. *Psychiatrists* 2. Other *medical doctors*, not specialized in psychiatry, 3. *Nurses* 4. *Psychologists* 5. *Social workers* 6. *Occupational therapists* 7. *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 counsellors) Rate per 100 000 population; UN = unknown
NUMERATOR	Number of human resources
DENOMINATOR	Total number of people in the general population divided by 100 000 **(#)**
NOTES	Include mental health staff working in government-administered, NGO, for-profit mental health facilities and private practice.

ITEM 4.1.2	**Psychiatrists working in various mental health sectors**
DEFINTION	Proportion of *psychiatrists* working in various mental health sectors
MEASURE	Number of psychiatrists working**:** 1. **only** in or for government-administered mental health facilities 2. **only** in or for mental health NGOs/for-profit mental health facilities/private practice 3. in or for both (a) government-administered mental health facilities **and** in or for (b) a mental health NGO/for-profit mental health facilities/private practice (i.e. this category is for *psychiatrists* combining work in a government-administered facility and work in one of the other sectors mentioned) Proportion; UN = unknown
NUMERATOR	Number of psychiatrists working in each mental health sector
DENOMINATOR	Total number of *psychiatrists* working in mental health

ITEM 4.1.3	Psychologists, social workers, nurses, and occupational therapists working in various mental health sectors
DEFINTION	Proportion of *psychologists*, *social workers*, *nurses*, and *occupational therapists* working in or for various mental health sectors
MEASURE	Number of *psychologists*, *social workers*, *nurses*, and *occupational therapists* working: 1. **only** in or for government-administered mental health facilities 2. **only** in or for mental health NGOs/for-profit mental health facilities /private practice 3. in or for both (a) government-administered mental health facilities **and** (b) a mental health NGO/for-profit mental health facility/private practice (i.e. this category is for professionals combining work in a government-administered facility and work in one of the other sectors mentioned) Proportion; UN = unknown
NUMERATOR	Number of psychologists, social workers, nurses, and occupational therapists working In or for each mental health sector
DENOMINATOR	Total number of *psychologists*, *social workers*, *nurses*, and *occupational therapists* working in mental health

ITEM 4.1.4	Staff working in or for mental health outpatient facilities
DEFINITION	Number of full-time or part-time mental health professionals working in or for *mental health outpatient facilities*
MEASURE	Number of mental health professionals: 1. *Psychiatrists* 2. Other *medical doctors*, not specialized in psychiatry, 3. *Nurses* 4. *Psychologists*, *social workers*, and *occupational therapists* 5. *Other health or mental health workers* Number; UN = unknown
NOTES	Include mental health staff working in government-administered outpatient facilities, NGO outpatient facilities and for-profit mental health outpatient facilities. Exclude professionals engaged exclusively in private practice.

ITEM 4.1.5	Staff working in community-based psychiatric inpatient units
DEFINITION	Number of full-time or part-time mental health professionals working in *community-based psychiatric inpatient units* per *bed*
MEASURE	Number of mental health professionals: 1. *Psychiatrists* 2. Other *medical doctors*, not specialized in psychiatry, 3. *Nurses* 4. *Psychologists*, *social workers*, and *occupational therapists* 5. *Other health or mental health workers* Number of mental health professionals per *bed*; UN = unknown; NA = not applicable
NUMERATOR	Number of mental health professionals
DENOMINATOR	Number of *beds* in *community-based psychiatric inpatient units* (#)
NOTES	Include mental health staff working in government-administered *community-based psychiatric inpatient units*, NGO *community-based psychiatric inpatient units* and for-profit *community-based psychiatric inpatient units*. Exclude professionals engaged exclusively in private practice.

ITEM 4.1.6	Staff working in mental hospitals
DEFINITION	Number of full-time or part-time mental health professionals per *mental hospital bed*
MEASURE	Number of mental health professionals: 1. *Psychiatrists* 2. Other *medical doctors*, not specialized in psychiatry, 3. *Nurses* 4. *Psychologists*, *social workers*, and *occupational therapists* 5. *Other health or mental health workers* Proportion; UN=unknown; NA= not applicable
NUMERATOR	Number of mental health professionals
DENOMINATOR	Number of *mental hospital beds* (#)
NOTES	Include mental health staff working in government-administered mental hospitals, NGO mental hospitals and for-profit mental hospitals. Exclude professionals engaged exclusively in private practice.

ITEM 4.1.7	Psychiatrists working in or near the largest city
DEFINITION	Per capita ratio of *psychiatrists* working in mental health facilities that are based in or near the largest city to the total number of *psychiatrists* working in mental health facilities in the country (or region)
MEASURE	Ratio; UN = unknown; NA = not applicable
NUMERATOR	Number of *psychiatrists* working in mental health facilities that are based in or near the largest city per 100 000 city population
DENOMINATOR	Number of *psychiatrists* working in mental health facilities in the entire country (or region) per 100 000 country population
NOTES	Choose the largest city in terms of population. Include the greater metropolitan area (agglomeration) of the city to determine the largest city. Exclude professionals engaged exclusively in private practice.

ITEM 4.1.8	Nurses working in or for mental health facilities in or near the largest city
DEFINITION	Per capita ratio of *nurses* working in or for mental health facilities that are based in or near the largest city to the total number of *nurses* working in or for mental health facilities in the country (or region)
MEASURE	Ratio; UN = unknown; NA = not applicable
NUMERATOR	Number of *nurses* working in mental health facilities that are based in or near the largest city per 100 000 city population
DENOMINATOR	Number of *nurses* working in mental health facilities in the entire country (or region) per 100 000 country population
NOTES	Choose the largest city in terms of population. Include the greater metropolitan area (agglomeration) of the city to determine the largest city.

FACET 4.2	Training professionals in mental health
DEFINITION	Aspects of training professionals in mental health

ITEM 4.2.1	Professionals graduated last year
DEFINITION	Number of professionals graduated in the last year in academic and educational institutions, per 100 000 general population
MEASURE	Number of mental health professionals: *1. Medical doctors* *2. Nurses* *3. Psychiatrists* 4. *Psychologists* with at least 1 year training in mental health care 5. *Nurses* with at least 1 year training in mental health care *Social workers* with at least 1 year training in mental health care *Occupational therapists* with at least one year training in mental health care Rate per 100 000 general population; UN = unknown; NA = not applicable
NUMERATOR	Number of professionals graduated in the last year
DENOMINATOR	Number of people in the general population divided by 100 000 **(#)**

ITEM 4.2.2	Refresher training for mental health staff on the rational use of psychotropic drugs
DEFINITION	Proportion of mental health staff working in or for mental health facilities with at least two days of *refresher training* on the rational use of psychotropic drugs in the last year
MEASURE	Number of mental health professionals: *1. Psychiatrists* 2. *Other medical doctors*, not specialized in psychiatry, *3. Nurses* 4. *Other health mental health workers* UN = unknown; NA = not applicable
NUMERATOR	Number of mental health staff by professional role working in or for mental health facilities with at least two days of *refresher training* on the rational use of psychotropic drugs in the last year
DENOMINATOR	Number of mental health staff by professional role working in or for mental health facilities **(#)**
NOTES	One day training is equivalent to 8 hours

ITEM 4.2.3	Refresher training for mental health staff in psychosocial (non-biological) interventions
DEFINITION	Proportion of mental health staff working in or for mental health facilities with at least two days of *refresher training* on *psychosocial* (non-biological) *interventions* in the last year
MEASURE	Number of mental health professionals: *1. Psychiatrists* 2. *Other medical doctors*, not specialized in psychiatry, *3. Nurses* *4. Psychologists, social workers, and occupational therapists* *5. Other health or mental health workers* Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of mental health staff by professional role, working in or for mental health facilities with at least two days of *refresher training* on *psychosocial* (non-biological) *interventions*
DENOMINATOR	Number of mental health staff by professional role working in or for mental health facilities in the last year (#)
NOTES	• One day training is equivalent to 8 hours. • Examples of *psychosocial* (non-biological) *interventions* are psychotherapy, provision of social support, counselling, rehabilitation activities, interpersonal and social skills training, and psycho-educational treatments. Do not include intake interviews, assessment, and follow-up psychopharmacology appointments as psychosocial interventions. • *Refresher training* includes in-service training provided by facilities as well as "continuing education credits" provided by professional organizations.

Reminders: - All questions are for the previous, full calendar year, unless otherwise specified.
- *Italicized* terms are defined in the 'frequently used terms' section (pages 11-14).

ITEM 4.2.4	Refresher training for mental health staff on child and adolescent mental health issues
DEFINITION	Proportion of mental health staff working in or for mental health facilities with at least two days of *refresher training* in the last year on child and adolescent mental health issues
MEASURE	Number of mental health professionals: *1. Psychiatrists* 2. *Other medical doctors*, not specialized in psychiatry, *3. Nurses* *4. Psychologists, social workers and occupational therapists* *5. Other health or mental health workers* Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of mental health staff by professional role, working in or for mental health facilities with at least two days of *refresher training* on child and adolescent mental health issues
DENOMINATOR	Number of mental health staff by professional role working in or for mental health facilities in the last year (#)
NOTES	• One day training is equivalent to 8 hours. • Examples of training on child and adolescent mental health issues include training on assessment and treatment of psychiatric disorders, developmental issues, learning disabilities, etc. • *Refresher training includes* in-service training provided by facilities as well as "continuing education credits" provided by professional organizations

ITEM 4.2.5	Psychiatrists emigrated to other countries
DEFINITION	Proportion of *psychiatrists* who emigrate to other countries within 5 years of the completion of their training
MEASURE	A= none (0%) B = a few (1 - 20%) C = some (21 - 50%) D = the majority (51 - 80%) E = all or almost all (81 - 100%) UN = unknown; NA = not applicable (e.g. no *psychiatrist* completed their training in the last five years)
NOTES	In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

FACET 4.3	User/consumer associations and family associations
DEFINITION	Membership and support for *user/consumer* associations and family associations

ITEM 4.3.1	Members of user/consumer associations
DEFINITION	Aggregate number of *users/consumers* that are members of *consumer* associations
MEASURE	Number; UN = unknown
NOTES	Avoid, if possible, double counting of *consumer* associations/members (e.g. members of regional associations may also be members of national/federal associations).

ITEM 4.3.2	Members of family associations
DEFINITION	Aggregate number of family members that are members of family associations
MEASURE	Number; UN = unknown
NOTES	• Avoid, if possible, double counting of family associations/members (e.g. members of regional associations may also be members of national/federal associations). • Family refers to the *user/consumer*'s family or extended family regardless of whether or not there is a legally defined relationship.

Reminders: - All questions are for the previous, full calendar year, unless otherwise specified.
- *Italicized* terms are defined in the 'frequently used terms' section (pages 11-14).

ITEM 4.3.3	Government economic support for user/consumer initiatives
DEFINITION	Government provides economic support to *user/consumer* associations for mental health initiatives
MEASURE	Y/N; UN = unknown
NOTES	Include financial support as well as in-kind support (e.g. continuous use of premises).

ITEM 4.3.4	Government economic support for family initiatives
DEFINITION	Government provides economic support to family associations for mental health initiatives
MEASURE	Y/N; UN = unknown
NOTES	Include financial support as well as in-kind support (e.g. continuous use of premises).

FACET 4.4	Activities of user/consumer associations, family associations and other NGOs
DEFINITION	Range of activities of *user/consumer* associations, family associations and other NGOs involved in mental health

ITEM 4.4.1	User/consumer associations and mental health policies, plans or legislation
DEFINITION	Involvement of *user/consumer* associations in the formulation or implementation of mental health policies, plans or legislation in the last two years
MEASURE	Y/N; UN = unknown; NA = not applicable

ITEM 4.4.2	Family associations involvement in mental health policies, plans or legislation
DEFINITION	Involvement of family associations in the formulation or implementation of mental health policies, plans or *legislation* in the last two years
MEASURE	Y/N; UN = unknown; NA = not applicable

ITEM 4.4.3	Interaction of mental health services with user/consumer associations
DEFINITION	Mental health facilities interacting with *user/consumer* associations in the last year
MEASURE	A = no interaction (0% of facilities) B = a few facilities have had interaction (1-20% of facilities) C = some facilities have had interaction (21-50% of facilities) D = a majority of facilities have had interaction (51-80% of facilities) E = all or almost all facilities have had interaction (81-100% of facilities) UN = unknown; NA = *user/consumer* associations do not exist
NOTES	In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 4.4.4	Interaction of mental health services with family associations
DEFINITION	Mental health facilities interacting with *family* associations in the last year
MEASURE	A = no interaction (0% of facilities) B = a few facilities have had interaction (1-20% of facilities) C = some facilities have had interaction (21-50% of facilities) D = a majority of facilities have had interaction (51-80% of facilities) E = all or almost all facilities have had interaction (81-100% of facilities) UN = unknown; NA = family associations do not exist
NOTES	In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

Reminders: - All questions are for the previous, full calendar year, unless otherwise specified.
- *Italicized* terms are defined in the 'frequently used terms' section (pages 11-14).

ITEM 4.4.5	User/consumer association involvement in community and individual assistance activities
DEFINITION	Number of *user/consumer* associations involved in community and individual assistance activities (e.g. counselling, housing, support groups, etc.)
MEASURE	Number; UN = unknown; NA = not applicable

ITEM 4.4.6	Family association involvement in community and individual assistance activities
DEFINITION	Number of family associations involved in community and individual assistance activities (e.g. counselling, housing, support groups, etc.)
MEASURE	Number; UN = unknown; NA = not applicable

ITEM 4.4.7	Other NGOs involved in policies, legislation, or mental health advocacy
DEFINITION	Number of **other** NGOs involved in policies, legislation, or mental health advocacy
MEASURE	Number; UN = unknown; NA = not applicable
NOTES	• Other NGOs refer to non-governmental organizations that conduct activities related to mental health and employ at least one full-time staff member who is a mental health worker. Examples of such NGOs may include: centres that provide care to rape survivors; walk-in centres for homeless people; centres specialized in specific disorders; half-way houses for battered women. • Mental health advocacy refers to various actions aimed at changing the major structural and attitudinal barriers to achieving positive mental health. These typically include promotion of human rights of people with mental disorders, efforts to reduce stigmatizing and discrimination and enhancing attention to the mental health needs and rights of general population.

ITEM 4.4.8	Other NGOs involved in community and individual assistance activities
DEFINITION	Number of **other** NGOs involved in community and individual assistance activities (e.g. counselling, housing, support groups, etc.)
MEASURE	Number; UN = unknown; NA = not applicable
NOTES	Other NGOs refer to those non-governmental organizations - that are neither *user/consumer* associations nor family associations - that conduct activities related to mental health and employ at least one full-time staff member who is a mental health worker. Examples of such NGOs may include: centres that provide care to rape survivors; walk-in centres for homeless people; centres specialized in specific disorders; half-way houses for battered women.

DOMAIN 5
Public Education and Links With Other Sectors

5.1	**Public education and awareness campaigns on mental health**
5.2	**Links with other sectors: formal collaboration**
5.3	**Links with other sectors: activities**

FACET 5.1	**Public education and awareness campaigns on mental health**
DEFINITION	Specification of activities, methods and targeted populations in educational and awareness campaigns on mental health

ITEM 5.1.1	**Coordinating bodies for public education and awareness campaigns on mental health**
DEFINITION	Existence of coordinating bodies (e.g. committees, boards, offices) that coordinate and oversee *public education and awareness campaigns* on mental health and mental disorders
MEASURE	Y/N; UN = unknown

ITEM 5.1.2	**Agencies promoting public education and awareness campaigns on mental health**
DEFINITION	Agencies, institutions, or services who have promoted *public education and awareness campaigns* on mental health and mental disorders in the last five years
MEASURE	1. Government agencies (e.g. Ministry of Health or Department of Mental Health Services) 2. NGOs 3. Professional associations 4. Private trusts and foundations 5. International agencies Y/N; UN = unknown

ITEM 5.1.3	**Populations targeted by specific education and awareness campaigns on mental health**
DEFINITION	*Public education and awareness campaigns* on mental health targeted at the general population and specific groups within the general population in the last five years
MEASURE	Campaigns exist targeted at: 1. The general population 2. Children 3. Adolescents 4. Women 5. Trauma survivors 6. Ethnic groups 7. Other vulnerable or minority groups Y/N; UN = unknown

ITEM 5.1.4	Professional groups targeted by specific education and awareness campaigns on mental health
DEFINITION	*Public education and awareness campaigns* on mental health targeted at professional groups linked to the health sector in the last five years
MEASURE	Campaigns exist targeted at: 1. Health care providers (conventional, modern, allopathic) 2. Complementary/alternative/traditional sector 3. Teachers 4. Social services staff 5. Leaders and politicians 6. Other professional groups linked to the health sector Y/N; NA= not applicable; UN = unknown

FACET 5.2	Links with other sectors: formal collaboration
DEFINITION	Formal collaboration in the form of laws, administration, and programmes with (other) health and non-health sectors aimed at improving mental health

ITEM 5.2.1	Legislative provision for employment
DEFINITION	Existence of legislative provisions concerning a legal obligation for employers to hire a certain percentage of employees that are disabled
MEASURE	A = no such legislative provisions exist B = legislative provisions exist but are not enforced C = legislative provisions exist and are enforced
NOTES	Only include if the legislation includes those with mental disabilities (i.e. either there is specific legislation pertaining to mental disabilities, or the legislation on disabilities includes those with mental disabilities).

ITEM 5.2.2	Legislative provision against discrimination at work
DEFINITION	Existence of legislative provisions concerning protection from discrimination (dismissal, lower wages) solely on account of mental disorder
MEASURE	A = no such legislative provisions exist B = legislative provisions exist but are not enforced C = legislative provisions exist and are enforced

ITEM 5.2.3	Legislative or financial provisions for housing
DEFINITION	Existence of legislative or financial provisions concerning priority in state housing and in subsidized housing schemes for people with severe mental disorder
MEASURE	A = no such legislative or financial provisions exist B = legislative or financial provisions exist but are not enforced C = legislative or financial provisions exist and are enforced
NOTES	The definition of severe mental disorder will vary across countries and settings. In most countries, severe mental disorder is considered to cover schizophrenia, other psychoses, bipolar disorder, and major depression.

ITEM 5.2.4	Legislative or financial provisions against discrimination in housing
DEFINITION	Existence of legislative or financial provisions concerning protection from discrimination in allocation of housing for people with severe mental disorder
MEASURE	A = no such legislative or financial provisions exist B = legislative or financial provisions exist but are not enforced C = legislative or financial provisions exist and are enforced
NOTES	The definition of severe mental disorder will vary across countries and settings. In most countries, severe mental disorder is considered to cover schizophrenia, other psychoses, bipolar disorder, and major depression.

Reminders: - All questions are for the previous, full calendar year, unless otherwise specified.
- *Italicized* terms are defined in the 'frequently used terms' section (pages 11-14).

ITEM 5.2.5	Formal collaborative programmes with other health and non-health agencies/departments
DEFINTION	Formal collaborative programmes addressing the needs of people with mental health issues between (a) the department/agency responsible for mental health and (b) the department/agency responsible for:
MEASURE	1. Primary health care/community health 2. HIV/AIDS 3. Reproductive health 4. Child and adolescent health 5. Substance abuse 6. Child protection 7. Education 8. Employment 9. Housing 10. Welfare 11. Criminal justice 12. The elderly 13. Other departments/agencies (specify in comments section) Y/N; NA = not applicable
NOTES	A formal collaborative programme is defined here as a programme that involves (a) a written agreement of collaboration and/or (b) a joint activity or publication.

FACET 5.3	**Links with other sectors: activities**
DEFINITION	Extent of activities outside the mental health sector that address the needs of people with mental health issues

ITEM 5.3.1	Provision of employment for people with severe mental disorder
DEFINITION	Provision of employment for people with severe mental disorder through activities outside the mental health facility
MEASURE	Users have access to programmes that provide outside employment for users at: A= no mental health facilities (0%) B = a few mental health facilities (1-20%) C = some mental health facilities (21-50%) D = majority of mental health facilities (51%-80%) E = all or almost all (81%-100%) UN = unknown
NOTES	• Exclude work that takes place on the premises of mental health facilities (e.g. sheltered workshops). • In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 5.3.2	Primary and secondary schools with mental health professionals
DEFINITION	Proportion of primary and secondary schools with either a part-time or full-time mental health professional (e.g. *psychologist*, *social worker*, *nurse* specialized in mental health)
MEASURE	Proportion; UN = unknown
NUMERATOR	Total number of primary and secondary schools with either a part-time or full-time mental health professional (e.g. *psychologist*, *social worker*, *nurse* specialized in mental health)
DENOMINATOR	Total number of primary and secondary schools

ITEM 5.3.3	Promotion and prevention activities in primary and secondary schools
DEFINITION	School-based activities to promote mental health and to prevent mental disorders
MEASURE	Promotion or prevention activities are provided in: A= no primary and secondary schools (0%) B = a few primary and secondary schools (1%-20%) C = some primary and secondary schools (21%-50%) D = majority of primary and secondary schools (51%-80%) E = all or almost all primary and secondary schools (81%-100%) UN = unknown
NOTES	• Promotion and prevention activities include all organized activities aimed at promoting mental health and/or preventing the occurrence as well as the progression of mental disorders. Examples of activities include those aimed at improving: (a) social skills, (b) emotional communication, (c) stress management, and (d) skills for coping with adversity. • In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 5.3.4	Educational activities with police officers
DEFINITION	Police officers participating in educational activities on mental health in the last five years
MEASURE	A= no police officers (0%) B = few police officers (1%-20%) C = some police officers (21%-50%) D = majority of police officers (51%-80%) E = all or almost all police officers (81%-100%) UN = unknown
NOTES	• Educational activities include trainings, educational meetings, or sessions to build practical skills. • In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 5.3.5	Educational activities with judges and lawyers
DEFINITION	Judges and lawyers participating in educational activities on mental health in the last five years
MEASURE	A= no judges and lawyers (0%) B = few judges and lawyers (1%-20%) C = some judges and lawyers (21%-50%) D = majority of judges and lawyers (51%-80%) E = all or almost all judges and lawyers (81%-100%) UN = unknown
NOTES	• Educational activities include trainings, educational meetings, or sessions to build practical skills • In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 5.3.6	Persons with psychosis in prisons
DEFINITION	Percentage of prisoners with psychosis
MEASURE	A = less than 2% B = 2-5 % C = 6-10% D = 11-15% E = greater than 15% UN= unknown; NA= not applicable
NOTES	In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

Reminders: - All questions are for the previous, full calendar year, unless otherwise specified.
- *Italicized* terms are defined in the 'frequently used terms' section (pages 11-14).

ITEM 5.3.7	Persons with mental retardation in prisons
DEFINITION	Percentage of prisoners with mental retardation
MEASURE	A = less than 2% B = 2-5 % C = 6-10% D = 11-15% E = greater than 15% UN= unknown; NA= not applicable
NOTES	In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 5.3.8	Mental health care of prisoners
DEFINITION	Prisons with at least one prisoner per month in treatment contact with a mental health professional, either within the prison or outside in the community
MEASURE	A = no prisons (0%) B = a few prisons (1 - 20%) C = some prisons (21 - 50%) D = majority of prisons (51 - 80%) E = all or almost all prisons (81 - 100%) UN = unknown
NOTES	In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 5.3.9	Social welfare benefits
DEFINITION	Proportion of people who received social welfare benefits because of disability due to mental disorder
MEASURE	Proportion; UN = unknown; NA = not applicable (e.g. disability benefits do not exist for any type of disability)
NUMERATOR	Number of people who received social welfare benefits because of disability due to mental disorder
DENOMINATOR	Number of people who received social welfare benefits because of disability due to any mental or physical disorder
NOTES	Social welfare benefits are benefits from public funds that are payable, as part of a legal right, to people with health conditions that reduce a person's capacity to function. These are often known as disability pensions.

DOMAIN 6
MONITORING AND RESEARCH

6.1	**Monitoring mental health services**
6.2	**Mental health research**

FACET 6.1	**Monitoring mental health services**
DEFINITION	Routine collection and reporting of key data by mental health facilities

ITEM 6.1.1	**Formally defined minimum data set items**
DEFINITION	There is a formally defined list of individual data items that ought to be collected by all mental health facilities
MEASURE	Y/N; UN = unknown

ITEM 6.1.2	**Mental health information systems in mental hospitals**
DEFINITION	Proportion of *mental hospitals* routinely collecting and compiling data by type of information
MEASURE	1. Number of *beds* 2. Number of inpatient admissions 3. Number of days spent in hospital 4. Number of involuntary inpatient admissions 5. Number of *users* who are physically restrained or secluded 6. Diagnoses Proportion; UN = unknown; NA = not applicable (e.g. no mental hospitals exist)
NUMERATOR	Number of *mental hospitals* collecting data (for each type of information) routinely
DENOMINATOR	Total number of *mental hospitals* **(#)**
NOTES	Routine collecting and compiling data means that data are collected, compiled, and are available at one place in the hospital all year long.

ITEM 6.1.3	**Mental health information systems in community-based psychiatric inpatient units**
DEFINITION	Proportion of *community-based psychiatric inpatient units* routinely collecting and compiling data by type of information
MEASURE	1. Number of *beds* 2. Number of inpatient admissions 3. Number of days spent in hospital 4. Number of involuntary inpatient admissions 5. Number of *patients* who are physically restrained or secluded 6. Diagnoses Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of *community-based psychiatric inpatient units* collecting and compiling data (for each type of information) routinely
DENOMINATOR	Total number of *community-based psychiatric inpatient units* **(#)**

ITEM 6.1.4	Mental health information systems in mental health outpatient facilities
DEFINITION	Proportion of *mental health outpatient facilities* routinely collecting and compiling data by each type of information
MEASURE	1. Number of *users* treated 2. Number of *user* contacts 3. Diagnoses UN = unknown; NA = not applicable
NUMERATOR	Number of *mental health outpatient facilities* routinely collecting and compiling data (for each type of information)
DENOMINATOR	Total number of *mental health outpatient facilities* **(#)**
NOTES	An outpatient contact is an interaction (e.g. a treatment session, an intake interview) involving a *user* and a staff member on an outpatient basis.

ITEM 6.1.5	Data transmission from mental health facilities
DEFINITION	Proportion of mental health facilities from which the government health department received data in the last year
MEASURE	*1. Mental hospitals* *2. Community-based psychiatric inpatient units* *3. Mental health outpatient facilities* Proportion; UN = unknown; NA = not applicable
NUMERATOR	Number of mental health facilities which transmitted data to the government health department in the last year (for each type of facility)
DENOMINATOR	Total number of mental health facilities (for each type of facility) **(#)**

ITEM 6.1.6	Report on mental health services by the government health department
DEFINITION	A report covering mental health data has been published by the government health department in the last year
MEASURE	A = No report B = Mental health data have been published in a report without comments on the data C = Mental health data have been published in a report with comments on the data UN = unknown

FACET 6.2	Mental health research
DEFINITION	Extent and content of mental health research

ITEM 6.2.1	Professionals involved in mental health research
DEFINITION	Mental health professionals working in mental health services who in the last five years have been involved in mental health research as a investigator or co-investigator (including through a thesis or dissertation): 1. *Psychiatrists* working in mental health services 2. *Nurses* working in mental health services 3. *Psychologists* working in mental health services 4. *Social workers* working in mental health services
MEASURE	Percentage of professionals involved for each professional category: A = none (0%) B = few (1-20%) C = some (21%-50%) D = the majority (51%-80%) E = all or almost all (81%-100%) UN = unknown
NOTES	In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

Reminders: - All questions are for the previous, full calendar year, unless otherwise specified.
- *Italicized* terms are defined in the 'frequently used terms' section (pages 11-14).

ITEM 6.2.2	Proportion of health research that is on mental health
DEFINITION	Proportion of indexed publications that are on mental health in the last five years
MEASURE	Proportion; UN = unknown
NUMERATOR	Total number of mental health publications on the country or region in the last five years as identified on PubMed
DENOMINATOR	Total number of health publications on the country or region in the last five years as identified on PubMed
NOTES	• Studies need to involve respondents of the country or region. Investigators may be national or foreign researchers. • The website of PubMed is: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi

ITEM 6.2.3	Type of mental health research
DEFINITION	Type of mental health research that was conducted in the last five years
MEASURE	1. Epidemiological studies in community samples 2. Epidemiological studies in clinical samples 3. Non-epidemiological clinical/questionnaires assessments of mental disorders 4. Services research 5. Biology and genetics 6. Policy, programmes, financing/economics 7. *Psychosocial interventions*/psychotherapeutic interventions 8. Pharmacological, surgical and electroconvulsive interventions Y/N; UN = unknown
NOTES	• Studies need to involve respondents of the country or region. Investigators may be national or foreign researchers. • Include research that is published in 'grey' literature (not published in scientific journals), national or international indexed and non-indexed journals, government reports, books and (other) monographs.

BRIEF VERSION OF ITEMS FOR WHO-AIMS 2.2

ITEM CODE	ITEM TITLE
B1 - 1.1.1	Last version of mental health policy
B2 - 1.1.3	Psychotropic medicines included on the essential medicines list
B3 - 1.2.1	Last version of the mental health plan
B4 - 1.3.1	Last version of mental health legislation
B5 - 1.4.2	Inspecting human rights in mental hospitals
B6 - 1.5.1	Mental health expenditures by the government health department
B7 - 1.5.2	Expenditures on mental hospitals
B8 - 1.5.4	Free access to essential psychotropic medicines
B9 - 2.1.1	Existence and functions of a national or regional 'mental health authority'
B10 - 2.1.2	Organization of mental health services in terms of catchment areas/service areas
B11 - 2.2.1	Availability of mental health outpatient facilities
B12 - 2.2.2	Users treated through mental health outpatient facilities
B13 - 2.2.6	Children and adolescents treated through mental health outpatient facilities
B14 - 2.3.2	Users treated in day treatment facilities
B15 - 2.4.1	Availability of community-based psychiatric inpatient units
B16 - 2.4.2	Beds in community-based psychiatric inpatient units
B17 - 2.4.6	Time spent in community-based psychiatric inpatient units per discharge
B18 - 2.5.2	Beds/places in community residential facilities
B19 - 2.6.2	Availability of mental hospital beds
B20 - 2.6.3	Change in beds in mental hospitals
B21 - 2.6.6	Involuntary admissions to mental hospitals
B22 - 2.6.7	Long-stay patients in mental hospitals
B23 - 2.6.10	Physical restraint and seclusion in mental hospitals
B24 - 2.7.3	Long-stay patients in forensic units
B25 - 2.8.2	Number of beds/places in other residential facilities
B26 - 2.9.1	Availability of psychosocial interventions in mental hospitals
B27 - 2.9.3	Availability of psychosocial interventions in mental health outpatient facilities
B28 - 2.10.1	Availability of medicines in mental hospitals
B29 - 2.10.3	Availability of medicines in mental health outpatient facilities
B30 - 2.11.1	Psychiatry beds located in or near the largest city
B31 - 3.1.2	Refresher training programmes for primary health care doctors
B32 - 3.1.5	Interaction of primary health care doctors with mental health services
B33 - 3.1.7	Availability of medicines to primary health care patients in physician-based primary health care
B34 - 3.2.3	Refresher training programmes for primary health care nurses
B35 - 3.2.4	Refresher training programmes for non-doctor/non-nurse primary health care workers
B36 - 3.2.6	Mental health referrals between non-physician based primary health care to a higher level of care
B37 - 3.3.3	Interaction of mental health facilities with complementary/alternative/ traditional practitioners
B38 - 4.1.1	Human resources in mental health facilities per capita
B39 - 4.1.4	Staff working in or for mental health outpatient facilities
B40 - 4.1.5	Staff working in community-based psychiatric inpatient units
B41 - 4.1.6	Staff working in mental hospitals
B42 - 4.2.2	Refresher training for mental health staff on the rational use of psychotropic drugs
B43 - 4.2.3	Refresher training for mental health staff in psychosocial (non-biological) interventions
B44 - 4.4.1	User/consumer associations and mental health policies, plans or legislation
B45 - 4.4.2	Family associations involvement in mental health policies, plans or legislation

Reminders: - All questions are for the previous, full calendar year, unless otherwise specified.
- *Italicized* terms are defined in the 'frequently used terms' section (pages 11-14).

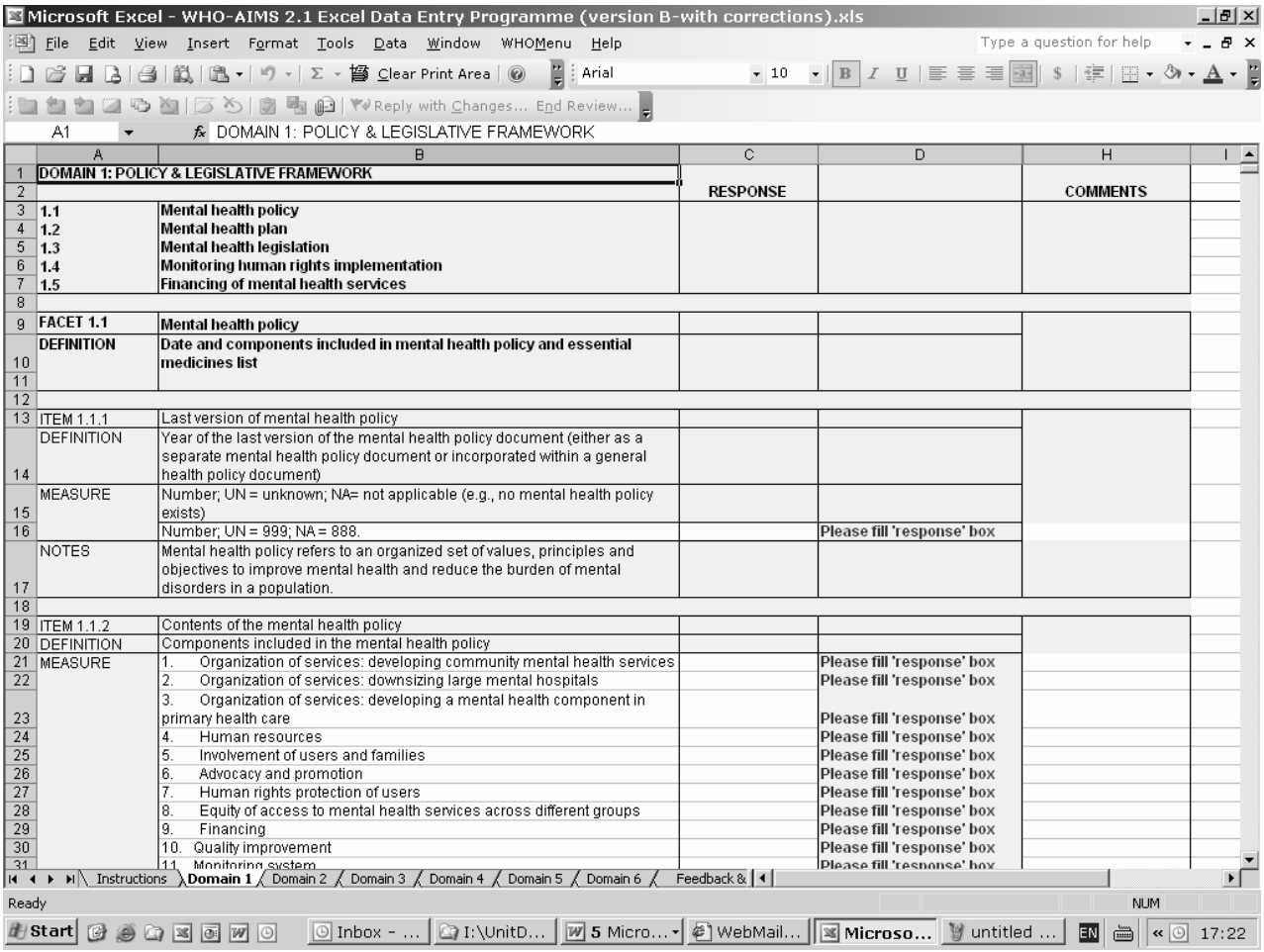
B46 - 4.4.8	Other NGOs involved in community and individual assistance activities
B47 - 5.1.4	Professional groups targeted by specific education and awareness campaigns on mental health
B48 - 5.3.1	Provision of employment for people with serious mental disorders
B49 - 5.3.2	Primary and secondary schools with mental health professionals
B50 - 5.3.8	Mental health care of prisoners
B51 - 5.3.9	Social welfare benefits
B52 - 6.1.5	Data transmission from mental health facilities
B53 - 6.1.6	Report on mental health services by the government health department
B54 - 6.2.2	Proportion of health research that is on mental health

WHO-AIMS 2.2 EXCEL DATA ENTRY PROGRAMME

The WHO-AIMS Excel Data Entry Programme is used to enter data collected for WHO-AIMS items. The programme automatically calculates percentages and ratios for the quantitative items and thus simplifies the data collection process for the country focal point person and eliminates the chance of computation errors. The programme has also been designed to alert the focal point person to possible data entry errors if an improbable value is entered (e.g. a greater number of outpatients are reported than outpatient contacts). Detailed instructions are provided to guide the country focal point person through the data entry process. Also included is a "question and answer" section.

An example of how the programme looks when it is opened appears below. Across the bottom of the screen there are seven different tabs labelled "Instructions, Domain1, Domain 2, Domain 3, Domain 4, Domain 5, Domain 6". These tabs are called "sheets" and each "sheet" corresponds to a different domain. The item number and description appear in the first and second column, and data are directly entered into the third column (has a C and the word 'response' at the top of the column). After a value has been entered, the words "please fill response box" in the fourth column will disappear. The fifth column (with the column heading "comments") is a place reserved for the focal point person to record any comments related to the item (e.g. this is a place where the focal point person can record the data source for the item).

To obtain a copy of the WHO-AIMS Excel Data Entry Programme please contact the WHO-AIMS team in Geneva.



	A	B	C	D	H	I
1	DOMAIN 1: POLICY & LEGISLATIVE FRAMEWORK					
2			RESPONSE		COMMENTS	
3	1.1	Mental health policy				
4	1.2	Mental health plan				
5	1.3	Mental health legislation				
6	1.4	Monitoring human rights implementation				
7	1.5	Financing of mental health services				
8						
9	FACET 1.1	Mental health policy				
10	DEFINITION	Date and components included in mental health policy and essential medicines list				
11						
12						
13	ITEM 1.1.1	Last version of mental health policy				
14	DEFINITION	Year of the last version of the mental health policy document (either as a separate mental health policy document or incorporated within a general health policy document)				
15	MEASURE	Number; UN = unknown; NA= not applicable (e.g., no mental health policy exists)				
16		Number; UN = 999; NA = 888.		Please fill 'response' box		
17	NOTES	Mental health policy refers to an organized set of values, principles and objectives to improve mental health and reduce the burden of mental disorders in a population.				
18						
19	ITEM 1.1.2	Contents of the mental health policy				
20	DEFINITION	Components included in the mental health policy				
21	MEASURE	1. Organization of services: developing community mental health services		Please fill 'response' box		
22		2. Organization of services: downsizing large mental hospitals		Please fill 'response' box		
23		3. Organization of services: developing a mental health component in primary health care		Please fill 'response' box		
24		4. Human resources		Please fill 'response' box		
25		5. Involvement of users and families		Please fill 'response' box		
26		6. Advocacy and promotion		Please fill 'response' box		
27		7. Human rights protection of users		Please fill 'response' box		
28		8. Equity of access to mental health services across different groups		Please fill 'response' box		
29		9. Financing		Please fill 'response' box		
30		10. Quality improvement		Please fill 'response' box		
31		11. Monitoring system		Please fill 'response' box		

TEMPLATE AND GUIDANCE DOCUMENT FOR WRITING COUNTRY REPORTS

The *WHO-AIMS Template and Guidance Document for Writing Country Reports* provides a structure for writing country reports based on WHO-AIMS data. A summary of this document is provided, as well as an example of a country report produced using this document (see appendix A). To obtain the complete Template and Guidance Document, please contact the WHO-AIMS team in Geneva.

The purpose of the Template and Guidance Document is to facilitate the report writing process. By using this document it should be possible to write a country report in approximately one day. The document contains the following core components:

1. **Introduction** (1 page): The introduction provides a brief overview of the country situation and health infrastructure.
2. **Domain summaries** (2 to 2 ½ pages per domain): This section constitutes the bulk of the report and provides a summary of the data for each domain. A detailed template provides the structure for writing the domain summaries (see example below).
3. **Executive summary and next steps in planning mental health action** (2 pages): The executive summary includes a very brief overview of the data for each domain (3-4 sentences on each domain) along with an analysis of the strengths and weaknesses of the mental health system.

WHO-AIMS Template: An Example

The template provides a structure for writing the domain summaries. Under each domain heading there are separate paragraphs on different topics. In the example below, the paragraph is on the financing of mental health services. Information or data that should be included in this paragraph are outlined by numbered points. A sample paragraph is also provided to demonstrate how the specific numbered points will be combined to constitute a paragraph. In addition, graphs are provided along with a list of data sources that are needed to complete each graph. All information provided in the examples is fictitious.

It is recommended that the focal point person uses the template as a basis for the report but also includes additional information not assessed in WHO-AIMS but nevertheless is relevant for planning purposes (e.g. details on notable variations within country/region, possible reasons for the present state, recent trends, significant events, future plans, significant barriers and facilitators to progress). The focal point person is also encouraged to add sentences or to make wording changes in order to make the sentences and paragraphs more readable.

An example of the template drawn from Domain 1

Domain 1: Policy and Legislative Framework

Financing of mental health services

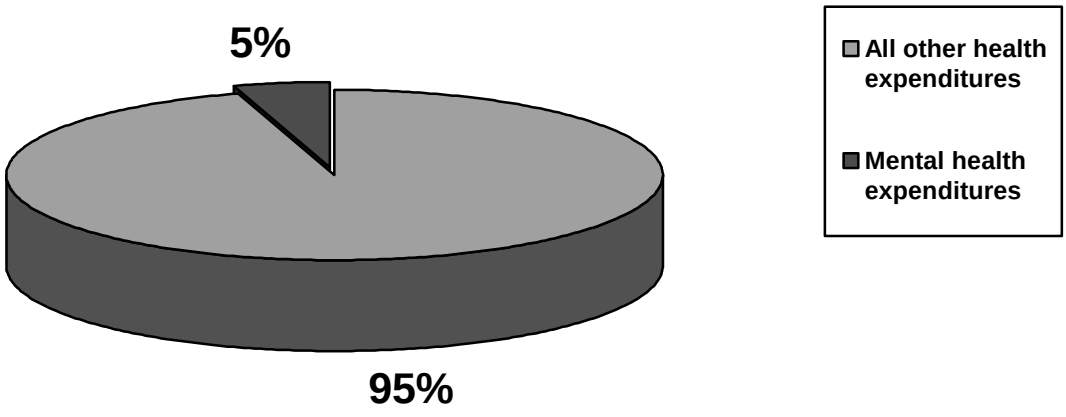
1. [Insert percentage from item 1.5.1] of health care expenditures by the government health department that are directed towards mental health.

2a. Of all the expenditures spent on mental health, [insert percentage from item 1.5.2] are directed towards mental hospitals.
2b. Also put data into graph 1.1
3. [Insert percentage from item 1.5.4] of the population has free access (at least 80% of the cost covered) to essential psychotropic medicines.
4. For those that pay out of pocket, the cost of antipsychotic medication is [insert data from item 1.5.5] and antidepressant medication is [insert data from item 1.5.6].
5. [Insert data from item 1.5.3] are covered in social insurance schemes.
6. Please add any additional notes on financing of mental health services as well a statement concerning data that you were not able to collect because it was unavailable. You can either create an additional paragraph for this purpose or integrate these details throughout the paragraph above.

Example paragraph on financing of mental health services

Five percent of health care expenditures by the government health department are directed towards mental health. Of all the expenditures spent on mental health, 45% of them are directed towards mental hospitals. In terms of affordability of mental health services, 50% of the population has free access to essential psychotropic medicines. For those that have to pay for their medicines out of pocket, the cost of antipsychotic medication is 2.67 dollars per day, and the cost of antidepressant medication is 1.28 dollars per day. Only severe mental disorders are covered in social insurance schemes.

GRAPH 1.1 HEALTH EXPENDITURE TOWARDS MENTAL HEALTH



DATA SOURCES FOR GRAPH 1.1
All other health expenditures: denominator 1.5.1 - numerator 1.5.1
Mental health expenditures: numerator 1.5.1

APPENDIX A: EXAMPLE OF A WHO AIMS COUNTRY REPORT USING THE TEMPLATE

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 Country X. 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 Country X 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.

Country X has a mental health policy and plans, 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. No human rights review body exists, human rights were reviewed only in some facilities, and 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 per 100,000 population is less than 1.0 for both 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 the use of restraints or seclusion are common, especially in mental hospitals.

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

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 favour of mental hospitals and the main city. There are no consumer associations. Family associations are present in the country and some have been involved in implementing policies and plans, and have had interaction with mental health facilities.

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

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

In Country X, the mental health system has all types of mental health 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 a substantial part of human resources are directed towards 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 the primary health and mental health system. Psychotropic medications are available, but only a small fraction of the population has free access to it. Access to mental health facilities is uneven across the country, favoring those living in or near the capital city. There are family associations, but no consumer associations. There are formal links between the mental health sector and other sectors, but many of the critical links are weak or not developed (e.g., links with the welfare, housing, judicial, work provision, education sectors). Mental health policy and plans exist, but financing of the mental health system is not mentioned in either. At present there is no mental health law. Some work has been done on human rights training and inspections of some facilities, but there is no review body and these actions need to be extended to all facilities. The mental health information system does not cover all relevant information in all facilities.

In order to put the information contained above into context, comparisons with regional norms are made. Country X, like most countries of the Americas, has a mental health policy. However, in comparison to other countries, it was implemented comparatively recently. Community care for patients is present, but as seen in many low and lower middle income countries, it is limited. 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 most 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. In contrast, 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 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. Moreover, 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. Unfortunately, the lack of human and financial resources to community mental health is a significant barrier to progress in the treatment of patients in the community. As a result, no significant progress has been made in provision of affordable medication, housing or employment for patients in the community.

WHO-AIMS COUNTRY REPORT

Introduction

Country X is located in South America with an approximate geographical area of 300,000 square kilometres and a population of 3.8 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 language used in the country is 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 the 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, i.e. 70% of physicians are based in the main city, and the surrounding 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, but with limited success. Overall, mental health system resources are scarce and centralized.

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

POLICY AND LEGISLATIVE FRAMEWORK

Policy, plans, and legislation

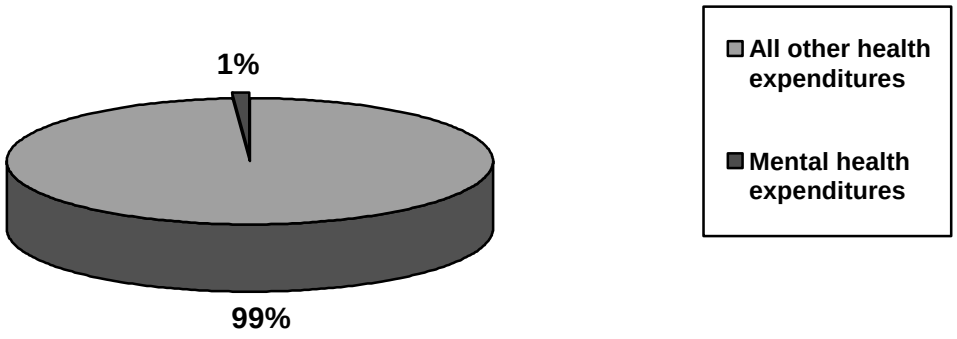
Country X's mental health policy was last revised in 2002 and includes the following components: (1) developing a mental health component in primary health care, (2) human resources, (3) involvement of users and families, (4) advocacy and promotion, (5) human rights protection of users, (6) equity and access to mental health services across different groups, (7) quality improvement, and (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: (1) developing community mental health services, (2) downsizing large mental hospitals, and (3) reforming mental hospitals to provide more comprehensive care. A timeframe and specific goals are mentioned in the plans, some of which have been reached in the last year. There is no disaster/emergency preparedness plan for mental health and there is no current mental health legislation. A mental health law draft is expected be submitted to Congress before the end of 2005.

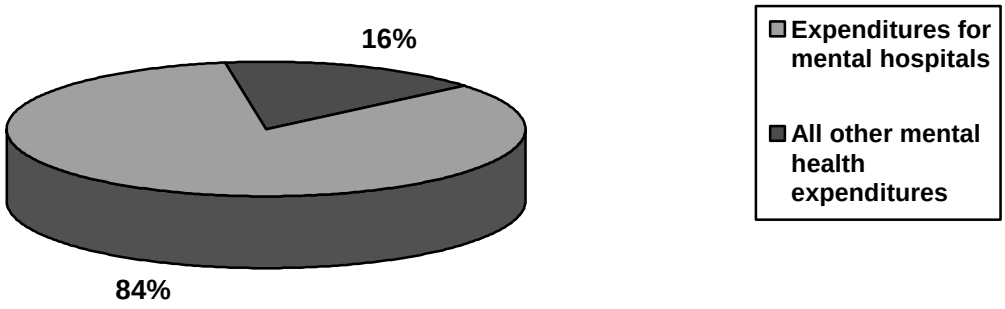
Financing of mental health services

One percent of health care expenditures by the government health department are directed towards mental health. Of all the expenditures spent on mental health, 84% are directed towards mental hospitals. Four 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 4% 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

No national human rights review body exists. One out of the three mental hospitals had at least one review/inspection of human rights protection of patients in 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 hospital staff had at least one day training, meeting, or other type of working session on human rights protection of patients in that year. No staff working in inpatient psychiatric units or community residential facilities staff had such training.

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.

MENTAL HEALTH SERVICES

Organization of mental health services

There is no 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 units available in the country for a total of 0.27 beds per 100,000 population. None of the beds in community-based inpatient units 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 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 the 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. Three 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 in 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 people with mental disorders in forensic inpatient units and 383 in other residential facilities such as homes for people 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.

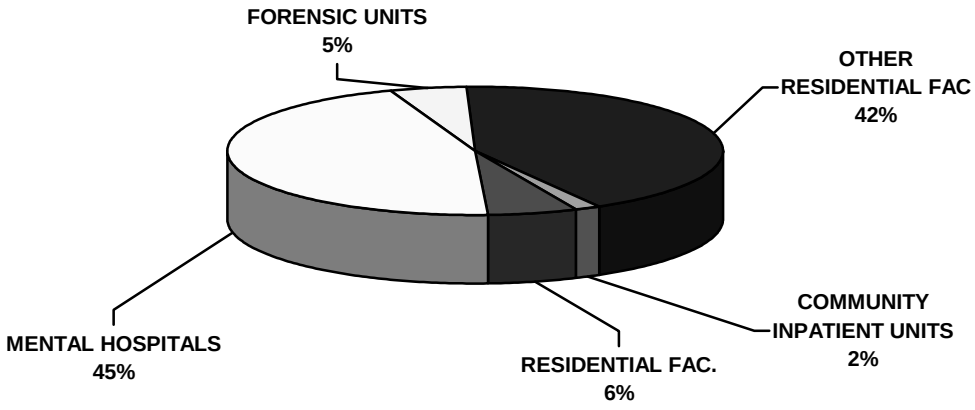
Human rights and equity

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. However, 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 the largest city. Such a distribution of beds prevents access to mental health services for 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

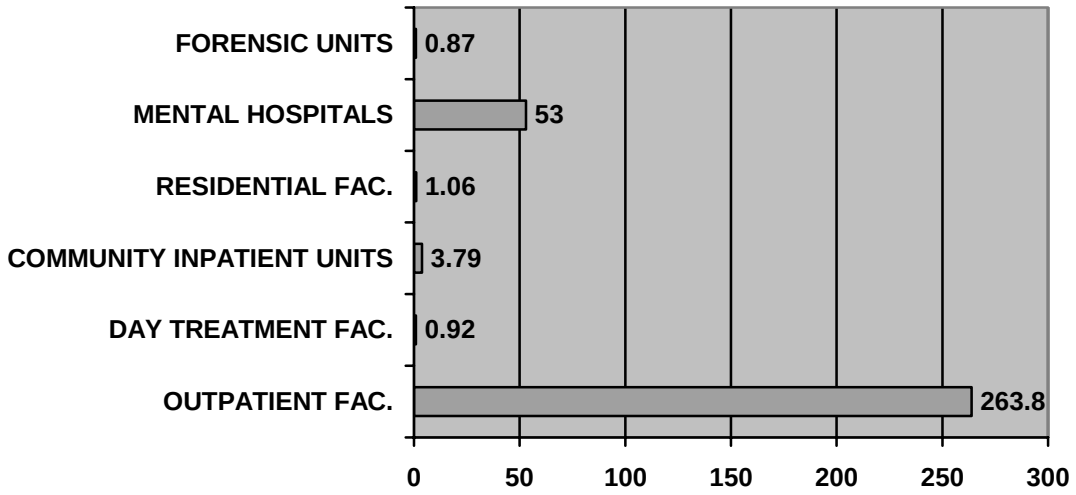
GRAPH 2.1 - BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES



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).

GRAPH 2.2 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES (rate per 100.000 population)

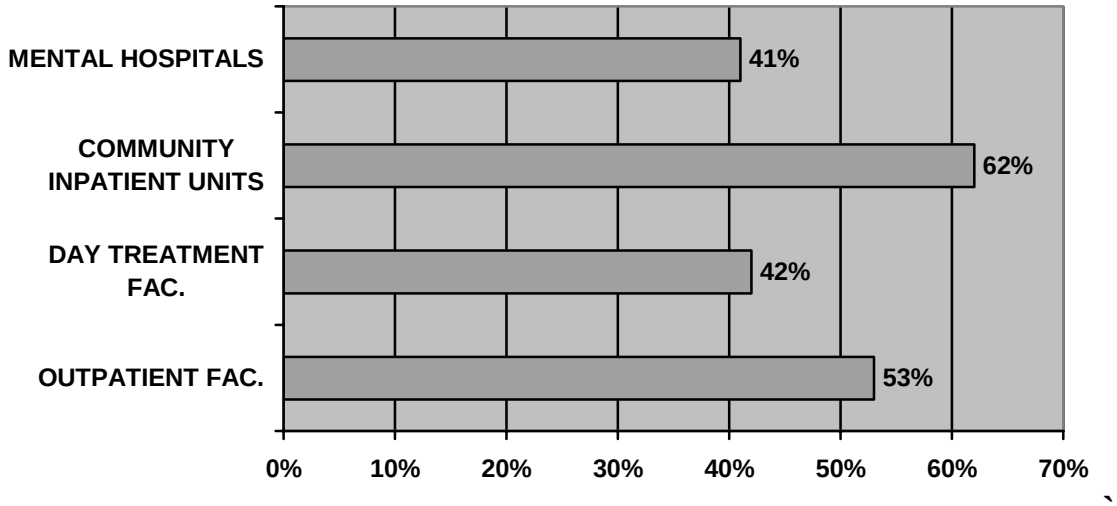


Summary for Graph 2.2

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

GRAPH 2.3 - PERCENTAGES OF FEMALE USERS TREATED IN MENTAL HEALTH FACILITIES



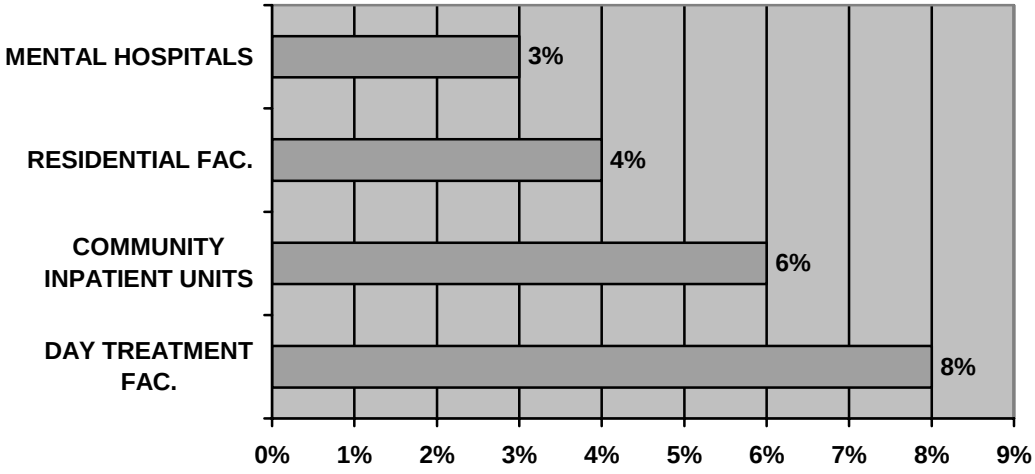
Summary for Graph 2.3

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

GRAPH 2.4 - PERCENTAGES OF CHILDREN AND ADOLESCENTS TREATED IN MENTAL HEALTH FACILITIES

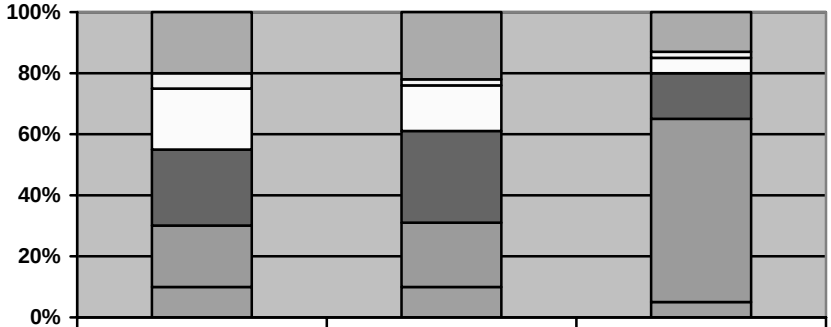


Summary for Graph 2.4

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

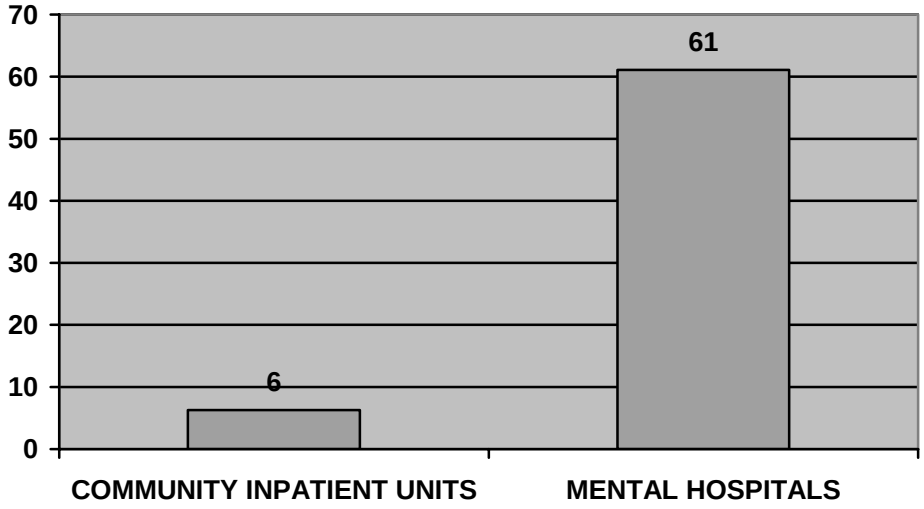


	OUTPATIENT FAC.	COMMUNITY INPATIENT UNITS	MENTAL HOSPITALS
OTHERS	20%	22%	13%
PERSONALITY DIS.	5%	2%	2%
NEUROTIC DIS.	20%	15%	5%
MOOD DIS.	25%	30%	15%
SCHIZOPHRENIA	20%	21%	60%
SUBSTANCE ABUSE	10%	10%	5%

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.

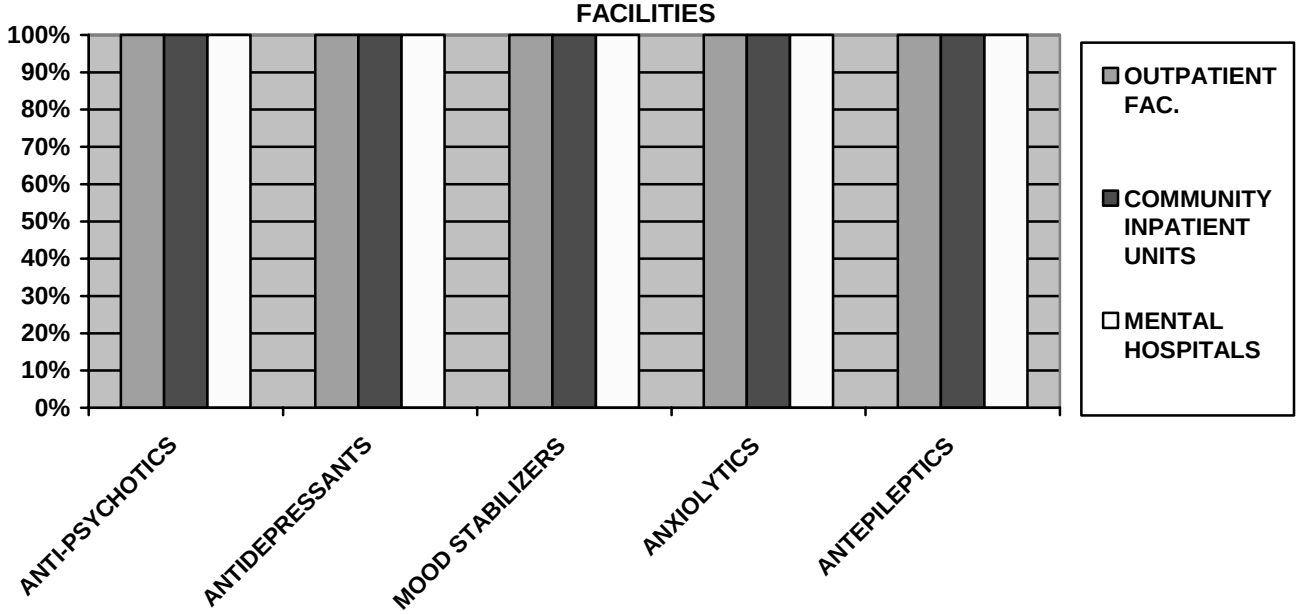
GRAPH 2.6 - LENGTH OF STAY IN INPATIENT FACILITIES (days per year)



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.

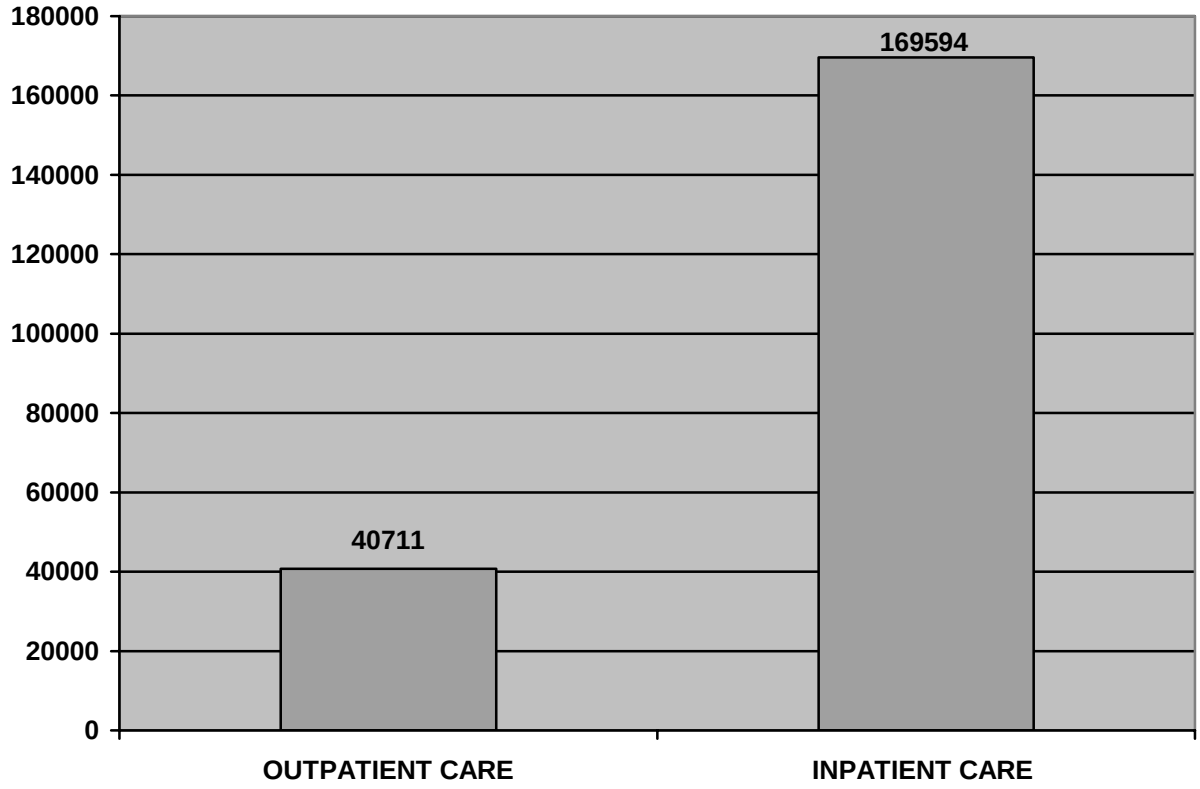
GRAPH 2.7 - AVAILABILITY OF PSYCOTROPIC DRUGS IN MENTAL HEALTH FACILITIES



Summary for Graph 2.7

Psychotropic drugs are widely available in all types of facilities.

GRAPH 2.8 INPATIENT CARE VERSUS OUTPATIENT CARE



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.

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.

[1] **Graph 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.**

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 the physician-based primary health care clinics make at least one monthly referral to a mental health professional. This is also true for non-physician-based primary health care clinics. As for professional interaction between primary health care staff and other care providers, none of primary 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 complementary/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).

HUMAN RESOURCES

Number of human resources in mental health care

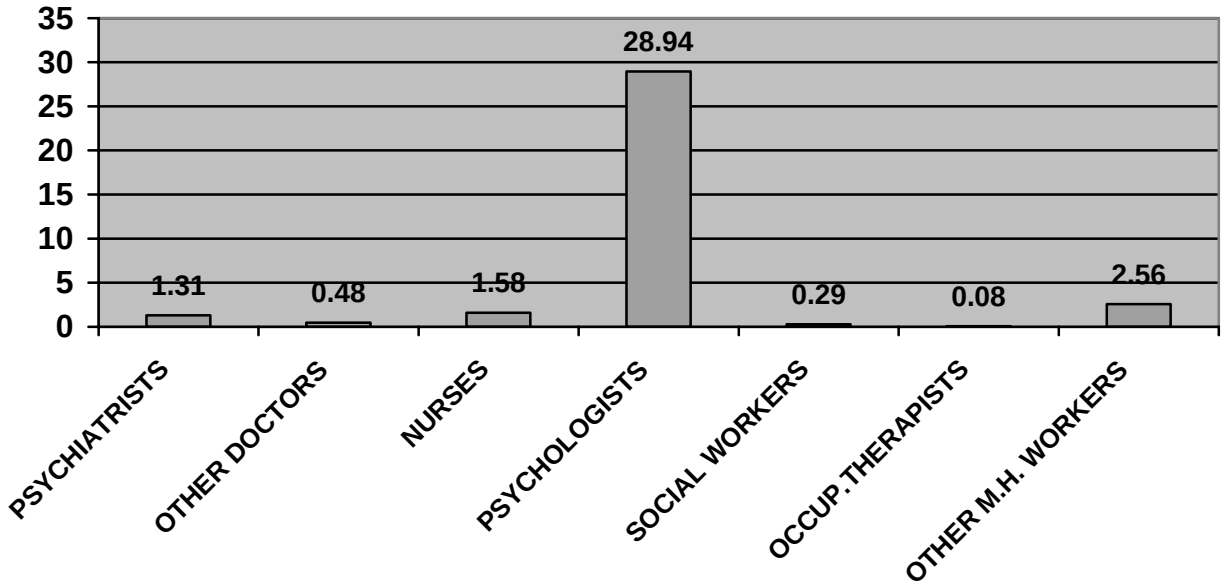
The total number of human resources working in mental health facilities or private practice per 100,000 population is 35.23. The breakdown according to profession is as follows: 1.31 psychiatrist, 0.48 other medical doctors (not specialized in psychiatry), 1.58 nurses, 28.94 psychologists, 0.29 social 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 and 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 unregulated, especially in the case of psychologists. Figures provided are best estimates based on official registration and data from professional associations.

Regarding the workplace, 49 psychiatrists work in outpatient facilities, 3 in community-based psychiatric inpatient units and 21 in mental hospitals. As for other medical doctors (i.e., those not specialized in mental health), 11 work in outpatient facilities, 5 in community-based psychiatric inpatient units and 11 in mental hospitals. There is 1 nurse working in an outpatient facility, 11 in community-based psychiatric inpatient units and 75 in mental hospitals. As for other mental health professionals, there are 63 psychologists, social workers and occupational therapists working in

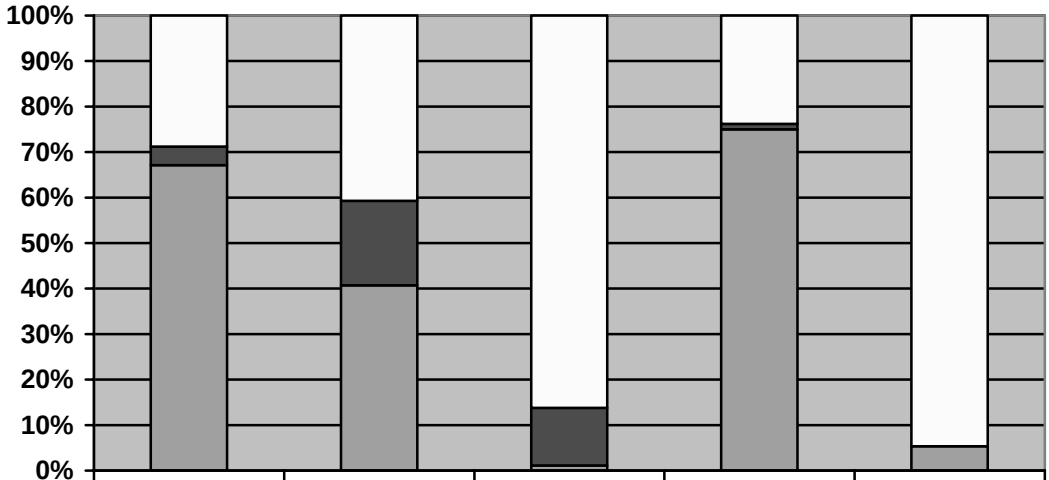
outpatient facilities, 1 of these professional works in a community-based psychiatric inpatient unit, and 20 of these professionals work in mental hospitals. Finally, regarding other health or mental health workers, 7 work in outpatient facilities, there are none working in community-based psychiatric inpatient units, and there 125 working 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 unfair: one psychiatrist in 1.1 and one nurse in 1.4 works in or near the largest city. It should be taken into consideration that psychiatrists, psychologists and social workers work only 12 to 15 hours per week in government administered facilities. Thus, 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)

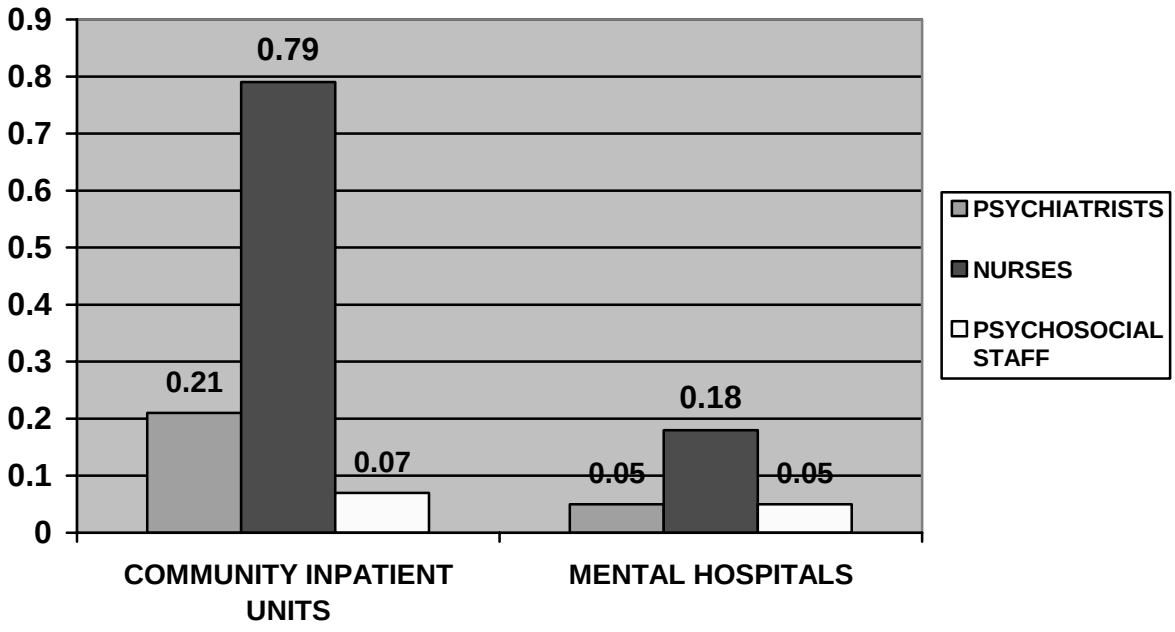


GRAPH 4.2 - STAFF WORKING IN MENTAL HEALTH FACILITIES
(percentage in the graph, number in the table)



	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

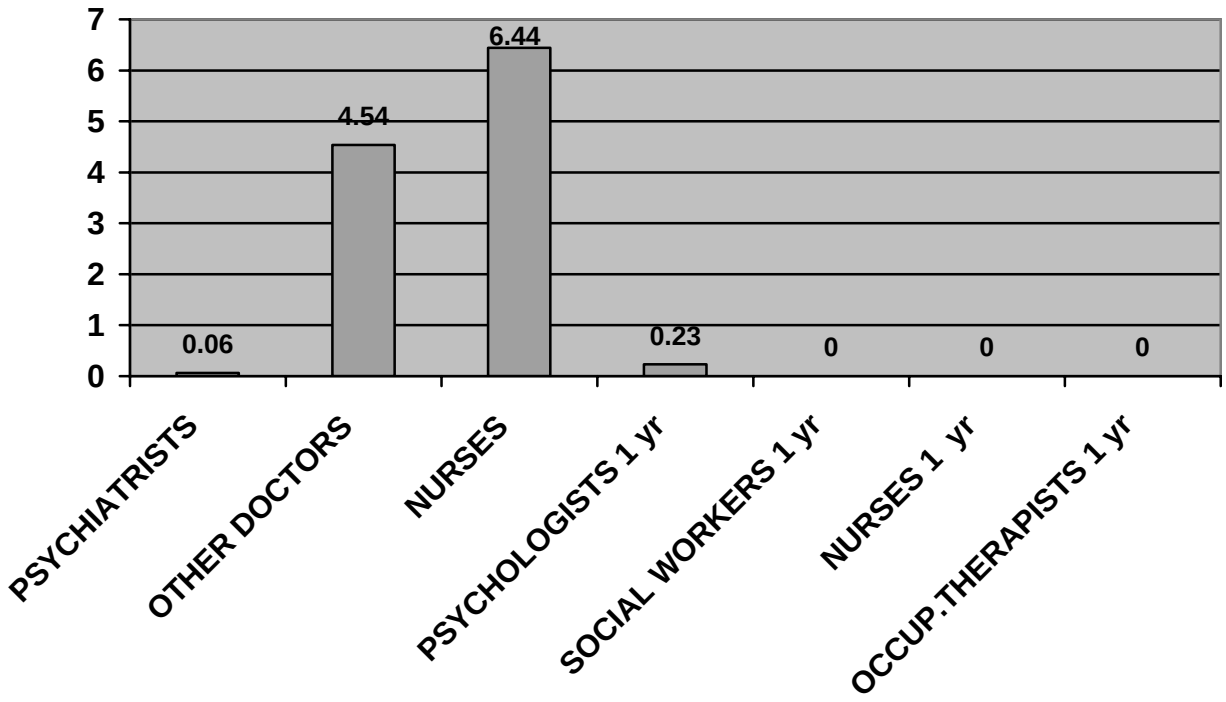
GRAPH 4.3 - RATIO OF HUMAN RESOURCES/BEDS



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, 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 years of the completion of their training. No mental health care staff attended refresher training on the rational use of drugs, psychosocial interventions, or 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 people 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 within 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.

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 all have promoted public education and awareness campaigns in the last five years. These campaigns have targeted the following groups: the 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 people 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 for people with mental disorders.

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.

MONITORING AND RESEARCH

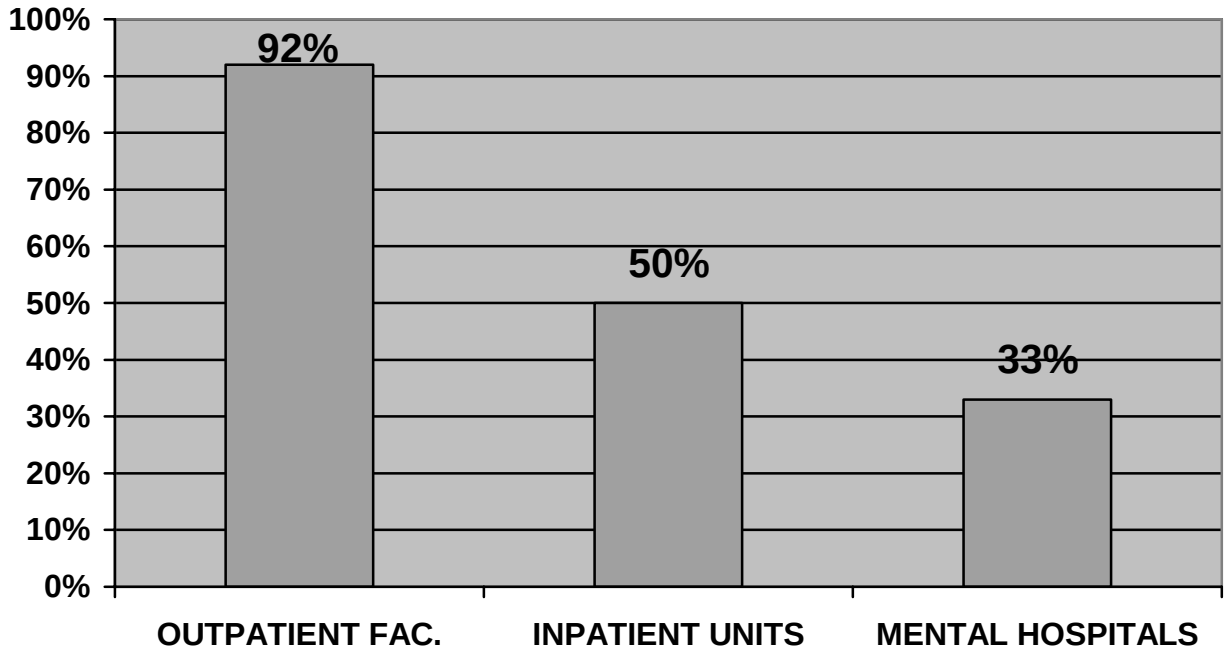
A formally defined list of individual data items that ought to be collected by all mental health facilities exists and. includes the number of psychiatric beds, number of admissions, number of days spent in hospital and diagnoses. As shown in the table 6.1, the extent of data collection is variable among 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 using the data transmitted to the government health department.

Research in Country X is focused on non-epidemiological clinical/questionnaires assessments of mental disorders and services research. The research 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 facilities.	67%	100%	92%
N° of days spent/user contacts in outpatient facilities.	33%	0%	100%
N° of involuntary admissions	0%	0%	---------- ----------
N° of users restrained	0%	0%	---------- ----------
Diagnoses	33%	0%	92%

GRAPH 6.1 - PERCENTAGES OF MENTAL HEALTH FACILITIES TRANSMITTING DATA TO HEALTH DEPARTMENT



NEXT STEPS IN PLANNING MENTAL HEALTH ACTION

The following institutions/people should receive a copy of this report. (The report should be translated to Spanish).

From the Ministry of Health for their involvement in mental health services and programs, and their budgeting and finance:

- Minister of Health
- General Director of Health Services
- General Director of Health Programs
- General Director of Finance

In charge of residential facilities in the community:

- Social Welfare Institute

Professional associations:

- Country X Society of Psychologists
- Country X Society of Psychiatrists
- Country X Association of Psychiatrists
- Country X Association of Nurses

In charge of training residents in Psychiatry and medical students and runs a psychiatric unit in general hospital:

- Department of Psychiatry, National University of X
- Other relevant government authorities:
- Secretary for Children and Adolescents
- Ministry of Education
- Secretary for Social Action
- Congress' Health Commission
- People's Defender

Agency in charge of special education and rehabilitation in Ministry of Education Family associations Worker's insurance
Other institutions:

- First Lady's Office (gives financial help to mental hospital and is important political contact)
- Mennonite Service of Mental Health (runs a mental hospital, few residencies and other facilities)
- Mennonite Voluntary Service (NGO, runs a day hospital in collaboration with Ministry of Health, could help in other initiatives)
- NGO involved in several psychiatric reform initiatives
- Mental Disability Rights International
- Human Rights NGOs

In addition to sending copies of the report, it might be convenient to make a presentation inviting the above mentioned individuals/groups/organizations. The presentation could be the first part (the first day or half day) of the planning workshop. Key mental health workers should also be included in the workshop.

Considering the WHO-AIMS data and the context given by the situations mentioned above, possible areas for action are:

- improvement of training on mental health issues and interaction with mental health services of primary health care workers and services
- provision of community care for patients (and their families) to avoid hospitalization and promote integration

The following could be possible actions in these areas:

- A **primary health care training program on mental health**, to be developed in regions over the country. Some topics for this training are: depression, psychosis, suicide, child and adolescent issues, alcohol abuse, anxiety disorders and patients with chronic complaints. This could be a medium/long term action.
- **Community residencies** for chronic patients. There are initiatives to start one residence, but expertise and funding are weak. This could be a short term action.
- Organization of **mobile outpatient assistance teams** to cover distant areas would improve access to services and have impact to avoid hospitalization. Mobile teams could also backup local primary health care services assisting mental patients. This could be a medium term action.

Workshops could be organized on each of these actions, or workgroups on these actions could be organized within the general planning workshop.

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) is a new WHO tool for collecting essential information on the mental health system of a country or region. The goal of collecting this information is to improve mental health systems and to provide a baseline for monitoring the change. WHO-AIMS is primarily intended for assessing mental health systems in low and middle income countries, but is also a valuable assessment tool for high resource countries. WHO-AIMS 2.2 consists of 6 domains, 28 facets and 156 items to cover the key aspects of mental health systems. In addition, it includes other resources, such as a data entry programme and a template for writing a country report, which allows countries to efficiently collect data and then quickly translate that information into knowledge that can assist planning.

The implementation of WHO-AIMS can generate information on strengths and weaknesses to facilitate improvement in mental health services. WHO-AIMS will enable countries 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.