**Mental Health Policy and
Service Guidance Package**

# HUMAN RESOURCES
# AND TRAINING
# IN MENTAL HEALTH

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A mental health service relies
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World Health Organization

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# Acknowledgements

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| **Mr Todd Krieble** | Ministry of Health, Wellington, New Zealand |
| **Dr Pirkko Lahti** | Executive Director, Finnish Association for Mental Health, Helsinki, Finland |
| **Dr Philippe Lehmann** | Swiss National Health Policy Project, Office fédéral de santé publique, Bern, Switzerland |
| **Dr Peter Lindley** | The Sainsbury Centre for Mental Health, London, United Kingdom |
| **Prof. Juan J. López-Ibor, Jr.** | Past President, World Psychiatric Association, López-Ibor Clinic, Madrid, Spain |
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| **Dr Olabisi Odejide** | Director, Post Graduate Institute for Medical Research and Training, University of Ibadan College of Medicine, Nigeria |
| **Mrs Judith Oulton** | Chief Executive Officer, International Council of Nurses, Geneva, Switzerland |
| **Dr Rampersad Parasram** | Ministry of Health, Port of Spain, Trinidad and Tobago |
| **Dr Vikram Patel** | Senior Lecturer, London School of Hygiene & Tropical Medicine, and Chairperson, The Sangath Society, Goa, India |
| **Dr Michel Perreault** | Senior Researcher, Douglas Hospital Research Centre, Verdun, Quebec, Canada |
| **Dr Jan Pfeiffer** | Centre for Mental Health Care Development, Prague, Czech Republic |
| **Dr Malcolm Philip** | The Sainsbury Centre for Mental Health, London, United Kingdom |
| **Dr Michael Phillips** | Beijing Huilongguan Hospital, Beijing, China |
| **Dr Yogan Pillay** | Equity Project, Pretoria, South Africa |
| **Dr Pino Pini** | Associazione Italiana per la Salute Mentale, Florence, Italy |
| **Professor Ashoka Prasad** | Ministry of Health, Mahe, Seychelles |

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| **Professor David Richards** | Professor of Mental Health, Department of Health Sciences, University of York, Heslington, York, United Kingdom |
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| **Ms Inkeri Siekkinen** | Human Resource Department, Ministry of Health, Cairo, Egypt |
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| **Mrs WAN Deborah** | Chief Executive Officer, New Life Psychiatric Rehabilitation Association, Hong Kong, China |
| **Dr Danny Wedding** | Director, Missouri Institute of Mental Health, St. Louis, MO, USA |
| **Dr Ray G. Xerri** | Director, Policy and Planning, Department of Health, Floriana, Malta |
| **Dr ZOU Yizhuang** | Director of Chinese Mental Health Network, Vice Director of Beijing Hui Long Guan Hospital, Standing Committee & Scientific Secretary of Chinese Society of Psychiatry, Editorial Standing Committee member of Chinese Journal of Psychiatry, Beijing, China |

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This module is part of the WHO Mental Health Policy and Service Guidance Package, which provides practical information for assisting countries to improve the mental health of their populations.

## What is the purpose of the guidance package?

The purpose of the guidance package is to assist policy-makers and planners to:

- develop a policy and comprehensive strategy for improving the mental health of populations;

- use existing resources to achieve the greatest possible benefits;

- provide effective services to persons in need; and

- assist the reintegration of people with mental disorders into all aspects of community life, thus improving their overall quality of life.

## What is in the package?

The guidance package consists of a series of interrelated, user-friendly modules that are designed to address the wide variety of needs and priorities in policy development and service planning. The topic of each module represents a core aspect of mental health.

The guidance package comprises the following modules:

> The Mental Health Context
> Mental Health Policy, Plans and Programmes
> Mental Health Financing
> Mental Health Legislation and Human Rights
> Advocacy for Mental Health
> Organization of Services for Mental Health
> Planning and Budgeting to Deliver Services for Mental Health
> Quality Improvement for Mental Health
> Improving Access and Use of Psychotropic Medicines
> Child and Adolescent Mental Health Policies and Plans
> Human Resources and Training for Mental Health
> Mental Health Information Systems

Legislation and human rights

Research and evaluation

Financing

Child and adolescent mental health policies and plans

Organization of services

Human resources and training

Policy, plans and programmes

Planning and budgeting for service delivery

Information systems

Advocacy

Improving access and use of psychotropic medicines

Quality improvement

Workplace policies and programmes

⬤ still to be developed

The following additional modules are planned for inclusion in the complete guidance package:

> Research and Evaluation of Mental Health Policy and Services
> Workplace Mental Health Policies and Programmes

**For whom is the guidance package intended?**

The modules should be of interest to:

- policy-makers and health planners;
- government departments at federal, state/regional and local levels;
- mental health professionals;
- groups representing people with mental disorders;
- representatives or associations of families and carers of people with mental disorders;
- advocacy organizations representing the interests of people with mental disorders, and their families;
- NGOs involved or interested in the provision of mental health services.

**How to use the modules**

- The modules can be used **individually or as a package**. They are cross-referenced with each other for ease of use. Country users may wish to go through each module systematically, or may use a specific module when the emphasis is on a particular area of mental health. For example, those wishing to address the issue of mental health legislation may find the module entitled *Mental Health Legislation and Human Rights* useful for this purpose.

- They can serve as a **training package** for policy-makers, planners and others involved in organizing, delivering and funding mental health services. They can be used as educational materials in university or college courses. Professional organizations may choose to use the modules as aids for training persons working in the field of mental health.

- They can be used as a framework for **technical consultancy** by a wide range of international and national organizations that provide support to countries wishing to reform their mental health policies and/or services.

- They can also be used as **advocacy tools** by consumer, family and advocacy organizations. The modules contain information of value for public education and for increasing awareness amongst politicians, opinion-makers, other health professionals and the general public about mental disorders and mental health services.

**Format of the modules**

Each module clearly outlines its aims and the target audience for which it is intended. The modules are presented in a step-by-step format to facilitate use and implementation of the guidance provided. The guidance is not intended to be prescriptive or to be interpreted in a rigid way. Instead, countries are encouraged to adapt the material in accordance with their own needs and circumstances. Practical examples from different countries are used throughout the modules.

There is extensive cross-referencing between the modules. Readers of one module may need to consult another (as indicated in the text) should they wish to seek additional guidance.

All modules should be read in the light of WHO's policy of providing most mental health care through general health services and community settings. Mental health is necessarily an intersectoral issue requiring the involvement of the education, employment, housing and social services sectors, as well as the criminal justice system. It is also important to engage in consultations with consumer and family organizations in the development of policies and the delivery of services.

Dr Michelle Funk                                   Dr Benedetto Saraceno

# HUMAN RESOURCES AND TRAINING IN MENTAL HEALTH

## 1. Introduction

Human resources (HR) are the most valuable asset of a mental health service. Such a service relies on the competence and motivation of its personnel to promote mental health, prevent disorders and provide care for people with mental disorders. In many mental health services, the largest portion of the annual recurrent budget is spent on personnel. Yet major difficulties are frequently encountered in the planning and training of human resources for mental health care.

Many countries have few trained and available personnel, or they experience distribution difficulties either within the country or regionally (e.g. too few staff in rural settings or too many staff in large institutional settings), staff competencies may be outdated or may not meet the population's needs, the available personnel may not be used appropriately, and many of the staff may be unproductive or demoralized.

Countries can take several courses of action to address these difficulties:

> An appropriate **HR policy** for mental health should be developed in order to provide a coherent framework for workforce development.
> Policy needs to be directly **linked to HR planning**, in consultation with health programme managers and training institutions.
> A systematic **method** is required for calculating the number of mental health staff needed and determining the mix of competencies required within a specified service organization.
> Appropriate **management strategies** are needed for leadership, motivation, recruitment, deployment and retention of often-scarce personnel.
> **Training** of mental health staff should be reviewed and improved, in keeping with evidence-based practices and the mental health needs of the population.
> Once staff are qualified, **continuing education, training and supervision** should be developed for the provision of the best quality care that meets users' needs.

This module aims to provide practical guidance on each of these courses of action, in order to assist countries to develop their human resources. Because of variations between countries, the module cannot provide specific norms (such as number of staff required per population unit).  Instead, a set of planning and training tools is provided to assist countries to calculate their own staffing requirements and to train health workers and mental health workers according to their specific needs.

These planning tools are based on the WHO pyramid framework for an optimal mix of services. This WHO framework is used as a template throughout this module. A situation analysis of the current staff supply is provided for each service level of the pyramid; in the needs assessment, staffing needs are established according to the service framework; and the training requirements for each service level are set out in the section on training.

## 2. Human resources: policy and models of care

### 2.1  The importance of a policy framework

A clear national policy is necessary for the development of HR for mental health. The HR policy should present the values and goals for developing a mental health workforce. It should also provide a coherent framework for planning, training and developing HR for mental health. With this policy framework in place, countries can plan

HR in a systematic manner; but without such a framework and the political will to support it, efforts will be at best fragmented and plans will not receive the political and financial support they urgently require.

The essential steps that are required to develop a mental health policy are set out in the module: *Mental Health Policy, Plans and Programmes*. Many of the key issues that need to be addressed in HR policy for mental health are covered in the discussion that follows.

## 2.2  Changing models of care

### 2.2.1  Community focus and deinstitutionalization

During the past 50 years, mental health care has undergone major changes in many countries around the world. Chief among these changes has been the development of community-based care. From an HR perspective, the implications of these changes have been substantial.  They have required:

> a reallocation of staff from hospital to community-based service settings;
> among staff, the development of a new set of competencies for work in community-based settings, and a new emphasis on recovery and rehabilitation in hospital settings;
> the training of a wider range of workers (for informal community care and primary care) in mental health; and
> reform of associated models of training, in keeping with new evidence-based care.

### 2.2.2  Integration with general health

Related to these developments, there has been an increasing emphasis on integrating mental health within general health care.  In developing countries with acute shortages of mental health professionals, the delivery of mental health services through general health care is the most viable strategy for increasing access of underserved populations to mental health care. Furthermore, mental disorders and physical health problems are closely associated and often influence each other.

This too has multiple implications for human resources, mainly the following:

> general health staff require training in basic mental health competencies in order to detect mental disorders, provide basic care and refer complex cases to specialist services; and
> mental health specialists need to be equipped to work collaboratively with general health workers, and provide supervision and support.

### 2.2.3  Multidisciplinary approaches

The development of a mental health workforce requires the coordination of multiple professional and non-professional disciplines. Teamwork is a basic competency, required for all categories of mental health workers.  Staff should be able to work:

> in a variety of community, residential and inpatient settings;
> across agencies, linking service users to a range of statutory and other services;
> with a variety of purchasing and service delivery models;
> in multidisciplinary and multi-agency teams;
> across service levels (for example liaising between primary care and specialist services);
> in a manner that sustains their competence and enthusiasm, even when faced with a variety of pressures and competing demands.

### 2.2.4 Intersectoral collaboration

In addition to multidisciplinary approaches within the health sector, there should be collaboration with other sectors. People with mental disorders have multiple needs related to health, welfare, employment, criminal justice and education. Thus the promotion of mental health within a country straddles a broad range of sectors and stakeholders, and is not limited to the activities of a ministry of health.

For these reasons, the mental health workforce should be developed intersectorally, with HR planning taking account of the need to provide mental health training to teachers, welfare workers, police officers and prison staff, among others. Key to the development of an intersectoral HR policy is concurrence between the government and training institutions (such as universities) about what types and numbers of trained mental health workers are needed; without this concurrence, an HR policy is unlikely to succeed. It is important that countries establish a clearly designated body to coordinate the many sectors involved in the development of a mental health workforce.

### 2.2.5 Changing staff roles

The change from hospital- to community-based care and the new emphasis on multi-disciplinary and intersectoral approaches inevitably mean changing roles for staff. This is a major issue in mental health reform. Professionals may be concerned about losing their professional identity, status, income, familiar work environments and familiar ways of working. Many professionals resist reform for these reasons. These changing roles present challenges for both management and health workers.

In some settings, the shortage of qualified practitioners has led to de facto, and unplanned changes in roles. For example, in many developing countries, although legislation does not approve it, nurses prescribe medication for service users because there are no doctors, or the available doctors do not have time to see the users.

### 2.2.6 Stigma and discrimination

People with mental disorders face stigma and discrimination from all sectors of society, including by some of the health workforce. For this reason, both HR planning and training need to address issues of stigma and discrimination. This includes training staff to combat stigma among themselves, within the health workforce and in other sectors of society.

## 2.3 Evaluation

It is important that in the process of workforce development, mechanisms are established to evaluate that workforce. How are the key stakeholders, institutions, interest groups and political processes interacting, and to what effect? Are services being delivered that are efficient, effective, equitable and accessible? The purpose of developing HR for mental health is, after all, not simply to build a workforce, but ultimately to improve the mental health of the population that it serves.

## 3. Planning: what human resources are needed for mental health?

How many people and what competencies are required to staff a mental health service? There is no absolute or global norm for the right ratio of mental health workers per population unit. Countries or regions need to determine the right number of personnel according to their specific needs and resources. This section provides step-by-step guidance to assist countries with this task.

Planning for HR normally takes the form of a cycle. The planning cycle begins with an analysis of the current HR situation, followed by a needs assessment. Targets are then set on the basis of information gathered from the situation analysis and needs assessment. Next, the targets are implemented through management, training and supervision. The implementation leads to a further situation analysis, as needs and targets are reappraised in an ongoing cycle.

## Step 1. Situation analysis

### Task 1: Review current HR policy
In order to be successful, HR planning should be informed by current policy and its implications for HR development. The first task for planners in any situation analysis is therefore to review existing mental health policy related to HR.

### Task 2: Assess current supply of staff
With the current policy framework in mind, the next task is to assess the current supply of mental health and general health staff: what human resources are *currently available* to provide mental health care for the population? In order to assess the existing supply of mental health staffing, planners need to review current staffing for *all* disciplines at *all* service levels.

Several variables need to be considered for an accurate assessment of the current supply of mental health staff:

> Number of mental health and general health staff currently employed in the public health sector
> Number of mental health and general health staff not currently employed in the public health sector
> Immigration and emigration
> Death and retirement
> Life events
> Training of new personnel and percentage entering mental health employment
> Financial, political and cultural factors
> Changes in productivity
> Competencies

### Task 3: Assess utilization of services
The final task in the situation analysis is to review the extent to which mental health services are currently being utilized. This information is important to provide planners with an indication of where staff are not able to meet the expressed demands of the population (i.e. an undersupply of staff, shown, for example, by excessive waiting times) or where staff numbers exceed the demand (i.e. an oversupply of staff).

## Step 2. Needs assessment

A needs assessment is essential to supplement the data about existing services gathered in the situation analysis. The situation analysis only provides a measure of the current service utilization and staffing supply, whereas a needs assessment enables planners to understand what staff are required to address the mental health needs of the community for services and care. Mental health needs are often hidden in the community and not met by existing services.

If HR planning continued to be based on supply alone (as it frequently is), historical patterns of funding and service planning would provide the basis for human resources, rather than the actual need for mental health care in the community.

In order to estimate staff based on a needs assessment, it may be necessary to gather a group of key informants or experts to recommend a set of services and the functions and competencies required to provide those services.

### Task 1: Estimate needs

The first task is to estimate the needs for care in the community. Details of how to conduct this task are presented in the module: *Planning and Budgeting to Deliver Services for Mental Health*. To summarize, the activities required are:

(i)   Establish the prevalence or incidence of the priority mental health conditions. These conditions need to be identified in the existing policy or strategic plan. Alternatively, in the case of mental health promotion, identify the target group expected to receive the promotion programme.

(ii)  Where necessary, make adjustments according to local population variables.

(iii) Identify the number of expected cases (or the number targeted for the mental health promotion programme) per year.

### Task 2: Map the services required for the identified needs: the WHO service framework pyramid

From an estimate of mental health needs, the services required to meet those needs can be estimated. It is important to determine what services are required and how they should be organized by outlining the profile of services in which staff are to be located. The WHO service organization framework pyramid can be used as a template to determine what services are to be provided at each service level.

### Task 3: Identify the staff required at each service level

The next task is to identify what staff are required at each service level. To plan systematically for the entire mental health service, functions and required competencies need to be identified for each of the service levels illustrated in the WHO service framework pyramid. In short, determine what functions are required for each given service, and how staff should be equipped to undertake those functions.

### Task 4: Estimate the number of staff required at each service level

Based on a broad outline of the functions, competencies and staff required at each service level, the number of staff can now be estimated. The identified need from task 1 can be converted into workload, by estimating the number of people who would utilize the required mental health services within a specified time frame. Once the expected workload for a service is identified, the number of staff needed can be calculated.

## Step 3. Target setting

### Task 1: Compare supply and need

Having calculated the current supply of staff and estimated staffing needs, targets can now be set. In order to set targets, the two sets of information gathered so far (about supply and need for staff) have to be compared. The comparison can be conducted by two methods: calculating the difference and the ratio.

### Task 2: Adjust targets according to utilization: "growing" human resources

When comparing supply and need, considerable discrepancy is likely to be found between the current staff available and the estimates of staff required to meet the needs of the population. It is also possible that estimates of staffing based on the needs assessment will not correspond with the actual utilization of services. It is therefore essential to provide a method of grading targets, taking into account the utilization of services and budget constraints.

The method suggested for addressing this in the module on *Planning and Budgeting* is to draw up a list of options and to set priorities according to certain criteria. To further assist planners, measures of the utilization of services can be used to guide the setting of annual staff targets. On this basis, graded targets can be set according to available budgets and the utilization of services, with the overall goal of developing human resources to meet the needs of the population.

Having calculated the difference between current supply and need, and set priorities for HR development in the light of current policy, the utilization of services and the available budgets, specific courses of action should be taken. These can be directed either at the supply of staff or the need for staff.

Important to bear in mind in "growing" the workforce is that this may not simply require increasing the number of staff, but also redistributing existing staff and developing new competencies. For example if there is to be a change from institutional to community-based models, the existing workforce may need retraining. It should not be assumed that the competencies are the same.

## Step 4. Implementation

Once staffing targets have been set, their successful implementation requires effective human resources management and training. These areas are discussed in separate sections (Sections 4 and 5) for reasons of emphasis.

## 4. Human resources management

### 4.1 Leadership, motivation and burnout

Leadership is the ability to cultivate vision and values that are shared by others, to initiate and guide action in a group or organization, and to build and sustain trust. It is as important in mental health as in any other area of the health service. Formally trained leadership is in short supply in health systems, and there are many people with leadership potential who are untrained and inexperienced.

The need for good staff motivation has a financial, clinical and humanitarian basis. A motivated workforce will be more cost-effective because it is more efficient (more work gets done for the same cost) and effective (the work that is done has better outcomes for service users). Motivated staff are more likely to remain satisfied with their work, to continue in their existing posts and to create greater stability for the service over time.

Staff morale and burnout are important areas of planning for mental health services. Staff often face burnout because of factors specifically associated with mental health care. Nevertheless, for many people the stress of mental health work can be challenging, and can provide an opportunity for rewards as clinicians see improvements in their clients and in service effectiveness.

## 4.2  Workforce availability

### 4.2.1  Recruitment and retention

An essential aspect of HR management is the capacity of a service to attract skilled staff and retain them over a sustained period of time. Broadly, three strategies may be outlined:

> Attract and retain
> Lead and inspire
> Support and sustain

### 4.2.2  Deployment

One of the most long-standing problems of HR management in mental health services is the deployment of staff to remote, rural or otherwise unpopular areas of the country. Various incentives have been used to encourage the deployment of staff in these areas, where there is often great need. These include legal, professional, financial, educational and management incentives.

### 4.2.3  Engaging private sector providers

Planners for HR in the mental health sector need to develop policy in relation to private sector providers. Increasingly, the boundaries between "private" and "public" sectors are becoming blurred in many countries.  This is true for the way services are financed, the way in which they are used, and the way in which service providers work. It is therefore essential that HR planners and policy-makers within the public sector develop a pragmatic and holistic approach, with the aim of building partnerships between formally designated "private" and "public" sectors.

### 4.2.4  Use of non-professionals for mental health care

During the 1960s and 1970s, a trend emerged of using non-professionals for delivering mental health care, known as deprofessionalization. Non-professional workers often provide effective care because they have better knowledge of the community, language and customs. Often, service users also more readily identify with them and form therapeutic alliances. It is important to ensure that non-professional workers are appropriately competent, and that professional staff can be drawn upon, when necessary, to deal with complex cases, provide supervision and consultation-liaison. If non-professional staff are to be trained and employed, consultation with professional staff is needed, to avoid the perception that non-professional staff are undermining professional staff, lowering standards of care, and providing service managers with a less costly workforce.

### 4.2.5  Developing partnerships with nongovernmental organizations

Nongovernmental organizations (NGOs) often play an important role in mental health promotion, prevention and treatment.  For the HR planner in mental health, NGOs can provide useful resources in terms of competencies and expertise for training and supervision of public sector staff, advice in service planning, and liaison over specific aspects of service provision (e.g. trauma services). However, NGOs do need to be regulated in terms of their labour practices and the services they provide.

Developing HR is usually a complex political process that relies on using strategic opportunities to develop mental health. Recent innovations in HR development for mental health provide an illustration of the need to adapt strategically to the current policy agenda.

## 4.3  Labour practices

Labour practices for mental health workers should comply with existing legislation and protocols on labour practices for general health workers and the general population within a country. In the development of all labour practices, the rights of mental health workers need to be respected. For example, there is a need for parity between mental health workers and other health workers in salaries and working conditions.

## 5. Education and training

Education and training of personnel for mental health should follow logically from the targets set by HR planning. Mental health training should aim to serve the mental health needs of the society by producing workers competent to deliver care, in a manner consistent with the goals of HR policy and planning.

This requires coordination and the development of consistent policies between the mental health delivery sector and the training sector. In many countries, this will mean close cooperation between the departments of education and health. The main training institutions should actively participate in the provision of mental health care in every setting (community, residential and hospital-based services). In short, there needs to be an open, constructive partnership between planners and trainers.

Consequently, this section uses the WHO service organization pyramid as the framework for discussing human resources education and training.  Training has to be closely linked to service levels, their functions and the competencies required to deliver any service.  For each level of the pyramid, this section outlines:

> the functions of the service level
> the competencies required by different health and mental health workers.

## 5.1 Service functions and training requirements for an optimal mix of mental health services

### 5.1.1 Informal community mental health services

Local community members who are not mental health professionals or health care professionals provide a variety of services. Examples of people working at this level of service provision include: lay volunteers, community workers, staff in advocacy organizations, coordinators of self-help/user groups, humanitarian aid workers, traditional health workers, and other professionals such as teachers and police officials.

### (i) Functions

It is important to point out that informal community mental health service providers are unlikely to form the core of mental health service provision, and countries would be ill-advised to depend solely on their services. However, they can complement formal mental health services and form useful alliances.

Some of the important functions performed by informal services are:
> supportive care including counselling and self-help
> help with activities of daily living and reintegration into the community
> advocating the rights of people with mental disorders
> preventive and promotive services
> practical support
> crisis support
> identification of mental health problems and referral to health services.

### (ii) Competencies required

By definition, local community members involved in providing informal community care are not expected to have formal mental health training. Moreover, since they constitute a heterogeneous group, it is not possible to prescribe minimum competency criteria for them. Instead, it would be useful to think of some discrete competencies that may enable such individuals to become more effective in helping people with mental disorders in the community.

Useful competencies include:

> a basic understanding of mental disorders
> basic counselling competencies
> advocacy skills.

## 5.1.2 Mental health services through primary health care

For countries with limited HR for mental health, delivering mental health services through primary health care is one of the most effective and viable routes for improving access to mental health care. Examples of professionals working at this level include general practitioners, general nurses, midwives, nursing assistants and community health workers.

### (i) Functions

> identifying mental disorders
> providing basic medication and psychosocial interventions
> referrals to specialist mental health services
> family and community psycho-education
> crisis intervention
> prevention of mental disorders and mental health promotion.

### (ii) Competencies required

> diagnosis and treatment of mental disorders
> counselling, support and psycho-education
> advocacy
> crisis intervention
> mental health promotion and prevention of disorders.

## 5.1.3 Mental health services through general hospitals

Integrating mental health services into general health services necessarily includes integrating those services into general hospitals. This way they can provide secondary level care to patients in the community and services to those who are admitted for physical disorders who also require mental health interventions. They also afford an excellent opportunity to reduce the stigma associated with seeking hospital-based care from separate mental asylums.

Examples of professionals working at this level include: hospital doctors with special interest in psychiatry, hospital psychiatrists, general nurses working in general health or psychiatric inpatient units, psychiatric nurses working in psychiatric inpatient units, psychiatrists and/or psychiatric nurses providing consultation-liaison services, social workers and psychiatric social workers, occupational therapists, psychologists and other health workers in hospitals (e.g. nursing assistants).

**(i) Functions**

> inpatient and outpatient mental health care and treatment
> consultation-liaison (C-L) service to other medical departments
> education and training
> links with primary health care and tertiary care
> research.

**(ii) Competencies required**

> diagnosis and treatment
> training and supervision
> advocacy
> knowledge of legislation related to mental health
> administration and management
> research.

### 5.1.4 Formal community mental health services

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

**(i) Functions**

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

**(ii) Competencies required**

> diagnosis and treatment
> training and supervision
> knowledge of relevant legislation, including mental health legislation
> advocacy and negotiation
> administration and management
> research.

### 5.1.5 Long-stay facilities and specialist mental health services

These are usually specialized, hospital-based facilities offering various services in inpatient wards and specialist outpatient clinic settings. Examples include long-stay inpatient facilities, medium and high security units, specialized units for treatment of specific disorders and related rehabilitation programmes (e.g. eating disorder units), specialist clinics or units dedicated to specific populations (e.g. children and adolescents, or the elderly) and respite care units. It is important to remember that such specialist units are not first-line care providers; they are usually tertiary care referral centres. They should not be confused with outdated asylums that offer custodial care.

Examples of professionals working at this level include: psychiatrists, mental health nurses, psychologists, psychiatric social workers and occupational therapists, who are likely to be specialists in the service provided, such as forensics, or children and adolescents, or eating disorders.

#### (i) Functions

The exact functions of these services depend on the area of specialization; for example, the functions and roles of professionals working in forensic units will be very different from those working in child and adolescent units. For these reasons, it is difficult to enumerate a common set of functions. Suffice it to say that the functions of these services include nearly all of the functions of mental health services in general hospitals and community-based mental health services plus the specific specialist function that the particular service is designed to deliver.

#### (ii) Competencies required

Professionals working at this level of service provision need specialized competencies in their particular area of expertise, such as forensics, or child and adolescent health. In addition, they require competencies that have been described under the previous levels of service provision. These include: knowledge of relevant legislation, education and training competencies, administrative and managerial competencies, advocacy competencies and research competencies.

Not all professionals working at these various specialized levels need to have all the competencies identified above. For example, forensic psychiatrists may have competencies in prescribing medication and authorizing fitness to stand trial, whereas forensic psychologists may have competencies in risk assessment and anger management.

## 5.2 Curriculum development

In many countries, achieving training goals will require a change in the way in which mental health education and training is conducted. There is often a phase lag, whereby clinical practice moves ahead of what training courses offer, as their curricula tend to change more slowly than clinical practice. Thus it is necessary to update curricula where they have become outdated or are no longer consistent with new models of community-based care.

To address this lag, evidence-based training is necessary to prepare workers who are competent to fulfil mental health service needs in the most relevant and efficient manner possible. Evidence-based training means that training must be conducted on the basis of the best available evidence for a particular practice or intervention, such as the use of the most cost-effective medications and psychosocial interventions, and the development of community-based care.

The three core principles of curriculum development are:

> assessing the *current training* provision
> assessing the *future needs* for which training is conducted
> *setting targets* for transforming current training towards future needs.

## 5.3  Continuing education, training and supervision

Continuing education and training (CET) is in the interests of both the mental health service and the staff. For the service, it ensures up-to-date care, in line with available evidence for the most effective interventions. For the staff, it ensures that their occupation remains stimulating and that their working life can follow a trajectory of career-long professional development.  Lifelong learning is a cornerstone of continued fitness to practice and is closely tied with the quality of care and patient safety.

In order for CET to function effectively, every mental health service needs to develop a sound policy and effective plan for staff development.The first step in developing CET is to draw up the underlying principles for staff development and a plan for implementation. The CET plan should cover:

> a survey of training needs for existing staff
> targets for specific training programmes
> supervision.

Supervision includes qualities of management, leadership and the transfer of technical information. The purpose of supervision is to promote continuous improvement in the care delivered by mental health workers. Everyone involved in the provision of mental health care should be in some form of regular supervision. Supervision is a continuous process that is carried out in a range of mental health settings.

## 5.4  Approaches to training

Recent developments in mental health training show a move away from traditional didactic or lecture-based methods towards problem-focused, student-centred, active learning methods. These involves changes in the direction of outcomes-oriented training, multidisciplinary learning opportunities, and an integrated, systems-oriented approach to the study of mental health that includes bio-psychosocial elements.

Mental health training reform therefore needs to keep pace with these developments and the latest evidence for cost-effective training methodologies. Choices about which specific method is appropriate will depend on the training objectives, training materials, the students, the environment and the available resources.

## 6.  Conclusion

This module provides a set of guidelines for HR policy development, planning, management and training.  It addresses countries with a range of resource scenarios – from those with minimal mental health services to those with relatively well-resourced services. Ultimately, the tools presented in this module need to be adapted to the particular circumstances and needs of the country concerned. Whatever the available resources, mental health services need to develop a long-term perspective by investing in the most essential assets of the service: the staff.

**The aims of this module are to:**

> Provide practical guidance for planning, management and training of people engaged in mental health work in a country or region.
> Assist countries to plan their workforce in a manner appropriate to their own mental health needs.

**The target audience includes:**

> Policy-makers
> Health planners
> Human resource managers
> Health educators and trainers
> Service providers
> Mental health workers
> General health workers
> Informal health providers
> Service users
> Families of service users
> Advocacy groups

**Scope of the module**

This module provides practical guidance on key topics of policy, planning and training for human resources (HR), along with illustrative examples from specific countries. The module is not prescriptive and should not be followed rigidly; rather, it should be adapted according to the unique contexts of national or regional health care systems. Human resources planning that uses the methodologies proposed in this module should be understood within the policy framework and strategic plans of the wider health care system. For maximal political and administrative support, HR planning should be aligned with this wider framework.

In an area as complex as HR for mental health, it is unrealistic to aim to provide detailed guidance for all areas. Where more detailed information is required, the reader is referred to other literature cited in the text. The following areas are **not** covered in this module:

> Specific guidance on advocacy and lobbying for mental health, such as strategies for convincing health administrators that mental health training is important and necessary. While there is guidance to help make the case for mental health, the specific strategies for undertaking these lobbying and policy tasks are covered in detail in other modules of the WHO Guidance Package, specifically those on *Advocacy for Mental Health; Mental Health Policy, Plans and Programmes*; and *Planning* and *Budgeting to Deliver Services for Mental Health.*

> An analysis of current planning and budgeting mechanisms, and the process of translating plans into budgetary realities. This is covered in some detail in the module, *Planning and Budgeting to Deliver Services for Mental Health*.

> Formulae for calculating the cost of human resources, which are covered in the module, *Planning and Budgeting to Deliver Services for Mental Health*.

> Detailed contents of mental health training curricula (e.g. mental health training curricula for primary health care nurses).

Instead, this module provides methods by which countries can assess their own training needs and devise their own training curricula. The areas covered contain broad principles of mental health training, key competencies that should be available at each service level, and continuing education, training and supervision. The annexes list resources that can be used for training curricula, and guidelines for the reform of training institutions.

Where specific issues arise that are not adequately covered in this module, or if technical assistance is required with regard to the application of any of its proposals to countries' specific circumstances, it is suggested that WHO be contacted (see page ii for contact details).

This module is intended for use in conjunction with other modules in the WHO Mental Health Policy and Services Guidance Package. These modules provide a framework for wider policy and service reform which may be required. Frequent cross-references are made to these other modules in the text. The modules can be accessed at the following website: http://www.who.int/mental_health/policy/en/

**Who should take responsibility for HR planning for mental health?**

Identification of who should take responsibility for HR planning for mental health will depend on the specific organizational set-up in the ministry of health (or equivalent government organization) and the size of the region or country to be served. In a local district, at least one person, or preferably a team of two or three, should take primary responsibility for such planning. They would need to liaise with a range of other stakeholders throughout this undertaking. For a larger region or country, a larger team will be required. However, it is important that a designated team take responsibility and leadership for this planning process. This leadership role may require the coordination of a range of different sectors. Competence in information gathering, consultation, management, planning and report writing will also be necessary.

In addition, the establishment of a functional link between the health ministry, which is responsible for HR planning, and those who are responsible for the delivery of training will help ensure that the training meets identified policy needs, that the training programmes are sustainable, and that the mental health training is linked with other health training programmes in non-mental health areas.

**What length of time is required to implement the steps proposed in this module?**

The time required to complete the steps associated with HR planning will depend on the availability of information for planning, the extent of the consultation process that is undertaken, and the scope of the development (for example, whether it is for a country, a region or an individual mental health service, and whether it is for all mental health workers or a single professional group). It is estimated that it would take 6 to 12 months to complete the first three steps of the planning cycle as set out in this module (situation analysis, needs assessment and target setting). The fourth step (implementation) is an ongoing process; initial evaluation could take place after a year, but substantial change is likely to take three to five years. Human resources planning needs to adopt a long-term view, given the length of time it takes to train a person. For example, in some countries there are three different planning horizons – 10 years, 5 years and 3 years – with an annual operational plan. The time frame needs to be adapted to countries' planning cycles.

# **1.** Introduction

Human resources (HR) are the most valuable asset of a mental health service. In many mental health services, the largest portion of the annual recurrent budget is spent on personnel (Thornicroft & Tansella, 1999). A mental health service relies on the competence and motivation of its personnel to promote mental health, prevent disorders and provide care for people with mental disorders.

Yet major difficulties are frequently encountered in the planning and training of personnel for mental health care. Many countries have few trained and available HR, and often face distribution difficulties within the country or region (e.g. too few staff in rural settings or too many staff in large institutional settings). Moreover, staff competencies may be outdated or may not meet the population's needs. In addition, the available personnel may not be used appropriately and many of the staff may be unproductive or demoralized.

Why is the record on HR planning so poor? There are several reasons, including: the lack of an appropriate body responsible for such planning; the lack of competencies and resources for HR planning; the lack of accurate or usable data for planning; long training periods for staff (which means that decisions to train more staff take time to filter into services); the high cost of training mental health professionals; training institutions that are out of touch with service and population needs; the perception by general health authorities that mental health is not a priority; stigma against working in a mental health environment; in some developing countries, the migration of skilled mental health workers to developed countries (i.e. "brain drain"); and professional attitudes which may hinder some aspects of HR development (Green, 1999).

Countries can take several courses of action to address these difficulties:

> Develop an appropriate *policy* for human resources in mental health in order to provide a coherent framework for workforce development.
> Directly *link the policy to HR planning*, in consultation with health care programme managers and training institutions.
> Use a systematic *methodology* for calculating how many mental health professionals are needed and what mix of competencies is required within a specified service organization.
> Adopt appropriate *management strategies* to promote leadership, motivation, recruitment, deployment and retention of often scarce personnel.
> *Review the training* of mental health staff, and improve it in keeping with evidence-based practices and the mental health needs of the population.
> Once the personnel are qualified, develop *continuing education, training and supervision* to ensure provision of the best quality care that meets users' needs.

This module aims to provide practical guidance on each of these courses of action. Because of variations between countries, the module cannot suggest specific norms (e.g. numbers of staff required per population unit). Instead, it provides a set of planning and training tools to assist countries in calculating their own staffing requirements, and for training mental health workers according to their own specific needs.

In some countries, a radical reappraisal of their model of mental health care may be necessary. Mental health HR planning in many countries, particularly developing countries, is often frozen within an outdated, post-colonial model of mental health care. Consequently, the model of care needs to be changed at the same time as addressing the mental health HR training and planning priorities.

*Human resources are the most valuable asset of a mental health service…*

*…Yet major difficulties are frequently encountered in the planning and training of personnel.*

*Countries can take several courses of action to address these difficulties.*

*This module aims to provide practical guidance on the planning and training of human resources in mental health.*

Box 1 provides a set of WHO recommendations for mental health for countries.

## Box 1. Ten recommendations for mental health (WHO, 2001a)

1. Provide treatment in primary care
2. Make psychotropic drugs available
3. Give care in the community
4. Educate the public
5. Involve communities, families and consumers
6. Establish national policies, programmes and legislation
7. Develop human resources
8. Link up with other sectors
9. Monitor community mental health
10. Support more research

It is important to have a clearly defined framework for the organization of mental health services based on these recommendations. WHO has developed a pyramid framework (Figure 1) which demonstrates an optimal mix of services. The predominant services should be self-care management, informal community mental health services and community-based mental health services provided by primary health care staff. These should be followed by psychiatric services based in general hospitals, formal community mental health services and, lastly, specialist mental health services. The emphasis placed on delivering mental health treatment and care through services in general-hospital-based services or community mental health services should be determined by the strengths of the existing mental health or general health system, as well as by cultural and socioeconomic variables. In this module, the issue of self-care is not addressed – workforce development starts with informal community care and moves up the pyramid.

*HR planning for mental health should be undertaken within a clearly defined service framework.*

## Figure 1. Optimal mix of mental health services: the WHO pyramid framework
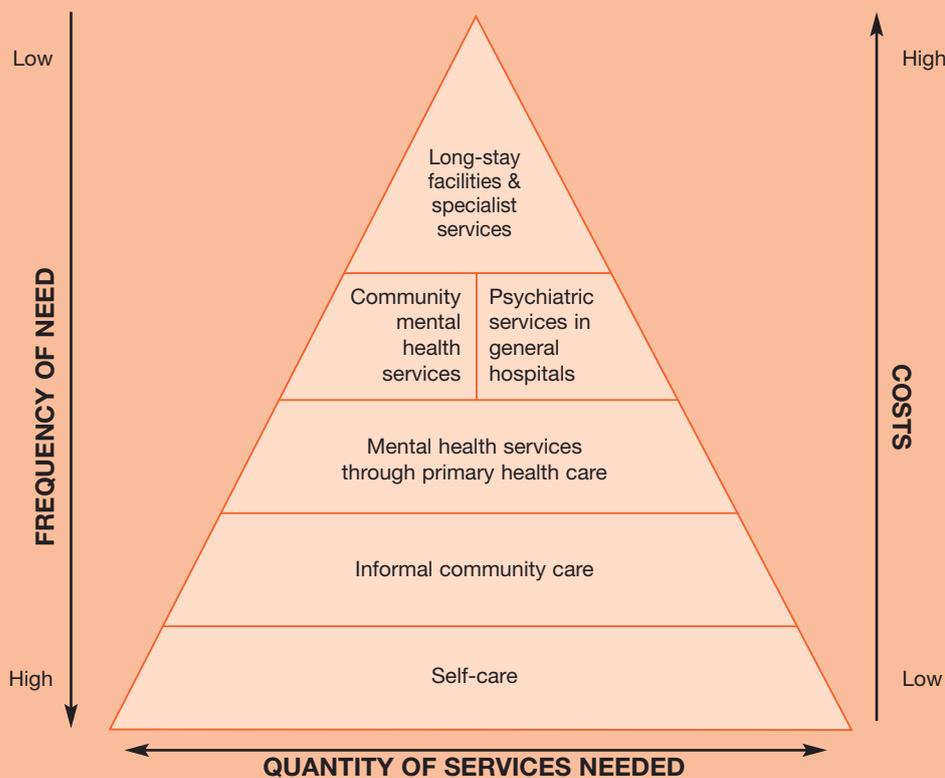
*WHO has developed a framework for an optimal mix of mental health services.*



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# 3. Planning human resources for mental health care

How many people and what competencies are required to staff a mental health service? There is no absolute or global norm for establishing the right ratio of mental health workers per population unit (Egger, Lipson & Adams, 2000). Countries or regions need to determine and plan for what they consider to be the right number of personnel according to their specific needs and resources. This section provides step-by-step guidance to assist countries with this task.

Planning for HR normally takes the form of a cycle (Figure 2). The planning cycle begins with an analysis of the current HR situation. A needs assessment is then conducted and targets set on the basis of information gathered from the situation analysis and needs assessment. These targets are implemented through management, training and supervision. The implementation leads to a further situation analysis, as needs and targets are reappraised in an ongoing cycle.

*This section presents tools to assist countries in HR planning, in line with their specific needs.*

*Planning for HR takes the form of a cycle.*

**Figure 2. The HR planning cycle: steps in planning human resources for mental health services**

**Step 1.** Situation analysis

**Step 2.** Needs assessment

**Step 4.** Implementation

**Step 3.** Target setting

This WHO pyramid framework is used as a template throughout this module. The situation analysis of the current staff supply is located in each service level of the pyramid. For needs assessment, staffing needs are viewed in terms of the service framework, and the training requirements for each service level are set out in the section on training. More details of each of these service levels and the care required are provided in the module, *Organization of Services for Mental Health*.

**Key points: Introduction**

> Human resources are the most valuable assets of a mental health service.
> Yet major difficulties are frequently encountered in the planning and training of human resources for mental health care.
> Several courses of action can be taken by countries to address these difficulties:
> - Develop an HR policy for mental health
> - Plan HR based on policy and service needs
> - Develop appropriate management strategies
> - Train staff, in keeping with policy and planning objectives
> - Establish continuing education, training and supervision
> This module aims to provide practical guidance on each of these courses of action, in order to assist countries in developing their human resources for mental health care.
> To use this guidance module, it is important to have a clear framework for the organization of mental health services. The WHO pyramid framework on the organization of services for mental health is used as a template for HR planning and training throughout this module.

# 2. Human resources: policy and models of care

## 2.1 The importance of a policy framework

A clear national policy is necessary for the development of HR for mental health. An HR policy should define the values and goals for developing a mental health workforce, and provide a coherent framework within which countries can plan, train and develop human resources for mental health. It should also provide a means of accountability and encourage continuous improvement in the quality of care. With such a policy framework in place, countries can plan HR in a systematic manner. But without it and the political will to support it, efforts will at best be fragmented and plans will not receive the political and financial support that they urgently require.

*In order to plan HR effectively, a foundation needs to be laid in appropriate policy.*

The WHO policy on human resources for mental health has been clearly articulated (WHO, 2001a):

*WHO has clearly articulated its policy on HR for mental health.*

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

This policy direction forms the foundation for HR planning and training. Countries should adapt this policy to their own circumstances and needs. For example, some countries may address HR policy for mental health as part of a broader HR policy for overall health care. Other countries may wish to address HR as a segment of their mental health policy.

*This policy direction forms the foundation for HR planning and training.*

The essential steps that are required to develop a mental health policy are set out in the module, *Mental Health Policy, Plans and Programmes*, available at: (www.who.int/mental_health/resources/en/Policy_plans.pdf).

Many of the key issues that need to be addressed in HR policy for mental health are covered in the discussion that follows.

## 2.2 Changing models of care

### 2.2.1 Community focus and deinstitutionalization

During the last 50 years, mental health care has undergone major changes in many countries around the world. Chief among these has been the development of community-based care. This has been made possible largely by innovations in treatment interventions, which have enabled people with mental disabilities to receive cost-effective care in the community. Moreover, the growth of the human rights movement focused attention on gross violations of basic human rights, including violations against people with mental disorders in mental asylums. And research has shown that mental asylums have little therapeutic effect; indeed, they sometimes

*During the last 50 years, mental health care has undergone major changes towards community-based care.*

exacerbate mental disability. The discrediting of mental asylums on humanitarian and clinical grounds has led to a reduction in the number of chronic patients in mental hospitals, the downsizing and closing of some hospitals, and the development of community-based mental health services as alternatives, a process known as deinstitutionalization.

The change towards community-based care has taken place in a variety of ways in different countries. However, many have argued that in developed countries the closing down of institutions has not been accompanied by adequate community service development (WHO, 2001a). In developing countries, mental health services have laboured under the legacy of colonial era asylums, with sparse service provision (WHO, 2003).

*This process has taken place in a variety of ways in different countries.*

From an HR perspective, the implications of these changes have been substantial. In particular,

*The change to community-based care has several implications for human resources.*

> staff have had to be reallocated from hospital-based to community-based service settings;
> staff have had to develop a new set of competencies for work in community-based settings;
> staff have had to develop new competencies for promoting recovery and rehabilitation in hospital settings;
> a wider range of workers in mental health has had to be developed (for informal community care and primary care); and
> associated models of training have required reform, in keeping with new, evidence-based care.

### 2.2.2  Integration with general health

Related to these developments, there has been an increasing emphasis on integrating mental health care within general health care. In developing countries with acute shortages of mental health professionals, the delivery of mental health services through general health care is the most viable strategy for increasing access to mental health care among underserved populations. Furthermore, mental disorders and physical health problems are closely linked and often influence each other. For example, people with common mental disorders such as depression and anxiety frequently present with somatic symptoms for treatment in general health care services.

*Mental health services are becoming increasingly integrated into general health care.*

An integrated service encourages the early identification and treatment of mental disorders and thus reduces disability. It also helps to reduce the stigma associated with seeking help from an independent mental health service. Other potential benefits include possibilities for the provision of care within the community and opportunities for community involvement in care (WHO, 2003).

Integrating the services has multiple implications for HR development, including:

*This integration necessitates appropriate training of general staff and specialists.*

> The need for training general health care staff in basic mental health competencies, to enable them to detect mental disorders, provide basic care and refer complex cases to specialist services; and
> The need to train mental health specialists to work collaboratively with general health workers, and to provide them with supervision and support.

There are different models that integrate mental health services into general health care, as discussed in more detail in the module, *Organization of Services for Mental Health*.

### 2.2.3 Multidisciplinary approaches

The development of a mental health workforce requires the coordination of different professional and non-professional disciplines. Because people with mental disorders have multiple needs, it is useful for mental health workers to work in teams or at least maintain continuous contact and consult with other mental health specialists. An essential element of training is therefore to encourage such teamwork, as this is a basic competency required for all categories of mental health workers.

Staff have to be ready to work:
> in a variety of community, residential and inpatient settings;
> across agencies, linking service users to a range of statutory and other services;
> with a variety of purchasing and service delivery models;
> in multidisciplinary and multi-agency teams;
> across service levels (for example liaising between primary care and specialist services);
> in a manner that sustains their competence and enthusiasm under a variety of pressures and competing demands.

(The Sainsbury Centre for Mental Health, 1997)

There should be sufficient overlap between disciplines to enable communication over common mental health concerns, but not so much overlap that there is duplication of roles or rivalry between professional groups. Some treatment competencies can be relatively easily shared across traditional disciplines, but not all.

Planners can address this key issue by planning training needs in a holistic manner, according to the competency mix required, rather than planning separately for each discipline. This requires open communication between the various disciplines (e.g. psychiatrists and psychologists, nurses and occupational therapists) in the design of training programmes. Specific disciplines need to have a clear understanding of the role of the other related disciplines.

Exposure to other disciplines during training programmes further assists collaboration between disciplines. For example, clinical psychologists need to be informed about the role of the occupational therapist or psychiatrist. An ethos of teamwork and multidisciplinary styles of working need to be emphasized for all disciplines.

### 2.2.4 Intersectoral collaboration

In addition to multidisciplinary approaches within the health sector, collaboration with other sectors is also necessary. People with mental disorders have multiple needs related to health, welfare, employment, criminal justice and education. Thus the promotion of mental health within a country should cover a broad range of sectors and stakeholders, and should not be limited to the activities of the ministry of health.

For these reasons, the mental health workforce should be developed *intersectorally*; it should include plans for providing training in mental health to teachers, welfare workers, police and prison staff. For example, training in primary mental health care of "first-contact" staff in areas such as schools, the police force and prisons is essential since they are likely to come into contact with people with mental disorders.

In addition, if first-contact personnel are sufficiently trained, decentralized care will become easier to implement and manage. A responsive treatment network (or consultation-liaison system) will be needed to support such staff. For example, through an initiative in Trinidad and Tobago, first-contact staff introduced a programme in one

of the nation's prisons (Rampersad Parasram, Ministry of Health, Port of Spain, Trinidad and Tobago, personal communication).

Key to the development of an intersectoral HR policy is concurrence between the government and training institutions (such as universities) about what types and numbers of trained mental health workers are required. In addition, policy-makers need to be aware of the potential conflicts of interest and tensions that can arise between the various stakeholders (training institutions, the ministry of health, private providers and health-care funding bodies). For example, with private health care growing in many countries, universities may tend to train mental health professionals oriented towards private practice in urban settings, when the policies of the ministry of health indicate the need to train personnel who are capable of providing mental health care in a community setting in remote rural areas.

For this reason, it is important that countries establish a clearly designated *body to coordinate the many sectors involved in the development of a mental health workforce*. Such a body needs to represent the range of stakeholders concerned with HR development and training.  For example, in Slovenia in 2002, the Slovenian Association for Mental Health (SENT), and the government office for the sick and disabled organized a conference on Psychosocial Rehabilitation in the Community, which resulted in the formation of a planning body – the National Council for Mental Health. This body consists of a group of experts in psychiatry and general practice, along with representatives from the ministries of health, education and work, as well as NGOs and representatives of users and carers. This group has taken on responsibility for initiating mental health reform in Slovenia (Vesna Svab, President, Slovenian Association for Mental Health (SENT), Ljubljana, Slovenia, personal communication).

Some countries may not have an educational institution that can participate in intersectoral coordination.  In that case a mental health training group could be set up within the ministry of health to undertake this role. For example, in Grenada, such a training group has been established within the Ministry,  under the overall direction of the Minister of Health and the Permanent Secretary (Stan Kutcher, Associate Dean, Clinical Research Centre, Dalhousie University, Halifax, Nova Scotia, Canada, personal communication).

### 2.2.5  Changing staff roles

The change from hospital- to community-based care and the new emphasis on multidisciplinary and intersectoral approaches inevitably mean changing roles for staff. This is a major issue in mental health reform. Professionals may be concerned about losing their professional identity, status, income, familiar work environments and familiar ways of working. Many professionals resist reform for these reasons.

These changing roles present challenges for both management and health workers. For management, the challenge is to engage actively with the health workers, listen to their needs and present the case for service reform and new evidence-based ways of working. For health workers, the challenge is to develop new competencies in community settings, to work in a flexible manner with other disciplines and across traditionally defined sectors, and to embrace change as an opportunity for further learning and personal and professional development. These issues are discussed in more detail in Section 4 below on HR management.

In some settings, the shortage of qualified practitioners has led to de facto, unplanned changes in roles. In many developing countries, although legislation does not approve it, nurses prescribe medication for service users because there are no doctors, or the available doctors do not have time to see the users. In other settings, aside from

prescribing medication, trained community nurses undertake the monitoring of medication (Stan Kutcher, personal communication). In some states in the United States, nurses have the authority to prescribe medication independently (Ivey, Scheffler & Zazzali, 1998).

Countries need to develop realistic standards for managing the appropriate issuing of prescriptions, and, where necessary, introducing legislation on this. Given that psychotropic medications can have significant side-effects, sometimes even resulting in death, great care is needed for adequate and appropriate training of staff, other than doctors, who are allowed to prescribe. It is important to ensure that the increasing number of nurses who are prescribing medicines, along with other advanced roles, are given appropriate training, continuing education and supervision as well as opportunities for consultation and referrals to medical doctors and other health providers.

As one example of the successful management of this issue, in Ghana trained nurses prescribe a restricted range of drugs. This has received approval from doctors in areas where there are only a few qualified specialists. Key elements have been the formal training and licensing of the prescriber (J.B. Asare, Director of Mental Health, Ministry of Health, Accra, Ghana, personal communication).

### 2.2.6  Stigma

People with mental disorders face stigma and discrimination in all sectors of society, including by the health-care workforce.  For this reason, HR planning and training need to address issues of stigma and discrimination. This includes training staff to combat their own tendencies to stigmatize as well as those of other members of the health-care workforce and other sectors of society.

For example, a national survey of Australian consumers and carers by the advocacy group SANE found that the disrespectful attitude of mental health professionals was a major concern. One reason for this may be that a number of the staff had been trained in large psychiatric hospitals where there were many people with severe chronic disorders whom they treated as "cases" rather than as people having a right to be respected. An essential aspect of training is addressing the attitudes of trainees so that they genuinely treat people with mental disorders as human beings worthy of the same respect as others. Staff also need to be made aware of  international and regional human rights standards and norms relating to mental health (see module on *Mental Health Legislation and Human Rights*).

Stigma is a particularly important issue for non-mental-health personnel (e.g. general doctors, nurses, police, social workers). They are often the first point of contact for people with mental disorders in general health services. Stigmatizing attitudes at this critical service level can become a barrier that prevents people with mental disorders from receiving the care they need.

### 2.3  Evaluation

It is important that in the process of development of the workforce, mechanisms be established to evaluate that workforce. How are the key stakeholders, institutions, interest groups and political processes interacting, and what is the outcome? Are services being delivered that are efficient, effective, equitable and accessible? (See module on *Evaluation of Mental Health Policy and Services*). The purpose of developing HR for mental health is, after all, not simply to build a workforce, but ultimately to improve the mental health of the population it serves.

The next section, on HR planning, needs to be read in the context of a country's relevant policy directions. Planning is not done in a vacuum; it is usually driven by policy and economic considerations. For example, an assessment of the existing supply and need for staff is always informed by the policy context and the particular agenda of the government or planning body responsible for mental health development. The HR plan needs to be based on the service delivery platform and the packages of care to be rendered at each level of care. It is within this framework that planning tools have been developed, as discussed in Section 3.

*Planning does not take place in a vacuum; it needs to take account of the policy environment.*

Key points: Human resource issues for mental health

> A clear national policy is necessary for the development of HR for mental health.
> During the last 50 years, mental health care has undergone major changes, largely towards community-based care.
> Mental health care has become increasingly integrated into general health care.
> These changes have required a reallocation of staff from hospital to community settings, a modification of their roles and new competencies.
> Increasingly, health workers have to work in multidisciplinary settings.
> They also need to work across sectors, including health, education, criminal justice, housing and social services.
> Changing staff roles represent challenges for management and health workers, (e.g. training them in the prescription of medicines).
> Planning and training need to address issues of stigma and discrimination.
> Evaluation should be an integral part of HR policy, planning and training.

# 3. Planning human resources for mental health care

How many people and what competencies are required to staff a mental health service? There is no absolute or global norm for establishing the right ratio of mental health workers per population unit (Egger, Lipson & Adams, 2000). Countries or regions need to determine and plan for what they consider to be the right number of personnel according to their specific needs and resources. This section provides step-by-step guidance to assist countries with this task.

Planning for HR normally takes the form of a cycle (Figure 2). The planning cycle begins with an analysis of the current HR situation. A needs assessment is then conducted and targets set on the basis of information gathered from the situation analysis and needs assessment. These targets are implemented through management, training and supervision. The implementation leads to a further situation analysis, as needs and targets are reappraised in an ongoing cycle.

*This section presents tools to assist countries in HR planning, in line with their specific needs.*

*Planning for HR takes the form of a cycle.*

**Figure 2. The HR planning cycle: steps in planning human resources for mental health services**

```
Step 1.              Step 2.
Situation            Needs
analysis             assessment


Step 4.              Step 3.
Implementation       Target
                     setting
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Before proceeding with each step, key concepts in the planning cycle should be clarified.

## Step 1. Situation analysis

The purpose of a situation analysis is to determine the current supply of staff (i.e. the human resources currently available to provide mental health care for the population). Other information that needs to be gathered at this stage concerns current mental health policy, the service organization and the current utilization rate of the mental health services. All of these carry important implications regarding the current situation of the workforce, and should therefore be included in the situation analysis.

## Step 2. Needs assessment

The purpose of the needs assessment is to identify the need for staff vis-à-vis the general population: what staff are needed to care for the number of people in the population estimated to have mental disorders? In the past, HR planning for general health services has used a "supply and demand" method (Green, 1999; Shipp, 1998). This involves estimating the current supply of staff, comparing it with the demand for staff (defined as the expressed need for care in a given population), and finding ways of addressing the discrepancy between supply and demand.

However, in mental health planning, the supply and demand method is not adequate to cater for the needs of a population, because many mental health needs are hidden. For example, people who are depressed seldom identify themselves as being depressed and rarely visit mental health services for treatment (Goldberg & Gater, 1996). More often, they are afraid to use the mental health services because of the stigma attached, or they may present to general health services with somatic complaints, or engage in risky or anti-social behaviour. Another example is the mental health needs of a mother who has just delivered a child. Epidemiological surveys (measures of need) suggest that 10% of such mothers suffer from post-partum depression. Because of improper understanding by the population at large, they seldom report to health workers and frequently go undiagnosed (i.e. they do not "demand" services). Measures of demand are therefore inadequate on their own. For this reason, a needs assessment is an essential component of HR planning for mental health.

## Step 3. Target setting

On the basis of information from Step 1 (the current situation) and Step 2 (the needs assessment), priorities are set and targets identified. These targets have to be adjusted in the light of budget constraints and the utilization of mental health services. Targets are therefore based on a variety of information, including current policy, supply, utilization and need. Ultimately, planning is based on these multiple sources of information.

## Step 4. Implementation

Implementation of the policy and planning targets then takes place through HR management and training. Owing to their importance, a detailed description of HR management is covered in Section 4, on human resource management, and in Section 5, on training.

This methodology can be used to plan human resources in a range of settings – not only within the health services. For example, planning the number of teachers or police officers required for counselling and mental health promotion can be calculated using this method. This is particularly important, because usually a range of agencies and

*Key concepts in the planning cycle need to be clarified.*

*The supply and demand method in HR planning for mental health is often not adequate to cater for the needs of a population, because many mental health needs are hidden*

*Targets should be informed by policy, supply, demand and need.*

sectors deliver mental health services. It is therefore necessary to plan in a systematic and coordinated fashion for all these sectors.

**How to navigate your way through the planning cycle:**

In the top right hand corner of each page, a small figure with shading will indicate where you are in the planning cycle. For example:

will indicate that you are in Step 1.

These steps do not need to be followed rigidly; countries can adapt them and change the order according to their own needs and priorities. For example, it may be more important for some countries to conduct a needs assessment (Step 2) before they review the current situation (Step 1). It should be emphasized that planning is an ongoing and lengthy process. Countries can begin the planning and reform process without necessarily completing every step in this module.

## 3.1  Step 1. Situation analysis

### 3.1.1  Task 1: Review current HR policy

In order to be successful, HR planning needs to be consistent with current policy (Egger, Lipson & Adams, 2000). The first task for planners in any situation analysis is therefore to review existing mental health policies and their implications for HR development.

As a guide, this may require answering the following questions:

> What is the current national mental health policy?
> Are there any other policies relevant to HR planning for mental health?
> What are the implications of the current policy for HR development?
> What strategies are most likely to succeed in the light of the current policy?
> What factors will facilitate the development of HR for mental health?

By incorporating current policy into strategic planning, plans are more likely to receive the political and financial support they require in order to meet their objectives. Moreover, planning without an awareness of the key policy issues can lead to a workforce that is likely to be out of touch with the current policy.

In South Africa, following the publication of the new mental health policy in 1997 (Department of Health, 1997), the national Department of Health set out to review current mental health service resources (including staff supply) in all provinces (Lund & Flisher, 2002a; 2002b). The purpose of this review was to reform the mental health services and develop comprehensive community-based mental health care in keeping with the new policy. This example illustrates a situation analysis that is clearly aligned with policy reform.

With the existing policy framework in mind, the next task is to assess the existing supply of staff in both mental health care and general health care (since general health workers may spend part of their time delivering mental health care within an integrated service). In other words, what human resources are *currently available* to provide the population with mental health care?

An assessment of the current supply of mental health staff, requires the review of current staffing for all disciplines at all service levels. In this context, it is important to know the broad organization of services.

The WHO pyramid framework, described in the introduction to this module, can provide a template for mapping the current supply of staff (Figure 3).  The broad perspective of current staff supply provided by this framework enables the identification of shortages in specific service levels. This will quickly highlight gaps in the overall current service provision.

**Figure 3. Assessing current staff supply at all service levels**



*The next task is to identify what human resources are currently available.*
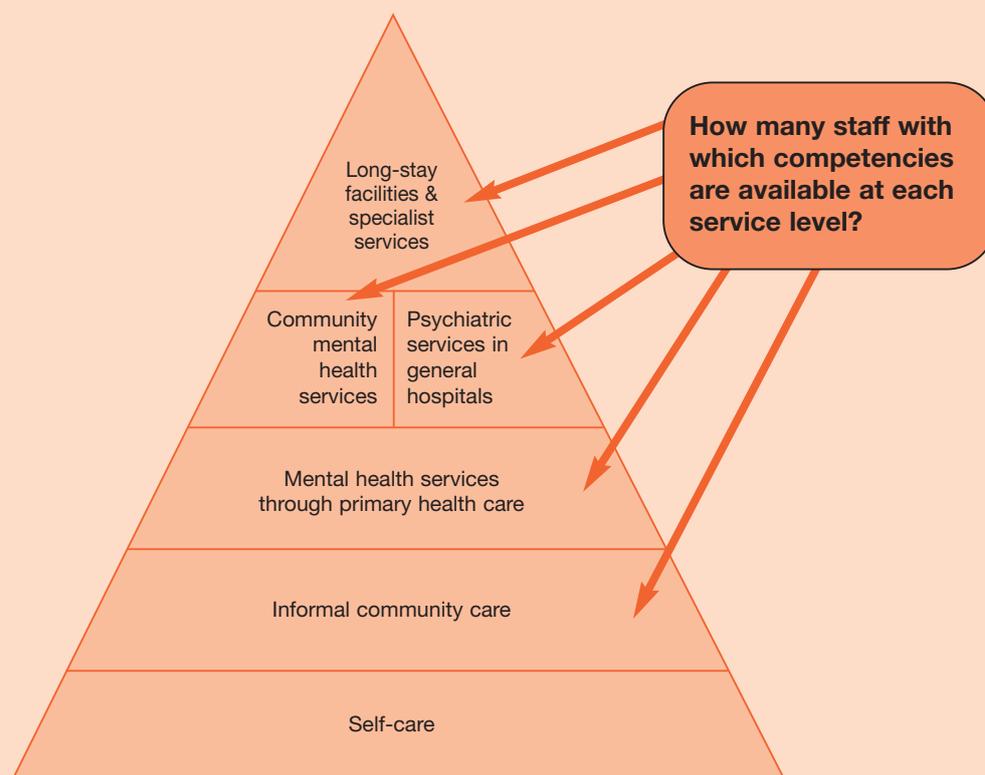
*The WHO pyramid framework can provide a template for mapping the current supply of staff*

**Variables influencing staff supply: How many health workers and with what competencies?**

Staff supply in all of the above service levels is dependent on several variables (illustrated in Figure 4). Each of these variables needs to be analysed in order to make an accurate assessment of the current supply of mental health staff.

**Figure 4. Variables influencing supply of staff in mental health care and general health care**
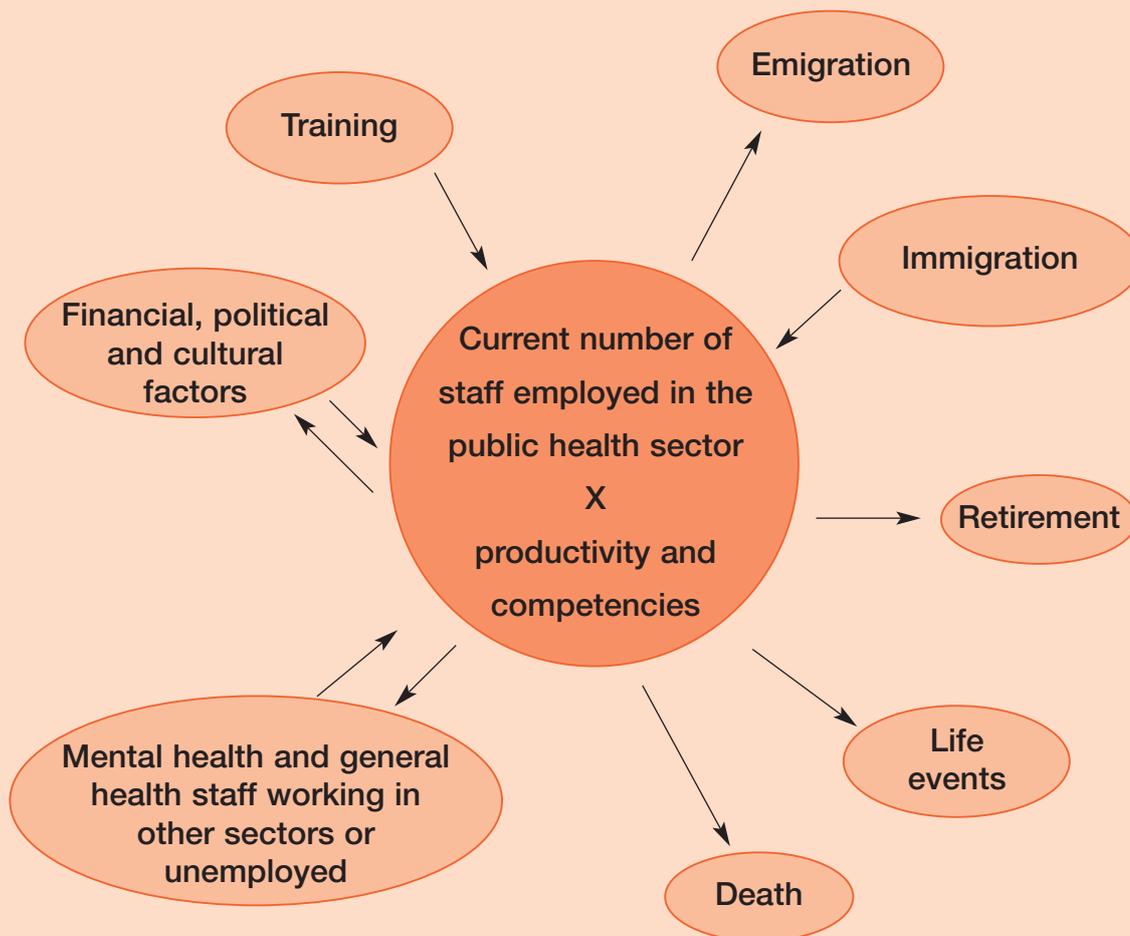


Source: adapted from Green, 1999.

**(i) Mental health and general health staff currently employed in the public health sector**

Information on staff currently employed in the public health sector is usually available from health service records or payroll records. If it is not available, a short-term solution is to conduct a survey of mental health and general health staff. In the longer term, personnel information systems need to be developed to allow ongoing monitoring of the number of staff currently employed.

In many instances, mental health services will not be delivered by specialists (e.g. psychiatrists and mental health nurses), but by general health personnel, who may spend only a portion of their time treating mental disorders. In other instances, mental health staff may work only on a part-time basis. For these reasons, it is useful to measure the number of staff in full-time equivalent (FTE) staff numbers (or whole-time equivalent (WTE), used in some countries). This is a measure of the number of staff available to provide a mental health service on a full-time basis. For example, if a nurse in primary health care spends 20% of her/his time in mental health care (including time spent consulting with service users, keeping records, report writing and supervision) then s/he represents 0.2 of an FTE mental health worker. In other words five such workers would be counted as one FTE mental health worker.

This assessment of the number of FTE general health workers who deliver a mental health service is important because general health staff can deliver many mental health services. For example, a community health worker can be trained in mental health competencies for case identification, emergency assessment and chronic care follow-up. In many countries this approach may be more useful because it integrates mental health care into the primary care system, and it is more cost-effective. Moreover, specialist mental health staff are generally in short supply.

**(ii) Mental health and general health staff not currently employed in the public health sector**

A second important consideration is the number of mental health and general health workers who are not currently employed within the public health sector. This consists of two groups:

> Those currently employed in other sectors, such as the private sector, NGOs, social services, education, the military and the police.
> Those qualified staff who are not currently working in their trained capacity (e.g. a trained psychiatric nurse working as a software programmer).

In order to predict likely future shifts in and out of the public health sector, past patterns can be observed. These patterns may change over time, depending on factors such as salaries, working conditions, standards of care and training.

**(iii) Immigration and emigration**

Immigration and emigration may be important considerations in HR planning. In many countries, mental health workers leave to work elsewhere, attracted by better salaries, and working and living conditions. In order to assess the current supply of staff and likely future trends, planners need to establish the number of staff who immigrate and emigrate annually. An understanding of the factors that influence these trends is important for future planning and training. For example, the International Council of Nurses has undertaken an extensive study of nurse migration. They identified both "push" and "pull" factors that influence the movement of nurses. Push factors include poor pay and working conditions, the impact of HIV/AIDS on the health systems of some countries, and the lack of personal safety in countries experiencing conflict and

*Information on staff currently employed within the public health sector is usually available from health service records or payroll records.*

*A second important consideration is the number of mental health and general health workers who are not currently employed within the public health sector.*

*In many countries, mental health workers leave to work elsewhere, attracted by better salaries, and working and living conditions. An understanding of the factors that influence these trends is important for future planning and training.*

economic instability. Pull factors include better salaries, and working and living conditions (Buchan, Parkin & Sochalski, 2003).

### (iv) Death and retirement

The loss of personnel due to death and retirement can be predicted based on past data and the age profile of the staff. However, it is important to collect accurate data regularly, as changes are likely over time. For example, in the United Kingdom, assuming a reasonable level of retirements and a reasonable level of post-school leavers qualifying in the health professions, one might expect the age profile to be relatively stable. This is not the case. The average age of a nurse in the national health service (NHS) is now around 40 years, when 10 years ago it was around 30 years. Half of all nurses in the United Kingdom are now over 40 years old and 25% are over 50 years old (Malcolm Philip, Sainsbury Centre for Mental Health, United Kingdom, personal communication). In some countries, HIV/AIDS has had a significant impact on the health-care workforce. Loss of staff due to death and retirement therefore needs to be closely monitored in any mental health service.

### (v) Life events

Another factor that influences supply relatively consistently over time are the "life events" which may affect the ability of staff to work. These include maternity, ill health, childcare, old age, care for older adults, stress and bereavement. The availability of support structures and resources to deal with these life events can have an influence. For example, the availability or lack of health facilities and education for the families of mental health workers in remote rural areas are likely to influence the decision of those workers to live and work in those areas.

The influence of life events on any workforce can be established by examining past records of the number of personnel who resign or take leave or early retirement for these reasons. Once again, past data can be used to predict likely future patterns, but accurate, up-to-date data needs to be maintained.

### (vi) Training of new personnel, and percentage entering mental health employment

The number of qualified staff expected to enter the labour market each year after training is an important consideration. This information should be available from training institutions (colleges and universities) within the country. Included in this information should be the availability of mental health training in institutions that train general health workers (e.g. what kind of mental health training nurses receive in nurse training programmes). Information on training in settings outside the country may be harder to obtain, although it may be available from sponsors of scholarships. There are likely to be smaller numbers in the last category, which generally represents specialist training.

Information on the number of staff qualifying from training institutions each year needs to be supplemented with information on the number expected to enter mental health employment. For a variety of reasons, recently qualified staff may choose not to work immediately in their new professions, and this should be taken into consideration.

### (vii) Financial, political and cultural factors

The financial rewards available to staff can significantly influence the current supply of staff. Staff are more likely to be attracted to highly paid positions, and to areas that are economically prosperous with higher standards of living. This has a major impact on staff distribution within and between countries. The mechanism for financing mental health staff also has an important influence on supply. For example, weak funding of

*The loss of personnel due to death and retirement can be predicted based on past data and the age profile of the staff.*

*Certain "life events" may affect the ability of staff to work.*

*The number of qualified staff expected to enter the labour market each year after training is an important consideration.*

public sector mental health services is likely to lead to professional staff seeking employment in the private sector, and providing services only to the wealthier segments of the population who can afford either out-of-pocket payments or private health insurance.

The political environment is also likely to have a major impact on the supply of staff. For example, in Indonesia, following the introduction of a policy of decentralization in 2001, 70% of the provincial governments did not allocate development and operational budgets for public mental hospitals in the 2001 fiscal year. This is in a context where most mental health personnel work in public mental hospitals. As a result, major problems have developed in recruiting and retaining mental health staff.

Similarly, the cultural environment, particularly the way in which the population perceives mental disorders, will have an impact on the supply of staff. Severe stigmatization of mental disorders in certain cultures influences the number of people who are prepared to seek employment as mental health workers.

### (viii) Changes in productivity

The effective supply of staff depends not only on the number of personnel available, but also on their productivity. Where staff can be deployed more efficiently, the effective supply can be increased in real terms. Several factors affect the productivity of staff, including:

> availability of equipment,
> availability of medication,
> inter-staff relations (both within and beyond their own disciplines),
> motivation of staff,
> the organizational setting,
> ability of managers to support and supervise,
> leadership among managers and health workers,
> appreciation shown by service users or communities served, and
> the terms and conditions under which staff work, including financial and non-financial rewards.

Thus, when calculating the current supply, it is important for HR planning not only to examine the number of available staff, but also to take account of the factors that influence productivity.

### (ix) Competencies

The final variable that influences the effective supply of staff is the existing competency and mix of competencies among staff.

Competencies reflect:
> knowledge, understanding and judgment,
> a range of skills: cognitive, technical and interpersonal, and
> a range of personal attributes and attitudes.

Competence is defined as "…a level of performance demonstrating the effective application of knowledge, skill and management" (International Council of Nurses, 1997: 44; see also The Sainsbury Centre for Mental Health, 2001). In practice, the concept of competency is used differently among different occupational groups, in different countries and in different health settings. In this module, the term is used broadly to refer to the components of competency such as knowledge, skills and attitudes.

In order to determine the mental health competencies currently available within a health service, it may be necessary to audit the competencies of the existing staff. In some situations this may not be necessary, as data on their competencies may be collected on a routine basis. In most instances, however, such an audit would be required.

A competency audit is a complex undertaking. Planners need to take into consideration both the existing staff numbers and the competencies with which staff categories are currently equipped. Important sources of information are HR managers, who should be able to provide data on staff competencies within their locality. A questionnaire circulated to key HR managers is one method of eliciting this data. Such data may be supplemented by information from consumer satisfaction surveys, to assess staff competencies from a user perspective. Sometimes it may be necessary to directly observe the type or level of mental health care provided by a range of health workers in a variety of routine settings.

*Several methods may be employed to assess competencies in a workforce.*

If this data is difficult to obtain, an alternative approach is to look at a worker's accreditation to perform certain tasks. For example, professional registration, whereby a medical practitioner is able to prescribe medication or a nurse is able to do a physical examination. Mental health workers may need to undertake a counselling course and receive regular supervision before they can be accredited to provide counselling.

These two approaches are not mutually exclusive. Planners can define the basic accreditation requirements for workers undertaking certain roles, and then assess a few of the basic competencies (such as the conducting of mental state examinations or drug calculations by nurses).

These competencies need to be understood in the context of the current mental health service framework. HR planners should be aware of the way in which the mental health services are organized in their country or region. This means understanding where staff and their competencies are currently concentrated within the service organization pyramid (illustrated in Figure 3 above). Using this service framework, the current staff competencies can then be clearly mapped out. Table 1 provides an example of a competency audit for each service level.

*Competencies need to be understood in the context of the current mental health service framework.*

**Table 1. Example: Auditing mental health competencies within the current workforce***

| Service level | Examples of current competencies | Examples of workers | Additional competencies that might be required |
|---|---|---|---|
| Informal community care (e.g. schools or the justice system) | > Communication skills<br>> Knowledge of childhood development<br>> Family support | Teachers | > Understanding of child and adolescent mental health<br>> Referral to mental health services<br>> Identification of possible mental health problems |
| | > Communication<br>> Crisis management<br>> Understanding of the law | Police officers | > Understanding of mental disorders<br>> Knowledge of stigma<br>> Rights of people with mental disorders<br>> Recognition of acute psychosis |
| Primary health care | > Physical assessment<br>> Health promotion<br>> Counselling and support | Nurses | > Mental health assessment<br>> Psychotropic medication maintenance<br>> Family support |
| | > Physical assessment<br>> Prescription of medication<br>> Communication | Doctors | > Mental health assessment<br>> Treatment of common mental disorders<br>> Family support |
| Community mental health | > Assessment<br>> Pharmacotherapy<br>> Psychotherapy<br>> Administration and management | Psychiatrists | > Supervision and secondary consultation<br>> Research and evaluation |
| | > Psychological assessment<br>> Psychotherapy | Psychologists | > Crisis intervention<br>> Assertive outreach |
| General hospital psychiatric unit | > Assessment<br>> Psychotropic medication maintenance<br>> Ward management | Mental health nurses | > Knowledge of stigma<br>> Rehabilitation<br>> Legal issues<br>> Brief psychotherapy<br>> Family education |
| Specialist mental health services | > Assessment<br>> Legal issues<br>> Treatment of mental disorders | Psychiatrists working in a forensic setting | > Knowledge of stigma<br>> Research skills<br>> Training of non-medical professionals (e.g. police officers) |

*Note: The disciplines and competencies used in this table are examples, and are not intended to cover all disciplines and competencies working in mental health.*

The information from the competency audit needs to be retained for comparison with the needs assessment (Step 2), and for eventual use as a basis for the setting of targets and the content of training curricula. In this way, gaps in current competencies can be addressed through the mental health training of future health workers and the provision of continuing mental health education for existing health workers (see Section 5 below, on training).

### What information sources can be used to calculate supply?

Obtaining information about the variables that affect staff supply may be difficult. Table 2 offers some suggestions as to possible sources of information.

**Table 2. Possible sources of information on variables affecting the supply of staff**

| Data | Source |
|---|---|
| Currently employed staff | Personnel records, surveys, professional registers |
| Other sectors | Registers of professional boards, personnel records in other sectors (e.g. education, housing, NGOs) |
| Emigration | Foreign affairs records |
| Immigration | Foreign affairs records |
| Training output | Training school records, education ministry |
| Deaths | Personnel records, national age-specific mortality rates |
| Retirement | Personnel records |
| Transfers | Survey registers |
| Productivity | Workplace audit, duty rosters, medication and equipment supply, interviews |
| Competencies | Competency audit, personnel records, accreditation mechanisms (e.g. professional societies) |

*Source: adapted from Green, 1999.*

Disciplines with large staffing levels, such as nursing, are likely to have existing planning processes, information systems and mechanisms for assessing the current supply of staff. Wherever possible, it is useful to use these existing systems. For example, in some countries, government bodies may produce information about labour markets, staffing of health services and social care services that could be a useful source of data.

However, in other countries with underdeveloped information systems it may be difficult to gain access to this information.  In this instance, it is important to draw on the best available data, and, where possible, to explore establishing information systems to gather and process this data (see module on *Mental Health Information Systems and Indicators*).

In many countries it might be simpler to identify the numbers of current staff at each service level than the competencies.  In this instance, it may be necessary to separate the tasks of counting staff and identifying their competencies. The former task is relatively easily done, and the latter may require a separate survey or more in-depth investigation of the activities of personnel.

A review of current staff disciplines should include not only clinical staff, but also staff involved in planning, management, training, policy development, service evaluation and programme design. This would include managers, epidemiologists, senior mental health professionals, economists, information technology specialists, management specialists and researchers (Mosley, 1994). Staff who provide services as part of general health care (e.g. pharmacists) and support staff (e.g. administrators and information managers) should also be included. In addition, in some countries where service users or consumers are employed as "consumer affairs advisers", peer counsellors or "consumer advocates", they too should be included in such a review. This review is essential for a comprehensive assessment of the current supply of clinical, management, planning and support staff.

*A review of current staff supply should focus not only on clinical staff.*

An analysis of the factors that affect personnel supply may yield different results for different regions within the same country. For this reason, a local analysis of the supply of personnel is often useful to supplement national data.

*A local analysis of the supply of staff is often useful to supplement national data.*

Table 3 provides an illustration of the calculation of the current supply of staff in a local area, taking into consideration some of the variables discussed above.

**Table 3. Example: Determining the current numbers of staff available for mental health care**

| Service level | Discipline* | Currently employed | Emigration** |
|---|---|---|---|
| **Informal community care** | Trained police, teachers or prison staff | 0 | |
| **Primary health care** | Community health workers**** | 20 | 0 |
| | Primary health care nurses | 12 | 0 |
| | General practitioners | 2 | 0 |
| **Formal community care** | Mental health nurses | 5 | -1 |
| | Psychiatrists | 0.5 | -0.2 |
| | Psychologists | 0.3 | -0.1 |
| | Occupational therapists | 0.6 | 0 |
| | Social workers | 1.5 | 0 |
| **General hospital psychiatric unit** | Mental health nurses | 5 | -2 |
| | Psychiatrists | 0.4 | -0.2 |
| | Social workers | 2 | 0 |
| **Specialist mental health services** | Psychiatrists | 0.5 | -0.2 |
| | Psychologists | 0.3 | -0.1 |
| | Pharmacists | 0.1 | 0 |
| **Central planning unit** | Administrators | 3 | 0 |
| | Information managers | 1 | 0 |
| | **Total** | **54.2** | **-3.8** |

\*      *Staff numbers are given as full-time equivalent (FTE).*
\*\*    *Numbers added and subtracted for emigration, immigration, death, etc., are calculated for one year, enabling a calculation of the annual supply of staff.*
\*\*\*  *The anticipated supply is calculated for one year from the present, taking into consideration all the variables identified (e.g. the number of new staff trained during a year). This figure would need to be interpreted in the light of additional information regarding productivity and the competencies of staff.*
\*\*\*\* *Including home-based care-givers.*

*Note: These are examples using nominal figures, and not official WHO recommendations.*

| Immigration | Death/retirement/ life events | Training (anticipated) | Anticipated supply*** |
|---|---|---|---|
|  |  |  | **0** |
| 0 | -2 | +5 | **23** |
| 0 | -2 | +3 | **13** |
| 0 | -0.1 | +0.5 | **2.4** |
| 0 | -0.5 | +1 | **4.5** |
| 0 | -0.1 | +0.2 | **0.4** |
| 0 | -0.1 | +0.2 | **0.3** |
| +0.1 | -0.2 | +0.2 | **0.7** |
| 0 | -0.3 | 0.5 | **1.7** |
| 0 | -1 | +2 | **4** |
| 0 | -0.1 | +0.2 | **0.3** |
| 0 | -0.3 | 0.5 | **2.2** |
| 0 | -0.1 | +0.2 | **0.4** |
| 0 | -0.1 | +0.2 | **0.3** |
| 0 | -0.1 | +0.1 | **0.1** |
| 0 | -0.5 | +1 | **3.5** |
| 0 | -0.2 | +0.5 | **1.3** |
| **+0.1** | **-7.7** | **+15.3** | **58.1** |

### 3.1.3   Task 3: Assess utilization of services

The final task in the situation analysis is to review the extent to which mental health services are currently being utilized. This information is important for indicating to planners areas where staff are not able to meet the expressed demands of the population, such as an undersupply of staff (shown by excessive waiting times) or an oversupply of staff (i.e. where staff numbers exceed the demand).

The information can be gathered as part of routine service monitoring, such as through existing information systems. If these information systems do not provide adequate information, a survey may need to be conducted. Useful indicators of utilization include:

> admissions
> bed occupancy
> average length of stay or admission (ALOS)
> outpatient attendance
> service users on case registers
> filled places in day services
> number of households with home-based care
> number participating in disorder prevention or mental health promotion programmes.

Definitions and formulae for each of these indicators, as well as a more detailed account of methods for assessing service utilization, are provided in the module on *Planning and Budgeting to Deliver Services for Mental Health*.

Because of the intersectoral nature of mental health service provision, these indicators gathered from within the health sector may need to be supplemented with indicators of utilization in other sectors. These include, for example, the number of mental health service users in homeless shelters or prisons, or the number of children receiving mental health care in schools.

This information can be used along with a range of other information on policy, supply and need in order to set HR targets (see Step 3).

Table 4 provides an example from a review of public sector mental health services in South Africa (Flisher et al., 1998).

**Table 4.  Example: Current public sector mental health service utilization indicators in South Africa**

| Indicator | National mean (provincial range) |
|---|---|
| Annual admission rate per 100 000 population | **150 (33-300)** |
| Bed occupancy rate* | **83% (63%–109%)** |
| Average length of admissions (days) | Psychiatric hospitals: **219 (60–3 650)** |
| (or average length of stay – ALOS) | General regional hospitals: **11 (1.5–28)** |
| | General district hospitals: **7 (1.5–14)** |
| Annual outpatient attendance per 100 000 population | **3 427 (1 215–5 490)** |
| Daily patient visits (DPV) per 100 000 | **13 (5–21)** |
| Community/hospital ratio (service utilization) | **66% (44%–93%)** |

\* Bed occupancy was not separated for acute and long-stay facilities in this study.

Note: Definitions and formulae for the indicators listed in the table are provided in the module, *Planning and Budgeting to Deliver Services for Mental Health*.

**Key points: Step 1. Situation analysis**

**Task 1: Review current HR policy**

Planners need to be informed about the current policies and their implications for HR development.

**Task 2: Assess current supply of staff**

In order to assess the current supply of staff, planners need to review current staffing for all disciplines in all service settings.  The supply of current staffing is dependent on several variables:

> Mental health and general health staff currently employed in the public health sector
> Mental health and general health staff not currently employed in the public health sector
> Immigration and emigration
> Death and retirement
> Life events
> Training of new personnel and percentage entering employment in mental health services
> Financial, political and cultural factors
> Changes in productivity
> Competencies

**Task 3: Assess utilization of services**

The final task in the situation analysis is to review the extent to which mental health services are currently being utilized.  This information is important for providing planners with an indication of where the existing level of staffing is not able to meet the expressed demands of the population.

### 3.2 Step 2. Needs assessment

A needs assessment is essential to supplement the data about existing services, gathered in the situation analysis. Although the situation analysis provides a measure of the current staffing supply, a needs assessment is necessary to assist planners to gauge what staff will be required to address the future mental health needs of the community.

If HR planning proceeded on the basis of supply alone (as it frequently does), the number of available staff would simply be based on the *status quo*. This means that historical patterns of funding and service planning, rather than the actual need for mental health care in the community, would provide the basis for human resources planning. As mentioned earlier, mental health needs are often hidden in the community and not met by existing services. Thus measures of current service utilization do not provide enough information on the need for services.

For example, in Romania, overutilization of hospital beds was to a large extent due to the relative lack of alternative community care and social assistance facilities. Planning on the basis of the current utilization of beds alone could lead to the erroneous view that more staff were needed, when in fact the whole service system might need to be reorganized, and more services provided in the community (Bogdana Tudorache, President of the Romanian League for Mental Health, Bucharest, Romania, personal communication). Similarly, in Slovenia, the current supply of staff cannot be calculated according to local situations, since most mental health personnel are concentrated in institutions. Therefore reform of the entire system is required, with planning based on need rather than on the current supply alone (Vesna Svab, President, Slovenian Association for Mental Health (SENT), personal communication).

Conducting a needs assessment requires several tasks. First, the need for services within the community has to be identified. On this basis, the services required to meet the identified needs can be estimated. The functions and competencies required to provide those services can then be identified. From the required competencies, the necessary staff can be estimated. Figure 5 illustrates this process.

**Figure 5. Estimating staffing based on service needs**
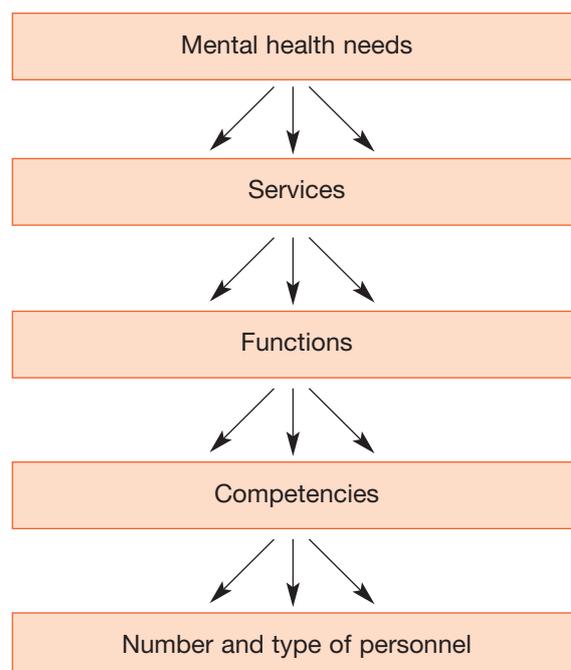


*Source: adapted from Green, 1999.*

In order to estimate staff using this method, it may be necessary to gather a *group of key informants or experts*, to recommend a set of services, and the functions and competencies required to provide those services. Those services should be in keeping with the best evidence regarding cost-effective care. The group of experts should therefore be well informed about the most recent research into evidence-based practices for treating and managing mental disorders. In addition, the group should include service users.

### 3.2.1 Task 1: Estimate needs

The first task is to estimate the need for care within the community are one type of source. For details of how to conduct this task, please refer to the module, *Planning and Budgeting to Deliver Services for Mental Health*.

To summarize, three activities are required:

> Establish the *prevalence or incidence* of the priority mental health conditions. The priority conditions need to be identified from the existing policy or strategic plan. Alternatively, in the case of mental health promotion, establish the target group that is expected to receive the promotion programme.
> Where necessary, make *adjustments* according to local population variables.
> Identify the *number of expected cases* (or the number targeted for the mental health promotion programme) per year.

To obtain a measure of the requirement for mental health services, information should be obtained from sources beyond the existing services. There are several possible sources:

> Epidemiological surveys of the extent of mental disorders in the community are one type of source. If local epidemiological data are not available, data may be adapted from other settings (for an explanation of this method, see the module on *Planning and Budgeting to Deliver Services for Mental Health*).
> If comparable data are not available, best estimates based on other sources of local information and expert opinions may be used. Qualitative data should be used as a basis for these rapid assessment methods.
> In the case of mental health promotion, population-based data regarding the number and demographic characteristics of people who could benefit from mental health promotion may be used (for example, in schools and prisons).
> Estimates should be made of vulnerable groups (for example, the number of people affected by natural disasters or conflict).

"Need" is also culturally determined, which makes it necessary to state what role a mental health programme/service would play in each country or region. Issues of culture and needs assessment are discussed in more detail in the module, *Planning and Budgeting to Deliver Services for Mental Health* (see also Patel, 2000; Swartz, 1998).

This needs assessment is likely to be conducted in the context of wider service planning (e.g. planning for beds, infrastructure and medication). Planners for human resources therefore need to draw on this information, where possible.

**Box 2. Example: Needs assessment, using epidemiological data for service planning in Australia**

During the late 1990s, the Australian Government commissioned a National Survey of Mental Health and Wellbeing (Henderson, Andrews & Hall, 2000). An academic research team worked with the Australian Bureau of Statistics to investigate the prevalence of mental disorders, as well as the characteristics of those affected – income level, education, type of accommodation, health and community services used. The Australian Institute of Health and Welfare also carried out a wide-ranging study of unmet needs for welfare services, with people with a mental disorder forming one of the largest groups in need of such support. This comprehensive research has proved an invaluable tool for assessing needs and planning mental health services in Australia.

### 3.2.2 Task 2: Map the services required for the identified needs: the WHO service framework pyramid

From the estimate of mental health needs, services required to meet those needs can be estimated. Staffing does not take place in a vacuum; it is therefore essential to outline the service organization framework, or profile of services in which staff are to be located. In short, what services are required, and how should they be organized?

*From the estimate of mental health needs, services required to meet those needs can be estimated.*

The WHO service framework pyramid (set out in the Introduction to this module, Figure 1) can be used as a template to calculate what services are to be provided at each service level. This exercise is likely to be conducted as part of wider service planning. Details of the tasks required are set out in the modules, *Organization of Services for Mental Health*, and *Planning and Budgeting to Deliver Services for Mental Health*.

*The WHO service framework pyramid can be used to identify an optimal mix of services.*

### 3.2.3 Task 3: Identify the staff required at each service level

The next task is to identify what staff are required at each service level. To plan systematically for the entire mental health service, *functions and required competencies need to be identified for each of the service levels* illustrated in the WHO service framework pyramid (Figure 1). In short, what functions are required for each given service, and how should staff be equipped to undertake those functions?

*To plan systematically for the entire mental health service, the functions and competencies need to be identified for each of the service levels in the WHO service framework pyramid.*

The specific functions and competencies for each service level in the WHO pyramid are set out in Section 5 on training.

For example, for primary health care, some important functions are to identify and manage mental disorders. Competencies for fulfilling these functions include the ability to diagnose (knowledge of symptoms and the course) and provide treatment (knowledge of and skills in providing medications, and psychosocial approaches for treatment and support) for a range of mental disorders. Different primary health care workers and professionals (e.g. general practitioners and general nurses) might perform different functions at each of the levels, and hence would need to have different types of competencies. The important point is that within the context of any service level, the right sorts of competencies should be available to fulfil the functions of the service.

To illustrate this process further, Figure 6 provides a more detailed example of the method for estimating the need for mental health staff at the primary health care level. In Part A of this example, the service need is identified and the functions and competencies required to meet this need are described. In Part B, the current personnel available with the appropriate competencies are outlined, together with gaps in the personnel and hence the training needs.

**Figure 6. Example: Estimating staffing from service needs, applied to primary health care clinics**

**Part A**

**Need:**

To detect and manage mental disorders in primary care. Numbers identified from a survey of a local community: clinic anticipates undertaking 7 new assessments and 30 routine follow-up contacts per day.

**Functions:**

> Identify mental disorders
> Provide basic medication and psychotherapeutic interventions
> Refer to specialist mental health services
> Family and community psycho-education
> Crisis intervention
> Mental health promotion and prevention of disorders

**Competencies:**

| | | | |
|---|---|---|---|
| Diagnosis | Prescription | Referral | Communication |
| Administrative tasks | Counselling | Crisis intervention | Knowledge of medication, MH |
| Psycho-education | Support | Advocacy | Prevention and promotion |

**Part B**

**Competencies, personnel and training**

| Competencies | Current personnel | Possible new personnel (or training of existing personnel) |
|---|---|---|
| Support | PHCN | Not required |
| Communication | PHCN | Not required |
| Admin. tasks | PHCN | Not required |
| Knowledge of medication, MH | Not available | CMHN or PHCN with MH training |
| Diagnosis | Not available | CMHN or PHCN with MH training |
| Referral | Not available | CMHN or PHCN with MH training |

| | | |
|---|---|---|
| Psycho-education | Not available | CMHN or PHCN with MH training |
| Crisis intervention | Not available | CMHN or PHCN with MH training |
| Advocacy | Not available | CMHN or PHCN with MH training |
| Counselling | Not available | CMHN or PHCN with MH training |
| Prevention and promotion | Not available | CMHN or PHCN with MH training |
| Prescription | Not available | GP or CMHN |

MH    -    Mental health
PHCN -    Primary health care nurse
CMHN -   Community mental health nurse
GP    -    General practitioner

*\* Note: the list of functions and competencies is not intended to be exhaustive; it is merely illustrative.*

*Source: adapted from Green, 1999.*

There are several advantages to this approach:

> Staffing needs are identified within the context of a broad service framework that addresses the range of mental health needs of the population.
> Staffing needs are estimated based on the needs of the population rather than on the current staffing situation alone. This will result in a workforce that is more appropriate for meeting the population's needs.
> Particular services are not immediately identified with particular disciplines. There is therefore scope for substitution and for a more creative use of staff.
> This means that services can be planned in a holistic manner, according to the competency mix required, rather than planning separately for each discipline.
> If competencies are not covered by existing staff, the need for new training may be identified.
> It is possible to demonstrate clearly to those controlling the budget, or to funding agencies, how the need for staff is estimated. It therefore offers a planning method that is rational and transparent.

In outlining the profile of staff needed, it is important that planners do not restrict themselves to the existing staff profiles. In some settings, these may not be appropriate, and the creation of novel mental health practitioners may be necessary. For example, in New Zealand, a new class of worker – a community mental health support worker – was created, resulting in 921 such workers operating in less than 10 years. This was in response to the need for a cost-effective mental health practitioner who was in touch with community needs and was able to work collaboratively with existing mental health professionals. The community mental health support worker helps mental health service users locate suitable housing, find employment, and re-establish social networks that assist with recovery. These non-clinical support services fill the gap between medical services and social services. Social services may not always have a good understanding of how best to support recovery from mental illness. The community

*There are several advantages to the approach of estimating staff from service needs.*

*It is important that planners do not restrict themselves to the existing staff profiles. New categories may be needed.*

mental health worker thus helps meet the social needs of mental health service users as part of a comprehensive recovery plan (Todd Krieble, Ministry of Health, Wellington, New Zealand, personal communication).

A similar example in China is the creation of a new class of psychiatric social workers. This has involved a long political process of establishing training programmes and getting recognition by the Bureau of Personnel for this category of provider (with concomitant promotion and salary categories) (Michael Philips, Beijing Huilongguan Hospital, China, personal communication).

In other countries, traditionally, care has been provided by doctors and nurses, and there will be a need to expand the profile of professionals to include psychologists, social workers and occupational therapists. However, in many countries that do not have the resources to develop these new professional categories, it is necessary to provide the existing workforce with mental health competencies. The example provided in Figure 6 above, is an illustration of how this may be done by training existing primary health care workers in basic mental health competencies.

In this process, it is important to identify the roles of various disciplines, to ensure that their roles are complementary but do not overlap excessively. As noted in section 2 above, the role of teams and the development of the workforce into effective multidisciplinary teams is an essential aspect of the redesigning of the workforce (The Sainsbury Centre for Mental Health, 1997).

### 3.2.4 Task 4: Estimate the number of staff required at each service level

Given a broad outline of the functions, competencies and staff required at each service level, numbers of staff can now be estimated. The identified need from Task 1 can be converted into workload by estimating the number of people expected to utilize the required mental health services within a specified time frame (for more detail, see the module on *Planning and Budgeting to Deliver Services for Mental Health*).

*The staffing numbers can be estimated based on the needs assessment.*

Once the expected workload for a service has been identified, the number of staff needed can be calculated using the following formula (adapted from Shipp, 1998):

$$\frac{\text{Expected workload in the facility (derived from service need)}}{\text{Standard workload (for one staff member)}} = \text{Staffing need}$$

The standard workload (denominator) can be estimated as follows. Every mental health facility (clinic, day hospital, inpatient ward) has its own pattern of work. Its workload requires effort, which can be measured either in time (e.g. time taken to complete an assessment), or in the rate of activities completed (e.g. number of service users seen during a day). For each type of workload, an *activity standard* can be set. This is a unit time or rate for each staff category (Shipp, 1998).

*For each type of workload, an activity standard can be set.*

This activity standard will differ, depending on the type of activity (inpatient, outpatient clinic), the staff categories involved (nurses, psychiatrists, occupational therapists) and the type of facility (primary, secondary or tertiary care). The standard can then be converted into an equivalent *annual* workload, by calculating how much of this work could be done by one person during a year, working according to specified professional quality standards, using specified competencies, and taking into account such factors as leave, absence due to illness, training, supervision, administrative tasks and travel time.

*This activity standard can be converted into an equivalent annual workload, known as the standard workload.*

It is necessary to use a range of information to calculate this figure. Worker and organizational factors will affect workload calculations. For example, less experienced workers generally will not manage as heavy a workload as experienced workers. In some services, such as hospital-based programmes, there may be existing strategies to calculate the required workload, while in others this may be more difficult. Moreover, there may be industrial agreements that define minimum staffing numbers.

The equivalent annual workload is known as the *standard workload*. This is the denominator in the above formula.

The numerator (expected workload) can be estimated from the number of people expected to use the identified service, as identified by the need estimation in Task 1.

Combining these two sources of information using the formula provides the staffing estimates needed for the specific facility. The workload can be adjusted according to the specific circumstances of the facility. For example, service users admitted to a tertiary psychiatric inpatient facility are likely to require different amounts of staff time than service users admitted to a district general hospital inpatient facility.

No adjustment in activity standards is necessary for different locations when the same task is required. For example, the same number of assessments in primary care settings can be conducted in region A as in region B. Thus standards of workload (and the quality of care) can be maintained across a given country. If there is likely to be variation within a country, and standards need to be adjusted, the activity standard can be set on a regional basis.

If necessary, this method can be extended to voluntary organizations and private providers, allowing for wider regulation and planning of human resources across sectors. For example, the activities of HIV counsellors in NGOs could be standardized across a given region to enable coordination of the different agencies working in the area (with their full participation in this process). This method can also be adapted to estimate staffing according to plans for future service development (e.g. anticipated increases in workload).

The results of this estimate may need to be adapted to the specific circumstances of the health service. An example is the calculation of required staffing within an integrated primary health care setting: if needs are calculated for primary health care workers who would spend only a portion of their time in mental health work, a proportional estimate may be of value. Thus, if it is estimated that six full-time equivalent primary health care nurses are required for mental health in a district, this may be adapted to a recommendation that 30 primary health care nurses are required for that district, each spending 20% of their time on mental health activities.

It is essential throughout this process to be explicit about the assumptions that have been used in the needs estimations, so that it is clear how the recommendations were derived. A thorough consultation process is an important means of making this process transparent (for a more detailed explanation of the workload indicators for staffing needs (WISN), see Shipp, 1998).

The example in Box 3 provides an illustration of this needs assessment method. Once again, this example is applied to only one service level (primary health care level). When applying this method to the comprehensive mental health needs of a population, similar calculations could be made for all service levels identified in the WHO pyramid (Figure 1).

**Box 3. Example: Estimating mental health staff needed in primary care clinics**

| Province: | X | | Year: | 2003 |
|---|---|---|---|---|
| District: | Y | | | |

| Expected workload* | Standard workload | PHC nurses** needed | Expected workload* | Standard workload | CHWs*** needed |
|---|---|---|---|---|---|
| New assessments | | | New assessments | | |
| 7 920 | /2 250 | = 3.5 | 7 920 | /1 125 | = 7.0 |
| Routine medication management | | | Routine medication management | | |
| 3 168 | /700 | = 4.5 | 3 168 | /350 | = 9.0 |

Source: adapted from Shipp, 1998.

\*    Expected workload includes the number of people expected to attend the clinic from a survey of the annual prevalence of identified severe psychiatric disorders during a year (estimated to be 30 new assessments and 12 service users for routine medication management per day, assuming 264 working days per year). Standard workload is estimated as cases seen per year, including time required for such aspects as administration, continuing training, supervision and leave (see text for detailed explanation).

\*\*   PHC nurses = primary health care nurses (full-time equivalent).

\*\*\*  CHWs = Community health workers (full-time equivalent). Data from clinics suggest that CHWs spend approximately twice as much time per user as nurses, their additional activities including home visits, family education and liaison with other sectors (such as the police, social services and NGOs).

*Note: These are examples, using nominal figures, and are not official WHO recommendations.*

**Key points: Step 2. Needs assessment**

**Task 1: Estimate needs**

The first task is to estimate the needs for care in the community, for example, how many people, and with what kinds of disorders will require care during an average year?

**Task 2: Map the services required for the identified needs**

From the estimate of mental health needs, the services required to meet those needs can be estimated. The framework for these services can be mapped, using the WHO pyramid. This covers:

> informal community mental health services,
> mental health services through primary health care,
> mental health services through general hospitals,
> formal community mental health services, and
> long-stay hospital facilities and specialist mental health services.

**Task 3: Identify the staff required at each service level**

The next task is to identify the staff needed, in terms of their functions and competencies, to deliver the services at each level (explained in detail in Section 5 on training).

**Task 4: Estimate the number of staff required at each service level**

With a broad outline of the functions, competencies and staff required at each service level, numbers of staff should be estimated. The identified need from Task 1 can be converted into workload, by estimating the number of people who would utilize the required mental health services within a specified time frame. Once the expected workload for a service and the standard workload per staff member are identified, the number of staff required can be calculated.

### 3.3  Step 3. Target setting

#### 3.3.1  Task 1: Compare supply and need

Having calculated the current supply of staff and estimated staffing needs, targets can now be set. In order to set targets, the two sets of information gathered so far (concerning supply of staff and need for staff) should be compared. The comparison can be conducted using two methods of calculation (adapted from Shipp, 1998):

> the difference, and
> the ratio

The *difference* between need requirements and current supply yields the number of new staff necessary to fulfil the requirements for the facility (difference = supply minus need). For example, if the supply indicates that there are 12 FTE nurses delivering mental health care in the local area, and the need indicates that 15 FTE nurses are required, 3 new FTE staff would be needed to fulfil the requirements for that service.

The *ratio* can be calculated by dividing the current staffing level by the staff needed (ratio = supply/need).  For example, if the staff need (for 8 nurses) exceeds the current staffing supply (of 6), a ratio can be generated (6/8) = 0.75 or 75%. This is an adaptation of the workload indicators for staffing need (WISN) ratio (Shipp, 1998).  If the ratio is 1.0, there are just enough staff to serve the facility; if the ratio is <1.0 there are not enough, and if it is >1.0 the facility has an excess of staff.

The ratio method is useful for comparing staff needs between regions or districts, as higher ratios are likely to indicate higher levels of human resource provision. It is a useful way of assessing which facility or area should be given priority when allocating resources. For example, a shortage of 3 nurses in a clinic where there should be 10 nurses yields a ratio of 0.7 (or 70%). A shortage of 7 nurses in a hospital that should have 70 nurses yields a ratio of 0.9 (or 90%). This shows that the nurses in the clinic are under much greater work pressure (30% understaffed) than the hospital (10% understaffed). Normally, the shortage of 7 nurses would demand more urgent attention, but an analysis of the ratios indicates where the demand is greatest. The same method can be used to indicate excess staff in certain areas.

The limitations of this method are as follows:

> It depends on the accuracy of existing service statistics and of the needs assessment (dealt with by improving accuracy; see modules: *Planning and Budgeting to Deliver Services for Mental Health* and *Mental Health Information Systems and Indicators*).
> There may be overlap between staff categories in certain activities (workload). This can be dealt with by allocating activities to staff categories proportionally (e.g. 60:40).
> Workload is usually calculated retrospectively and may be outdated. This can be dealt with by maintaining up-to-date workload data; it is assisted by the fact that the workload is not likely to change rapidly – percentage changes can be added to modify figures if necessary.
> The workload may be affected by the supply of technologies and medication. For example,  a lack of psychotropic medication may affect the nature of work which the clinical staff can perform. This can be dealt with by including this consideration in staffing estimations – if the supply of medication is expected to improve/increase, the estimation of the workload should be adjusted accordingly. For example, a more consistent supply of medication may alter the need for rehabilitation work.

*The next task is to compare supply and need. This can be done by calculating the difference and the ratio.*

*There are some limitations to using  the ratio method.*

### 3.3.2 Task 2: Adjust targets according to utilization: "growing" human resources

When comparing supply and need, it is likely that there will be considerable discrepancy between the current staff available and the estimates of staff required to meet the needs of the population. It is also possible that estimates of staffing based on a needs assessment will not correspond with the actual utilization of services, as demonstrated in Australia (Andrews & Henderson, 2000). It is therefore necessary to use a method of grading targets, taking into account the utilization of services and budgetary realities.

The method suggested for this is to draw up a list of options and set priorities according to certain criteria (see module on *Planning and Budgeting to Deliver Services for Mental Health* for a description of this method and a list of criteria).

To further assist planners, it is suggested that measures of the utilization of services be used to guide the setting of annual staffing targets. On this basis, graded targets can be set according to available budgets and the extent of utilization of services, with the overall goal of developing human resources to meet the needs of the population (see Figure 7).

There is frequently tension between need and utilization in mental health planning. This method allows planners to set targets according to need, while adjusting those targets according to current utilization, as the workforce is "grown" to keep pace with increased utilization over time.

In order to be able to use utilization measures it is necessary to gather accurate data on the utilization of mental health services on a routine basis (see Step 1, Situation Analysis: Task 3 above, for some of the indicators which may be used to measure the utilization rate).

**Figure 7. "Growing" human resources: adjusting targets over time, according to utilization.**
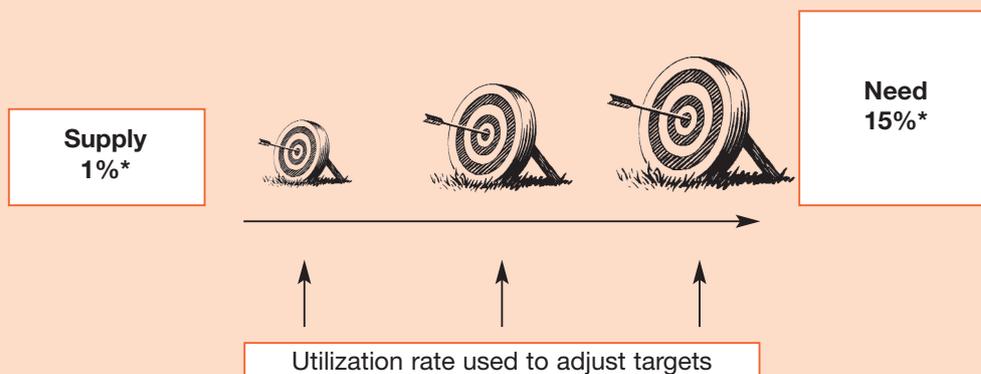


\*     The figures of 1% and 15% represent the proportion of the population covered by mental health staff.  These are nominal figures, used for illustrative purposes only, and are not WHO recommendations.

To illustrate this process more concretely, Figure 8 provides an example of staffing figures taken from South Africa's mental health services, with adjustments according to anticipated increases in utilization.

**Figure 8. Example: From supply to need, based on data from South Africa's mental health services**
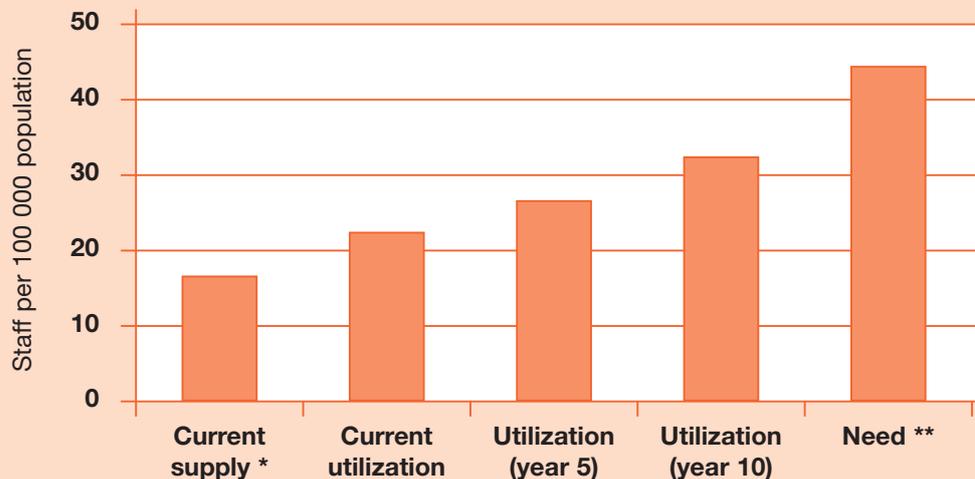


\*   Supply figures taken from Lund & Flisher, 2002b.
\*\*   Needs figures taken from Flisher et al., 1998.

Having calculated the difference between current supply and need, and set priorities for HR development in the light of current policy, the utilization of services and the available budgets, specific courses of action can now be taken.

These can be directed either at the supply of staff (Green, 1999) or the need for staff. The following are examples of the courses of action that countries can take.

**(i) Set targets for supply**

> Change the output of training programmes (up or down), for example, by setting quotas for universities or training institutions according to projected needs for staff. Projections can be obtained from anticipated needs, as determined in the above estimations. These quotas should be set in consultation with the training institutions concerned.
> Change the content of the training programmes to produce appropriate competencies (see Section 5 below on training).
> Develop and deliver new mental health training programmes that can be embedded into the existing health care service.
> Clarify the mental health competencies that are expected of all health care professionals, in keeping with their role (e.g. accident and emergency nurses need to know how to deal with violent psychotic people).
> Identify areas where staff can be used more efficiently.
> Identify new job roles, to make more appropriate use of staff based on changes in the service organization. For example, develop new roles of community-based care, clarify the roles of voluntary workers, or enhance the role of the voluntary sector.
> Identify new categories of mental health workers, such as community mental health support workers.

*Specific courses of action can be taken, directed at either the supply of or the need for personnel.*

> Recruit or contract mental health personnel not currently working in the public sector, including providing incentives to attract mental health staff to the public sector from the private sector. Financial incentives might include benefits and income security, even if salaries cannot be matched.
> Establish targets for retention of current mental health staff (i.e. aim at a reduction in the percentage of staff lost to the service each year).
> Introduce incentives for mental health staff to work in underserved areas, such as rural areas. For example, in South Africa, clinical psychologists are required to undertake one year of community service immediately after qualifying. Exposure to these areas during training or community service can demonstrate to staff the potential rewards of working there.
> Ensure that general health posts that include a mental health component are advertised and described accurately to include the mental health component.
> Change personnel policies to improve retention of staff.

**(ii) Set targets for need**

> Change the service objectives (up or down), and hence the personnel requirements.
> Change the competency mix required by changing the way in which the service is provided (e.g. using primary care workers to manage mental health at primary level and reserving complex problems for specialist staff).

**(iii) Growth and change**

In "growing" the workforce, it is important to bear in mind that this may not simply require increasing the number of staff, but also redistributing existing staff and developing new competencies. For example, if there is to be a change from institutional to community-based models, the existing workforce may need retraining. It should not be assumed that the competencies are the same.

Growth and change could be facilitated through new combinations of professionals, support staff and local community members, such as traditional healers. Thus "growing" the workforce may not mean "more staff" so much as "staff working differently".

*"Growing" the workforce may require not only increasing the number of staff, but also redistributing existing staff and developing new competencies.*

Planning also needs to consider unintended consequences of certain interventions. By trying to develop a workforce in one area, shortages may be created in another. For example, a lot of emphasis on training and encouraging people to work in the community might create or exacerbate shortages in hospital settings.

In this context, the use of pilot projects and small innovations at a time are useful. New schemes can be more manageable if implemented on a small scale and carefully evaluated, as this identifies barriers and feasibility issues before major changes are made to the whole service structure.

WHO research has shown the importance of devising HR strategies that fit the particular situations countries face (Egger, Lipson & Adams, 2000). In short, "the solution must fit the problem" (Table 5). These strategies have been used by countries in reforming HR policies for general health, and may require significant political and financial support (WHO, 2000).

**Table 5. Finding solutions that fit the problem**

| Problem | Solution |
|---|---|
| Uneven staff distribution | ✔ More efficient use of available staff<br>✔ Create mechanisms and incentives for staff redistribution<br>✔ Make use of multi-skilled personnel<br>✔ Create a closer match of competencies to functions |
| Insufficient staff numbers | ✔ Educate and train appropriate staff<br>✔ Provide retraining for general health staff in mental health competencies<br>✔ Review the competency mix of the existing workforce<br>✔ Reform training curricula to match competencies to needs in a more efficient manner<br>✔ Strengthen and support teamwork, setting a local list of priorities for the team<br>✔ Identify new categories of mental health workers, such as community mental health support workers<br>✔ Involve and train family members, users and volunteers as "local experts" for specific support or contact activities (while being careful not to substitute these workers for trained mental health workers) |
| Low staff motivation | ✔ Improve salary conditions<br>✔ Establish career/promotion structures<br>✔ Introduce incentives<br>✔ Improve working conditions<br>✔ Invest in management training<br>✔ Develop supervision and support structures<br>✔ Develop a supportive leadership<br>✔ Involve local leaders in specific strategies aimed at shared, "innovative" objectives<br>✔ Link at least part of the incentives for all local team members to the attainment of these objectives |
| Staff leaving the public sector for the private sector | ✔ Contract private providers for specific clinical or service development tasks<br>✔ Improve salary and working conditions in the public sector (particularly benefits)<br>✔ Introduce career-long learning plans for public sector employees<br>✔ Regulate private providers<br>✔ Provide flexible contracts which enable partnerships between the public and private sectors |

The precise competency mix and number of mental health staff required in a particular country will also depend on a range of variables that cannot be quantified. These include social and cultural factors and the local population's perceptions of the need for mental health care. For example, in Cambodia, efforts have been made to coordinate a community mental health programme with traditional healers (Somasundaram et al., 1999).  In Nigeria, many state governments now give recognition to traditional healers in general health care, including mental health (O. Odejide, Director, Post Graduate Institute for Medical Research and Training, University of Ibadan College of Medicine, Nigeria, personal communication).  In other settings, lay counsellors may play a crucial role in mental health care. Calculations of appropriate staff numbers would therefore need to be adjusted, taking into account the supplementary role of accredited traditional healers and lay counsellors in the provision of care.

*A range of variables that cannot be quantified may also affect the required number and competency mix of staff.*

**Key points: Step 3. Target setting**

**Task 1: Compare supply and need**

Having calculated the current supply of staff and estimated staffing needs, targets can be set. In order to set targets, the two sets of information gathered so far (on supply of and need for staff) should be compared.

**Task 2:  Adjust targets according to utilization: "growing" human resources**

When comparing supply and need, it is likely that there will be considerable discrepancy between the current staff available and the estimates of staff required to meet the needs of the population.  It is therefore necessary to adopt a method of grading targets, taking into account the utilization of services and the budgetary realities.

Having calculated the difference between current supply and needs, and set priorities for HR development in the light of current policy, utilization of services and budgetary allocations, specific courses of action can be taken. These can be directed either at the supply of staff or the need for staff. Several potential targets and strategies can be identified.

**3.4  Step 4. Implementation**

Once staffing targets have been set, their successful implementation requires effective HR management and training. Owing to their importance, these areas are discussed separately in Sections 4 and 5 respectively.

A detailed discussion of the implementation of mental health service plans can be found in the module, *Planning and Budgeting to Deliver Services for Mental Health*.

# 4. Human resource management

## 4.1 Leadership, motivation and burnout

Leadership is the ability to cultivate vision and values that are shared by others, to initiate and guide action in a group or organization, and to build and sustain trust.

Leadership is as important in mental health as in any other aspect of the health service (International Mental Health Leadership Programme, www.cimh.unimelb.edu.au/imhlp/overview.html). Formally trained leadership is in short supply in health systems; there are many people with leadership potential who are untrained and inexperienced (WHO, 1993).

The following are some of the qualities that leaders need to develop:

> A good understanding of the vision of the mental health service and of the mental health aspects of health policy;
> An ability to develop and communicate that vision, including the ability to mobilize resources and generate political goodwill;
> The capacity to identify critical issues affecting the achievement of service objectives;
> Confidence, stemming from knowledge of having the required competencies and experience;
> The capacity to motivate others and mobilize commitment to the service objectives;
> The ability to work either as part of a team or independently with limited supervision;
> The ability to delegate responsibility;
> Good listening skills and respect for the autonomy of others; and
> Open-mindedness and community orientation.

Actions needed to develop leadership in mental health services include:

> Detection of leadership potential among existing staff,
> Training of leaders (WHO, 1993),
> Placement of leaders in positions where their leadership skills can be used for the benefit of the service, and
> Ongoing evaluation of leaders in that role.

The need for *good motivation* of staff has financial, clinical and humanitarian implications. A motivated workforce is more efficient (getting more work done for the same cost) and effective (with better outcomes for service users). Motivated workers are more likely to remain satisfied with their work, continue in their existing posts and create greater stability for the service over time.

Motivation also influences the capacity to adapt to or initiate appropriate change in an organization. Well-motivated staff are more likely to adapt to change and to provide a service that is in keeping with the ever-growing evidence for effective care. In turn, evidence-based interventions are more likely to improve outcomes, leading to greater motivation. At the managerial level, highly motivated staff have been shown to need less direction and supervision, welcome more responsibility, and seek more feedback on their performance. Finally, staff who are motivated are more likely to feel personally fulfilled and to have their own needs and rights met (WHO, 1993).

*Leadership is as important in mental health as in any other aspect of the health service.*

*Leaders need to have a good understanding of the vision of the mental health service. They also need to be able to communicate and develop that vision.*

*Good staff motivation brings financial, clinical and humanitarian benefits.*

Several factors can be associated with improved staff motivation (WHO, 1993):

> Scope for achievement and success
> Recognition of achievements
> Good relations with colleagues
> Identification with the group or a sense of belonging
> Opportunities for personal growth
> Opportunities for solving problems
> Committed leadership of the group or team
> Autonomy and self-regulation
> Reduction of unnecessary hierarchy and bureaucracy
> Transparency and accountability of service plans
> Participation in decision-making
> Job security
> Improved living conditions and general security
> Ongoing professional development
> Structured emotional and psychological support

What are the implications of these factors for motivation in the mental health service? An organization attempting to foster a well-motivated workforce needs to provide the best financial rewards and security it can afford, provide an environment which encourages teamwork and friendship, offer opportunities for status and recognition early in a person's career, offer staff security and support during their childbearing and childrearing years, ensure opportunities to explore new avenues later on in their career, and continually review its agreement with the staff members to ensure that appropriate needs are being met (WHO, 1993).

Ghana provides an example of how staff motivation can be improved in spite of limited resources. Although it has been difficult to increase the salaries of mental health staff compared to general health staff, in some instances it has been possible to provide free accommodation and faster promotions in the mental health sector. This has not only improved motivation but also attracted staff (J.B. Asare, Chief Psychiatrist, personal communication).

Staff *morale and burnout* are important areas to consider in planning for mental health services. Staff often experience burnout because of factors specifically associated with mental health care: they frequently deal with service users whose behaviour may be strange or bizarre; there is the occasional threat of verbally and physically aggressive behaviour from users; some staff may be physically assaulted by users; in underresourced services, neglected wards, unavailability of necessary medications, poor sanitary conditions and overcrowding can contribute to low staff morale; many people with mental disorders can be very demanding of clinicians, occasionally blaming those who offer help with their problems; and people with severe and enduring mental disorders frequently make slow progress and offer few rewards to staff – indeed clinicians' major contact with service users is during times of difficulty or crisis (Thornicroft & Tansella, 1999). This applies particularly to staff who are "low" in the clinical hierarchy – those who usually have the most face-to-face contact with service users, and little say in the nature and organization of their work.

As an example, the experience of assault will have a major impact if staff are not trained to assess risk and intervene in potentially dangerous situations. Staff morale can be affected by the wider social environment, especially in countries with high levels of HIV/AIDS and personal insecurity associated with violence and civil conflict. Caution must be exercised in engaging staff who themselves have had traumatic experiences but who have not resolved their emotional and psychological difficulties. These

difficulties may add to stressful experiences in providing care for people with mental disorders.

Nevertheless, for many people the stress of mental health work can be challenging and provides an opportunity for rewards, as clinicians see improvements in their clients and in the effectiveness of their services. For example, among inner-city community mental health teams in the United States, although staff have experienced emotional exhaustion and depersonalization, their sense of personal accomplishment and job satisfaction have remained high (Oliver & Kuipers, 1996).

Strategies that tackle staff stigma and improve negative staff attitudes towards service users may also improve morale. For example, by adopting a more recovery-focused approach and removing negative language, staff will feel more optimistic about their work and more hopeful of the outcomes for people who use the service. When service users get well and stay well, staff tend to feel good about their work.

In some instances, it may be necessary to adjust the expectations of staff according to the setting. For example, staff working with people with severe chronic disorders cannot be expected to help achieve the same recovery rate as staff working with less severe conditions. Encouraging staff to adjust their expectations according to the reality of their work environment is likely to reduce the likelihood of burnout. Barriers and solutions to staff burnout are presented in Table 6.

*Stress can be challenging and provides opportunities for personal and professional fulfilment.*

### Table 6. Barriers and solutions to staff burnout

**Barriers**

Staff burnout characteristics (Mosher & Burti, 1989, cited in Thornicroft & Tansella, 1999):

> No energy
> No interest in clients
> Clients are seen as frustrating, hopeless, untreatable
> Higher absenteeism
> High staff turnover
> Demoralization

Staff burnout causes:

1. Setting is too hierarchical
2. Too many externally introduced rules, no local authority and responsibility
3. Work group is too large or lacking cohesion
4. Too many clients, feeling over-whelmed
5. Too little stimulation
6. Too much routine

**Solutions**

Work characteristics (Rosen, 1999, cited in Thornicroft & Tansella, 1999):

1. Opportunities for control
2. Opportunities for skill use
3. Variety
4. Environmental clarity (including regular feedback, predictability of others' actions and clarity of role expectations)
5. Financial rewards
6. Physical security
7. Opportunity for interpersonal contact
8. Valued social position

## 4.2 Workforce availability

### 4.2.1 Recruitment and retention

An essential aspect of HR management is the capacity of a service to attract skilled staff and retain them in their positions over a sustained period of time. Broadly, three strategies may be outlined (The Sainsbury Centre for Mental Health, 2000):

> **Attract and retain.** Ensure that the HR strategy is at the heart of the wider organizational strategy. As with HR policy, consistency with the wider organizational strategy helps secure the political and financial support necessary for appropriate recruitment. Attracting staff also requires effective recruitment strategies. This may include combating stigma about working in a mental health setting. Successful strategies undertaken in New Zealand have included marketing mental health as a challenging and rewarding area of the health sector, and offering a special bridging programme for new graduate nurses to attract them into mental health (Todd Krieble, Ministry of Health, Wellington, New Zealand, personal communication).

> To assist with recruitment, the expectations of a post should be clearly defined in the job description. This should include a listing of the professional and personal qualities desired, such as caregiver, decision-maker, manager, communicator, community leader, teacher and supervisor; as well as descriptions of good practice and standards of care. A good job description clarifies the expectations of the post and enables an assessment of whether the incumbent is capable of filling it.

> **Lead and inspire.** The promotion of high quality leadership and management is likely to contribute to the recruitment and retention of a motivated workforce (see earlier discussion on leadership).

> **Support and sustain.** The mental health workforce is likely to be sustained by active support, such as the development and implementation of a mental health promotion strategy for staff and improved motivation (see earlier discussion on motivation).

Retention is a cost-effective strategy worth emphasizing. Halving an annual attrition rate of 20% may be worth more in actual staff numbers than it is possible to train in a given year. The staff who leave the service are often experienced and fulfil a particular function in a team, which makes them difficult to replace by a newly trained individual. In New Zealand, for example, the emphasis in HR planning for mental health services is on retention of existing staff in a context in which there are adequate numbers of trainees but difficulties in retaining staff in the service (Todd Krieble, Ministry of Health, New Zealand, personal communication).

Strategies for improved retention might include:

> Improving remuneration.
> Job customization (adjusting job description to the needs of categories of workers, as well as of individual employees).
> Providing ongoing education and opportunities for skills development.
> Improving social ties among staff, for example, through social gatherings such as sports clubs, so that loyalty is generated not only in relation to the service but also vis-à-vis colleagues.
> Hiring people who have existing ties with the community, for example, by hiring community health workers who originate from the communities that they serve.
(Cappelli, 2000).

*A service must have the capacity to attract skilled staff and retain them.*

*Retention is a cost-effective and essential strategy*

To improve retention in developing countries, it is strongly recommended that specialist training be provided within the country, rather than sending trainees to developed countries. In addition to being more cost-effective, this is important as it provides training that is appropriate to the context. By obtaining international assistance, it is possible to establish within-country training programmes in countries without established mental health training programmes. For example, in Cambodia since 1994, the Ministry of Health, the University of Oslo and the International Organization for Migration (IOM) have been providing training programmes for mental health workers. So far, 20 psychiatrists and 20 specialist mental health nurses have received their training within the country. Another six psychiatric residents and nine nurses participated in the training programmes in 2003. The training is international in its orientation, and the faculty has been recruited mainly from the other countries in the region. The programme for the psychiatrists is of three years' duration, and the mental health nurses are trained for one-and-a-half years (Hauff, 1996).

If the competencies and financial resources are not available for specialist training, it may be more cost-effective to send candidates out of the country for such training. During this process, it is essential to prevent "brain drain" by ensuring that the necessary incentives are in place to attract the qualified specialists back to their country of origin. For example, in Trinidad and Tobago, an exchange programme for psychiatric trainees was arranged between the Ministry of Health and foreign universities (Rampersad Parasram, personal communication).

Once there is a critical mass of experience within a country, it becomes preferable to develop specialist training within the country. This can be facilitated through upgrading the skills of key personnel by linking their training to that provided by outside experts who are committed to an ongoing programme of development. In Grenada, for example, consultants from Dalhousie University, Canada have developed a novel mental health training model for health professionals in low- and middle-income countries (Stan Kutcher, personal communication) (see Annex 3 for more detail).

### 4.2.2 Deployment

One of the most long-standing problems of HR management in mental health services is the deployment of staff to remote, rural or otherwise unpopular areas of countries. Various obligations or incentives have been used to encourage the deployment of staff to these areas, where there is often great need (WHO, 1993). These include:

> Legal strategies, such as a compulsory requirement for all mental health workers to serve in certain areas for a period of time (e.g. one-year community service immediately after qualification, as applied in South Africa to medical doctors and clinical psychologists).

> Professional strategies, such as post-qualification training opportunities awarded only after completion of service in a less popular area; linking of popular posts with less popular posts, and rotated; special recognition for work in less popular areas, and better opportunities for promotion; and/or exemption from military service for those working in mental health services in less popular areas.

> Financial strategies, such as higher salaries for less popular posts; special benefits such as a car, subsidies for accommodation and children's education; a higher pension; or a better residence in rural areas.

> Educational strategies, such as preparing personnel during their training to function in remote rural areas with minimal technology and a high degree of independence; providing educational opportunities for individuals from remote

rural areas (e.g. scholarships), who are more likely to remain in those areas once qualified; special training for staff already working in these areas, such as bringing staff together for shared experiences and training; training that includes preparation for work with less qualified colleagues such as village health workers, home-based carers and traditional healers; and providing opportunities for ongoing support and supervision from academic institutions.

> Management strategies, such as "fly in and fly out" remote clinics, whereby the mental health worker regularly visits communities (perhaps once a month). An increasing use of technology is also possible with telepsychiatry. For regions where it is difficult to attract psychiatrists, the use of telepsychiatry may be a cost-effective way of assessing service users, consulting with primary care providers and/or providing education and training.

HR managers for mental health need to select which of these strategies are most appropriate and most feasible for their particular situation.

In Ghana, for example, an effective way of getting mental health staff to work in remote areas is through implementation of the Government's decentralization policy. District political authorities and institutions are asked to select personnel or school leavers from their areas to be trained as mental health workers in their districts. Since they live in those areas and share cultural characteristics with them, when they return to the areas after their training, they usually stay and work there for some time. This is preferable to redeployment of urban mental health workers, who would often rather resign than serve in a remote rural area. Periodic specialist support to deprived areas is also proving useful in boosting the morale of the staff working in those areas (J.B. Asare, personal communication).

The deployment of adequately trained staff to underserved areas is an ongoing process and not a one-off task. Countries need to develop systems for addressing staff deployment effectively on a long-term basis. These include:

> annual reviews of staff distribution throughout the region/country;
> evaluation of the cost-effectiveness of various staff deployment strategies (as described above); and
> ongoing support, supervision and training structures for staff in remote rural areas.

### 4.2.3 Engaging private sector providers

HR planners in the mental health sector need to develop policy in relation to private sector providers. Increasingly, the boundaries between the "private" and "public" sectors are becoming blurred in many countries. This is true for the way services are financed, with the private contracting of many "public" services. It is also true for the way in which they are used, with some service users drawing on a range of private and public health insurance providers to fund their service needs. And it is also seen in the way in which service providers work, with many public sector employees supplementing their income with private practice.

It is therefore essential that HR planners and policy-makers within the public sector develop a pragmatic and holistic approach, with the aim of building partnerships between formally designated "private" and "public" sectors. For example, in a country with a predominantly private system of care, this may pose a threat to the public sector by attracting employees away from that sector with the prospect of improved income and work conditions. However, there may also be opportunities. Private sector providers may be contracted to provide specific services (training of public sector providers, training of students, outpatient clinic sessions). Other advantages could be

*Deployment of adequately trained staff to underserved areas is an ongoing process.*

*There is an increasing blurring of the boundaries between the "public" and "private" sectors.*

*HR planners in the public sector need to build partnerships between the private and public sectors.*

that the public sector would pay only for services rendered and would not need to provide salaries, benefits, administer tax returns, or, in some cases, facilities.

In Trinidad & Tobago, a significant majority of psychologists work in the private sector, thus causing critical shortages in the public sector. As a response to this, an initiative by one of the regional health authorities involved the hiring of private psychologists on a sessional basis (i.e. through part-time contracts to undertake specific work such as consultations with service users). This could prove a useful approach, since it may be impossible for small island or other developing countries to afford the services of significant numbers of highly skilled professionals (Rampersad Parasram, personal communication).

There is also a need to regulate private sector provision and flow of staff, particularly in situations of partnerships between the public and private sectors (see module on *Mental Health Financing*).

### 4.2.4 Use of non-professionals for mental health care

During the 1960s and 1970s in the United States, a trend emerged of using non-professionals for delivering mental health care, known as "deprofessionalization" (Ivey, Scheffler & Zazzali, 1998). Non-professional workers often have a more direct knowledge of the community, language and customs. Moreover, service users can often more readily identify with them and form therapeutic alliances. Examples include religious counsellors, community workers, family members (World Fellowship for Schizophrenia and Allied Disorders, 2001) and traditional healers. It is important to ensure that non-professional workers are appropriately competent, and that professional staff can be drawn, upon when necessary, to deal with complex cases, provide supervision and consultation-liaison.

If non-professional staff are to be trained and employed, consultation with professional staff is needed to avoid the perception that non-professional staff are undermining the professional staff, lowering standards of care, and providing service managers with a less costly workforce. This can be done by creating formal links between professional and non-professional groups. Supervision and support of non-professionals by professionals is an important strategy.

In Ghana, the exodus of mental health professionals has outweighed the numbers that can be recruited. Access to mental health care had already been a problem. It therefore became necessary to train volunteers. To this end, a pilot project through the WHO Nations for Mental Health Project was started in 1999 for three years. Volunteers selected by their communities were trained to identify people in their villages who had mental disorders. They referred the identified cases to providers – mainly nurses, medical assistants and midwives – trained to treat uncomplicated cases. A community mental health nurse visited the facilities and offered support. The volunteers, who lived in the communities, visited the patients and reported relapsed cases. The Government has now adopted the project and it is being extended to other disricts (J.B. Asare, personal communication).

In Trinidad & Tobago, a successful initiative was the appointment of recovered alcoholics as alcoholism rehabilitation officers (AROs). These appointments were made after thorough training. The strengths of these AROs lay in their personal experience, commitment and empathy (Rampersad Parasram, personal communication).

In KwaZakhele township, Port Elizabeth, South Africa, community volunteers have been trained to assist service users to remain engaged with the extremely overstretched mental health services. The volunteers contact people who have dropped out and

encourage them to start using the services again, as the professional nurses have no resources to undertake community visits. Training materials and sustainable courses have been developed, with a high level of community approval and participation, in a partnership between community-based organizations, the University of Port Elizabeth and the University of Manchester (David Richards, Professor of Mental Health, Department of Health Sciences, University of York, United Kingdom, personal communication). See Section 5 on training for more details of training materials used in this programme.

### 4.2.5  Developing partnerships with NGOs

Nongovernmental organizations often play an important role in mental health promotion, prevention and treatment. For the HR planner for mental health, NGOs can provide useful resources in terms of competencies and expertise for training and supervision of public sector staff; consultation for service planning and liaison over specific aspects of service provision (e.g. trauma services). However, NGOs need to be regulated with regard to their labour practices and the services they provide.

*NGOs can provide useful resources in terms of expertise for service provision, consultation, training and supervision.*

In Slovenia, an NGO (the Slovenian Association for Mental Health (SENT)) has initiated a training programme for service users, their families, and service providers covering basic education about mental health and mental disorders, care management, self-help, human rights and rights of users of mental health services, legal procedures, team and multidisciplinary work, social skills training and vocational rehabilitation. This has broadened public awareness about mental health and improved communication between users, families and service providers (Vesna Svab, personal communication).

In the United Republic of Tanzania, some religious NGOs run rehabilitation services. A good example is the Lutindi Lutheran Church Mental Health Rehabilitation Centre, which over the years, has evolved into an excellent rehabilitation facility. Lay people from different sectors run it with support from experienced mental health nurses. It is a 100-bed facility that organizes a range of occupational activities such as farming, animal husbandry, various handicrafts as well as literacy education. The centre is one of the resource facilities for training staff in a health-care setting on how to run cost-effective rehabilitation services. It offers an ideal form of in-service training (Joseph Mbatia, Ministry of Health, Dar es Salaam, United Republic of Tanzania, personal communication).

Human resources are often developed by NGOs, using low-cost methods and locally available resources. An example is that of Ashagram, an NGO working in rural India, where uneducated youth are trained as mental health workers to provide rehabilitation services for people with severe mental disorders (Chatterjee et al., 2003).

### 4.2.6  Using strategic opportunities to develop HR

Human resources development is usually a complex political process that relies on using strategic opportunities to develop mental health care (Freeman, 2000; Walt, 1994). Recent innovations in HR development for mental health provide an illustration of the need to adapt strategically to the current policy agenda. For example, in South Africa, where funding of staff for mental health services is limited within formal public sector health care, a national crime prevention strategy has provided the opportunity to develop and train general health staff and teachers in mental health skills. This initiative provided the means to train general health workers in "victim empowerment", including counselling training for health practitioners. It also led to the setting up of "violence referral centres" in certain disadvantaged areas (crisis centres for emotional problems), the creation of violence prevention programmes in schools (training of teachers for mental health promotion in schools), and the development of mother-infant bonding programmes for violence prevention in poor communities (Freeman, 2000).

*Human resources development is often a complex process that relies on using strategic opportunities to develop mental health care.*

This is a clear example of the adaptation of HR strategies to the political and economic context within which mental health is to be developed. It is also particularly appropriate for mental health because, since many people with mental disorders do not visit health services, they can be identified in schools and in the criminal justice system.

## 4.3 Labour practices

Labour practices for mental health workers should comply with existing legislation and protocols on labour practice in general within a country. In the development of labour practices, the rights of mental health workers need to be respected. For example, there is a need for parity between mental health workers and other health workers in terms of salaries and working conditions.

In some countries' mental health services, it may be necessary to review existing labour practices. The goal of such a review would be to ensure that current labour practices respect the rights of mental health workers and are consistent with labour practices in other sectors of the country.

Areas that would need to be covered in a review of labour practices for mental health services include the following:

> staff selection
> affirmative action
> induction
> deployment
> unionization
> discipline
> conflict management
> licensing

These issues are discussed in more detail in the *Training Manual on Management of Human Resources for Health* (WHO, 1993).

*Labour practices for mental health workers should comply with existing legislation and protocols.*

### Key points: Human resource management

> Leadership is as important in mental health as in any other aspect of the health service.
> There are financial, clinical and humanitarian grounds for good staff motivation
> Staff morale and burnout need to be taken into account in HR planning for mental health services. Staff often face burnout because of factors specifically associated with mental health care.
> An essential aspect of HR management is the capacity of a service to attract skilled staff and retain them over a sustained period of time.
> One of the most long-standing problems of HR management in mental health services is finding staff willing to work in remote, rural areas or otherwise unpopular areas of the country. Various incentives may be used to encourage the deployment of staff in these areas, where there is often great need.
> Human resource planners in the mental health sector need to develop policy in relation to, and work in partnership with, private sector providers.
> There are many opportunities for working with non-professional providers in mental health.
> Human resources development is usually a complex political process that relies on the use of strategic opportunities to develop mental health care.
> Labour practices for mental health workers should comply with existing legislation and protocols on labour practices for other health workers and for the general population within a country.

Education and training of personnel for mental health should follow logically from the targets set by HR planning (Green, 1999). The training should aim to serve the mental health needs of the society by producing mental health workers competent to deliver care in a manner consistent with the goals of HR policy and planning (Boelen et al., 1995).

This requires coordination and the development of consistent policies between the mental health delivery sector and the training sector (WHO, 1995). In many countries, this will require close cooperation between the departments of education and health. The main training institutions need to actively participate in the provision of mental health care in every setting (community, residential and hospital-based services). The risk of a major gap between education, training, real-life settings and everyday work settings is greater at times of rapid transformation of the mental health system; in these instances, particular attention needs to be paid to the links between training institutions and services. In small, low-income countries where training institutions do not exist, a training team may need to be established by the ministry of health, and developed over time. Members of the team should reflect the competencies and roles required and be embedded in the health care system.

In short, there needs to be an open, constructive partnership between planners and trainers. The design of training courses should be based on the target competencies required for the mental health workforce, as outlined in the target-setting process (described above). Consequently, this section uses the WHO service organization pyramid (Figure 1) as the framework for discussing HR education and training. Training should be closely linked to service levels, their functions and the competencies required to deliver any service. At each level of the service organization pyramid, this section outlines:

> *functions* of the service level,
> the *competencies* required by different professionals and mental health workers, and
> *examples* of useful training programmes, teaching strategies and resources.

This section provides examples of overall competency requirements at different levels of service provision, but not for each category of health worker or professional at that service level. It is not possible to provide such details for all the countries of the world. This is so for two reasons: first, it would be too prescriptive and would not necessarily suit the needs of all the countries; and second, it would fail to capture the wide variations in service provision in different countries. It is recommended that a detailed analysis of competency requirements for each professional at different service levels be carried out at the country level, where the information needed for such analysis will be available.

Two further points deserve to be highlighted:

(i) Services, service functions and professionals listed for each service level will vary for different countries. Thus, examples of training programmes and teaching strategies presented in this section are not an exhaustive list of all possible programmes and strategies; they are provided for illustrative purposes only.

(ii) Different professionals working at each service level do not all have or need the same competencies. For example, professionals at the primary health care level include doctors, nurses, midwives and health care assistants. The competencies outlined below are for the respective service level rather than for individual

*Training of personnel for mental health should conform with the targets set by HR planning.*

*There needs to be an open, constructive partnership between planners and trainers.*

*In this section, training requirements are set out for each level of the WHO service organization pyramid.*

*Services, service functions and professionals listed for each service level will vary for different countries.*

*Different professionals working at each service level do not all have or need the same competencies.*

professionals. Different countries may follow different models; for example, some countries may require all professionals to have a basic minimum of all the competencies outlined below, and only some of the professionals working at that level to have a higher level of a particular competency. Other countries may require each professional group to have only specific competencies for that group and not other competencies, while simultaneously ensuring an appropriate mix of professionals from different groups at each service level so that all the necessary competencies are available at that level of service provision.

## 5.1 Service functions and training requirements for an optimal mix of mental health services

### 5.1.1 Informal community mental health services

Local community members who are not professionals in mental health or health care provide a variety of services. Examples of people working at this level of service provision include: lay volunteers, community workers, staff in advocacy organizations, coordinators of self-help/user groups, humanitarian aid workers, traditional health workers and other professionals such as teachers and police officers.

*Local community members who are not professionals in mental health or health care provide a variety of services.*

Many of these informal community-care providers have little or no formal mental health care training, but in many developing countries they are the main source of mental health provision. They are usually easily accessible and generally are well accepted in local communities. They can help with the integration of people with mental disorders into the community, and thus play an important supportive role to formal mental health services.

### (i) Functions

It is important to point out that informal community mental health service providers are unlikely to form the core of mental health service provision. Indeed, countries would be ill-advised to depend solely on their services. However, they can complement formal mental health services and form useful alliances.

*Countries would be ill-advised to depend solely on the services of informal community mental health service providers.*

Some of the important functions performed by informal services are:

> *Supportive care, including counselling and self-help*. They can provide basic counselling for brief and acute mental health problems. This includes individual supportive counselling, family support, as well as group-based counselling for people with mental disorders and for their families. They can play a useful role in catalysing the setting up of self-help groups as well as support groups for individuals, carers and their families. They can also provide day-care services for people with mental disorders.

*Informal sevicies can complement formal mental health services by performing several important functions.*

> *Help with activities of daily living and community reintegration*. Many people with mental disorders have difficulty gaining access to the services necessary for living in the community. For example, a number of people with chronic and severe mental illnesses have enormous difficulties with activities such as shopping, travelling on public transport and obtaining benefit payments, to name a few. Informal services can play an important role in helping such individuals with these activities, thereby assisting them to reintegrate into the community.

> *Advocating the rights of people with mental disorders*. Informal services can play an important role in advocacy. For example, they can educate individuals and their families about mental health issues and leadership, help individuals and their families to form their own organizations and contribute to the development, planning,

evaluation and monitoring of mental health services. They can also contribute to the development of mental health policies and legislation. Other advocacy actions include awareness raising, dissemination of information and education and training.

> *Preventive and promotive services*. Examples of such services include teachers providing mental health interventions in schools, preventive programmes for alcohol and substance misuse, and interventions aimed at reducing domestic violence. In most countries community members, who are not necessarily mental health professionals, provide these services, and in many instances these interventions are part of wider health and/or social interventions.

> *Practical support*. In many communities, lay people provide basic, practical support, such as community-based housing for people with mental disorders, employment opportunities in sheltered workshops as well as in open employment, and shelters for women who are victims of abuse and domestic violence.

> *Crisis support*. Informal services can play a useful role in crisis intervention, such as counselling in humanitarian emergencies, setting up and running telephone help-lines, crisis support and help to families in distress, and counselling support to women who are victims of domestic violence.

> *Identification of mental health problems and referral to health services*. When informal service providers are able to identify people with mental health problems but lack the competencies to address those problems, a key function is to refer those individuals to the relevant health services equipped to deal with such problems.

**(ii) Competencies required**

By definition, local community members involved in providing informal community care are not expected to have formal mental health training. Moreover, it is a heterogeneous group comprising lay people and family members, who may have no mental health training, traditional healers, who may be trained in indigenous systems of healing, and professionals from other fields, such as human rights activists, lawyers, teachers and police personnel, who may be involved in many of the functions described above. It is therefore not possible to prescribe minimum competency criteria for individuals involved in providing informal care. Instead, it is useful to think of some discrete competencies that may enable such individuals to become more effective in helping people in the community who suffer from mental disorders.

*This heterogeneous group may have a range of competencies, and it is not possible to prescribe minimum competency criteria.*

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

> *Basic understanding of mental disorders*. This includes understanding the symptoms of mental disorders and how they affect the behaviour of individuals with those disorders. It also requires an understanding of the need for treatment, including medical and psychosocial interventions. In addition, it is useful to have an understanding of the needs of people with mental disorders for ongoing treatment, the role of psychological and environmental factors in precipitating relapse, and the effect of mental disorders on individuals' ability to deal with the activities of daily living, and to handle stigma and discrimination.

*Nevertheless, a range of useful competencies may be identified.*

> *Basic counselling competencies*. This includes listening and communication skills, especially empathic listening. Training should be provided in basic competencies, such as the need to maintain confidentiality, managing conflicts of interests when dealing with individuals as well as their families, maintaining a neutral stance and dealing with disturbing emotions. The aim is to enable informal community caregivers

to provide basic supportive counselling interventions. It is not expected that they will necessarily be trained in specific psychotherapy techniques, although in certain instances they may be under the supervision of trained professionals.

> *Advocacy*. This is particularly useful because informal community caregivers are the best placed to advocate on behalf of people with mental disorders to professional service providers (including health and mental health care providers) as well as institutions. They may need to be informed about the legal framework and entitlements of people with mental disorders, as well as be trained in effective public communication and negotiating skills to help them in their advocacy work.

**Box 4. Informal community mental health services: Examples of training programmes, strategies and resources**

**SOUTH AFRICA**

*Helping People with Mental Illness: A Mental Health Training Programme for Community Health Workers*

A system of outreach for people who had stopped contact with services has been developed with volunteers and mental health clinic staff in the KwaZakhele community, part of the Nelson Mandela Metropolitan Municipality in the Eastern Cape Province of South Africa. KwaZakhele is home to over half a million people with very high rates of poverty and unemployment, and with limited access to statutory mental health services. Using educational materials and trainers provided by the University of Manchester (United Kingdom) and the University of Port Elizabeth (South Africa), volunteers were trained to understand the main features of common and severe mental health problems, appreciate the role of mental health treatments, and develop the skills to communicate effectively with people with mental health problems. Course materials were developed using a "train the trainer" lay-led approach, to enable the volunteers who were initially trained to deliver additional training to more volunteers. The course consists of eight modules on different topics in mental health, including helping people with their drug treatments, other ways to manage mental health problems, and tracing people who default from mental health services. The modules can be combined in various ways to prepare courses for different target groups. For example, a course to introduce people to some basic knowledge about mental illness and to teach them how to talk to people who have mental health problems can be designed using just three of the modules. Each module comprises a course of about three hours' duration. The instructions are easy to follow and each pack contains all the materials needed. These materials are designed in such a way that an ordinary person can use them to train other people. Following training, volunteers have implemented the outreach system in collaboration with the mental health services in KwaZakhele. In a preliminary evaluation, volunteers successfully traced 85% of patients who had lost contact with services. Of these, 58% returned to their clinic for appointments, while other outcomes (such as moved away, deceased or in hospital) were identified for the remainder.

These modules are available on the WHO website and can be accessed at: http://www.who.int/mental_health/policy/education/en/

**SOUTH AFRICA**

*Training Manual for South African Police Services* prepared by the National Directorate of Mental Health and Substance Abuse, Department of Health, South Africa. These guidelines were drawn up to help police officers handle situations where they are required to assist or deal with a person with a mental disorder. The manual includes

information on mental disorders, an outline of the mental health services in South Africa and training scenarios. In particular, the manual provides guidance for handling practical situations involving a person who might be mentally ill, the management of a person with a mental disorder who is potentially or actually violent, and training in calming and restraint techniques. This manual can be accessed on the WHO website at: http://www.who.int/mental_health/policy/education/en/

**UNITED KINGDOM**

*Disability Alliance, Training Programme in Benefits and Mental Health.* The aim of this course is to give participants a greater awareness of mental health issues and how they affect people who can claim benefits. They are taught interviewing skills and learning strategies to help claimants deal with the system and make successful claims. The course is targeted at volunteers and those working in advice centres, who have a reasonable knowledge of the benefits system. For more information, see the following website: http://www.disabilityalliance.org/train17.htm

**GHANA**

*Psychiatric Notes for Volunteer Community Workers*. These notes, prepared by the Mental Health Unit, Ministry of Health, Ghana, as part of the Nations for Health Project, are aimed at helping volunteers who work with people with mental disorders. The notes are divided into six chapters covering mental health symptoms, common mental disorders such as depression, psychosis, alcohol and drug abuse and epilepsy, and their management, and coping with stress and ethical issues in community mental health. These notes can be accessed on the WHO website at: http://www.who.int/mental_health/policy/education/en/

*Note: These examples are provided for illustrative purposes only, and do not constitute endorsements by WHO.*

### 5.1.2 Mental health services through primary health care

For countries with limited human resources in mental health, delivering mental health services through primary health care is one of the most effective and viable strategies for improving access to mental health care. In most countries, the primary health services are vastly better developed and reach a larger proportion of the population than the mental health services. Not surprisingly, therefore, initiatives to improve access to mental health care in many countries have initially focused on providing mental health services in primary health care. Examples of professionals working at this level include general practitioners, general nurses, midwives, nursing assistants and community health workers.

**(i) Functions**

> *Identifying mental disorders*. There is a significant association between mental and physical disorders, and primary health care services have the opportunity to identify mental disorders when people seek help for physical health problems.

> *Providing basic medication and psychosocial interventions*. Primary care services can provide cost-effective interventions for common as well as severe mental disorders. In particular, individuals with chronic, stable mental disorders who are resident in the

*For countries with limited human resources in mental health, delivering mental health services through primary health care is one of the most effective and viable strategies for improving access to mental health care.*

*Primary health care services can perform several functions related to mental health care.*

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community and need continuing psychotropic medication and psychosocial interventions can be helped by primary care services without requiring repeated visits to specialist services. Many people with chronic, severe mental disorders have difficulty in adhering to prescribed treatment, and hence run the risk of repeated relapses. Primary care services can provide supervised medication and support to these individuals by monitoring symptoms and functioning, thus reducing relapses and helping to improve long-term outcomes. This has a dual advantage: it is easier for patients, as primary care services tend to be more easily accessible geographically, and less expensive; and it reduces the burden on specialist mental health services, which can thus be better utilized for specialist treatment and supervision and training activities.

> *Referrals to specialist mental health services*. Primary health care services can function as an entry point as well as a referral point for mental health care. They can make appropriate referrals to specialist mental health services after preliminary identification and treatment of presenting problems. This has many advantages: individuals are able to avoid unnecessary visits to specialist services, which are usually less accessible and tend to have higher direct and indirect treatment costs; and when referrals are necessary, they are usually referred to the most appropriate specialist service, thus saving individuals efforts and costs in finding the right service for their specific problem. Health services also benefit because appropriate referrals reduce wastage of scarce financial and human resources. It is therefore extremely important for a clear and functional referral and linkage system to be in place that links primary health care services with mental health services.

> *Family and community psycho-education*. There is evidence that people are more likely to adhere to treatment plans if they understand their illness and its treatment. Knowledge about the symptoms, the natural history of a disorder and effective treatments has been shown to improve outcome (Craighead et al., 1998). Primary health care services are well placed to deliver simple family psycho-education, both in the course of routine clinical work as well as during specific interventions for certain disorders.

> *Crisis intervention*. Primary care services are best placed to provide crisis intervention because they are usually the individual's first point of contact with the health care services. Crisis intervention can prevent the development of severe symptoms and episodes of illness as well as prevent the deterioration of pre-existing disorders. Primary care services can provide clinic-based as well as ambulatory crisis-intervention services. They are also well placed to involve secondary care mental health services if required.

> *Prevention of mental disorders and mental health promotion*. This is an essential function of primary care services. Suicide prevention is a particularly important area, for which WHO has developed guidelines (WHO, 2004a). An example of mental health promotion is enhancing community connectedness by establishing support services for marginalized people (WHO, 2004b).

## (ii) Competencies required

> *Diagnosis and treatment of mental disorders*. Primary care staff should have knowledge of the symptoms and course of major mental disorders, and of available psychotropic medicines (especially those that are available at the primary care level) and their potential side-effects. In addition, they should have competencies in evaluating and monitoring the mental state of individuals, and in arriving at a diagnosis of mental disorder; evaluating and monitoring response to treatment; evaluating and monitoring side-effects of medication; evaluating safety (e.g.

*Various competencies may be identified for different primary health care workers.*

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assessing suicide risk); and managing safety issues (e.g. managing potential or actual violence). They also require competencies in carrying out functional assessments of people with mental disorders.

> *Counselling, support and psycho-education*. They should have competencies in providing psycho-education to patients and their families, and basic competencies in supportive counselling and providing emotional support to individuals and families in distress due to mental disorders.

> *Advocacy*. Staff should have the knowledge and skills to tackle the problems of stigma and discrimination faced by people in the community with mental disorders. They should have an understanding of the human rights and the legal entitlements of people with mental disorders in their country. To be effective advocates, primary care staff require competencies in engaging the community and families in a dialogue about the rights of people with mental disorders, and in promoting and ensuring that those rights are respected.

> *Crisis intervention competencies*. At this level, it is important to have basic knowledge of the theoretical basis of different crisis intervention models, and the knowledge and competencies to evaluate the type and severity of a crisis. It is also important to have the ability to carry out any necessary therapeutic interventions, including counselling support, use of emergency medication and referral for admission to hospital if necessary.

> *Mental health promotion and prevention of disorders*. Primary care staff need to be equipped to identify common risk factors and protective factors in their communities, and deliver mental health interventions that have been shown to promote mental health or prevent disorders at the primary health care level (WHO, 2004a; 2004b).

Health care workers at the primary health care level are not expected to have all the competencies mentioned. General practitioners, for example, might be expected to have competencies to prescribe and monitor psychotropic medications, whereas nurses might need only those competencies necessary to monitor and manage psychotropic medication use.

*It is not expected that all health care workers at the primary health care level will have all the competencies mentioned.*

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### 5.1.3  Mental health services through general hospitals

Integrating mental health services into general health services necessarily includes integrating the former into general hospitals. Based in general hospitals, these services can provide secondary level care to patients in the community, along with treatment for those admitted for physical disorders who also require mental health interventions. They provide an excellent opportunity to reduce the stigma associated with seeking hospital-based care from stand-alone mental asylums.

*Integrating mental health services into general health services necessarily includes integrating the former into general hospitals.*

Examples of professionals working at this level include: hospital physicians with a special interest in psychiatry, hospital psychiatrists, general nurses working in general health or psychiatric inpatient units, psychiatric nurses working in psychiatric inpatient units, psychiatrists and/or psychiatric nurses providing consultation-liaison services, social workers and psychiatric social workers, occupational therapists, psychologists, and other health workers in hospitals (e.g. nursing assistants).

#### (i) Functions

*Several functions may be identified for mental health services in general hospitals.*

> *Inpatient and outpatient mental health care and treatment*. These services can provide short-term inpatient care for acute mental disorders, as well as inpatient care for managing an acute crisis that requires brief hospitalization. Inpatient treatment can be provided to voluntary individuals as well those requiring involuntary admission for assessment and treatment.

Many general hospitals run traditional outpatient services where specialist mental health staff are available to provide regular consultation. People utilizing these services include those discharged to the community after an inpatient stay, those referred by primary care staff for specialist opinion, and people with chronic mental disorders living in the community (with carers/families/long-stay homes) who require regular review and supervision of their medication.

> *Consultation-liaison (C-L) service to other medical departments*. C-L services provide a useful opportunity to educate and train general health care staff about mental health issues. They also help to bridge the artificial separation between physical and mental disorders. Physical disorders can have mental health implications, and the risk for people with mental disorders of suffering physical disorders is likely to be the same as, if not higher than, that for the general population.

> *Education and training*. In most countries, general hospitals serve as the primary training base for all health professionals. This provides an opportunity to integrate mental health education and training into general health education and training. Psychiatric departments in general hospitals can also serve as training centres for mental health professionals such as psychiatrists, psychologists, mental health nurses and psychiatric social workers.

> *Links with primary health care and tertiary care*. Mental health services in general hospitals can provide supervision and support to primary care staff delivering mental health interventions to local communities. As stated above, a functional and well developed referral system from primary care to mental health services in general hospitals is necessary to provide primary care staff with support in carrying out mental health interventions. Primary care staff need to know that they can seek specialist help when required, especially when dealing with mental health emergencies. A properly developed referral and linkage system also helps to overcome delays in seeking specialist help, prevents duplication of services – which results in inefficient use of scarce mental health resources – and also helps to plug any gaps in mental health service delivery.

Mental health services in general hospitals can also act as referral centres to tertiary mental health care for those requiring specialist interventions, including long-stay community facilities and specialist inpatient services such as forensic services and child and adolescent mental health services. Mental health services in general hospitals are therefore a key conduit in providing "seamless" mental health care – from primary mental health care to tertiary, specialist mental health services.

> *Research*. Mental health departments in general hospitals can act as hosts for clinical as well as service-related research, as they may have access to the institutional resources (e.g. libraries and electronic health information) and human resources (e.g. statisticians) required for conducting such research.

### (ii) Competencies required

> *Diagnostic and treatment competencies*. Professionals at this service level need specialist competencies in diagnosing common as well as severe mental disorders and specialist competencies in using psycho-pharmacological treatments. They need competence in understanding the links between physical and mental disorders and the overlap between the two. They should also be able to undertake specialist psychotherapeutic interventions, especially time-limited psychotherapeutic techniques.

*Several competencies may be needed for staff delivering mental health services in general hospitals.*

> *Training and supervision*. Professionals at this level should be competent to train and supervise. Typically they will be required to supervise and train primary care staff and those working at the informal care level. They will also need to train and supervise clinicians and professionals to work at the general hospital level of care. In addition, in many countries professionals working in general hospitals will be involved in basic medical teaching and training of medical students and psychology and social work students at the undergraduate level.

> *Advocacy*. Professionals at the general hospital level should be able to negotiate with families and communities. Additionally, they need to be competent to advocate on behalf of those with mental disorders at the level of policy-makers, planners and government officials. They are expected to participate in policy-making bodies as well serve as serve as advisers to local and regional planning agencies. These provide useful opportunities for advocating policy initiatives and seeking to secure better and well-provided mental health services.

> *Knowledge of mental health legislation and other legislation related to mental health*. Professionals at this level should be proficient in their understanding of relevant local mental health legislation and the procedures for effective implementation of legislation in clinical practice. They should also have knowledge of other legislation that concerns those with mental disorders, such as disability legislation and social security legislation, so as to secure the best possible benefits for such people. Knowledge of relevant legislation also helps in effective advocacy with policy-makers and lawmakers, such as advocating changes in existing legislation to secure the rights of people with mental disorders.

> *Administrative and managerial competencies*. The ability to lead and manage teams and get involved in managing and developing human resources is important at this level. In many countries, professionals at this level are involved in administrative functions such as heading departments and/or institutions, participating in the budget allocation process and managing budgets. Therefore a basic knowledge and understanding of administrative functions and procedures is necessary.

> *Research competencies*. Basic research competencies such as writing and designing protocols, study design, implementing research protocols, analysis of results (including basic statistical analysis), and writing about studies for publication are necessary if professionals at this level are to effectively participate in clinical and service research.

An example of the distribution of competencies amongst mental health professionals and workers in general hospitals might be for psychologists to have competencies in time-limited psychotherapy interventions, and social workers to have competencies in counselling and assisting with access to a range of other services and benefits.

**Box 6.  Mental health services through general hospitals: Examples of training programmes, strategies and resources**

*The Clinical Research Unit for Anxiety and Depression (CRUfAD)*
This is a group of researchers and academics concerned with anxiety and depression. It works in association with the University of New South Wales School of Psychiatry. The CRUfAD website has sections on self-help for people with anxiety and depressive disorders as well as on clinician support. The clinician support section has descriptions of various anxiety and mood disorders, patient treatment manuals (that can be downloaded free of charge) for treating various anxiety and mood disorders, and resources for training in and use of cognitive behaviour therapy. For further information, see: http://www.crufad.com/cru_index.htm

## 5.1.4 Formal community mental health services

Formal community mental health services cover a wide array of settings and different levels of care provided by mental health professionals and para-professionals. They include community-based rehabilitation services, hospital diversion programmes, mobile crisis teams, therapeutic and residential supervised services and home help and support. Many countries do not have these services, for two reasons: a lack of emphasis on community-based delivery of care and the lack of trained human resources to deliver such services.

*Formal community mental health services cover a wide array of settings and different levels of care provided by mental health professionals and para-professionals.*

Examples of professionals working at this level include: psychiatrists, community psychiatric nurse, psychologists, psychiatric social workers, occupational therapists and community psychiatric workers.

### (i) Functions

*Several functions may be identified for formal community-based mental health services.*

> *Community-based rehabilitation and treatment programmes*. The aim of these programmes is to assist people with mental disorders to live a full life in the community. There are many models of community-based service provision, such as case management, intensive home support and outreach services. All these models have their strengths and weaknesses, and the choice of a particular model in a country depends on various factors, including the socio-cultural context, how health services are organized and the availability of financial and human resources.

> *Residential services*. Community mental health services in many countries are also involved in providing therapeutic and supervised residential services, either on their own or in collaboration with other services such as social services and housing departments. This varies from country to country depending on their particular context of social and health care provision.

> *Crisis-intervention services*. These services need to be provided in association with primary care providers, who are usually the first "port of call" in a crisis. This requires good referral and linkage systems with primary care services as well as with mental health services in general hospitals. In some countries, community mental health teams also provide home-based, intensive crisis-intervention services through mobile and outreach crisis teams. In other countries, hospital diversion programmes try to divert people in crisis from hospital admission to other, community-based facilities such as crisis shelters.

> *Education and training*. Community mental health services are usually involved in educating and training staff for their own services and for primary health care as well as training mental health professionals working in general hospitals.

> *Collaboration with other community- and hospital-based service providers*. Community-based mental health services need to develop good intersectoral collaboration, because people with mental disorders have complex needs that cut across service sectors. Collaboration is important both within the health sector (i.e. intrasectoral collaboration) as well as outside the health sector (i.e. intersectoral collaboration). The module, *Organization of Services*, pp. 51-52, provides a more detailed discussion on collaboration within and between sectors

> *Research*. Community mental health services need to participate in research, especially service delivery research such as investigating the effectiveness of different models of service delivery. Since they have first-hand knowledge of delivering community-based services they can be helpful in the determining of research priorities and the framing of questions.

## (ii) Competencies required

> *Clinical competencies*. Professionals working at this level need all the competencies required of professionals working in the previous level of service (psychiatric services in general hospitals). In addition they need specialist competencies in designing and implementing community-based treatment plans and in providing home-based services. They should be able to design and implement case management, intensive home support and outreach services for special populations.

> *Knowledge of relevant legislation, including mental health legislation*. Professionals should be conversant with legislation that concerns people living in the community who suffer from mental disorders. This includes mental health legislation as well as that covering other areas such as benefit entitlements, employment, housing and education. They should have knowledge about the rights of people with mental disorders and the skills and knowledge to use legislation to promote respect for the rights of such people.

> *Advocacy and negotiating competencies*. In addition to the advocacy competencies outlined for the previous professional groups, professionals in community mental health services need good negotiating skills, as they will be required to deal with other sectors and other stakeholders in the community with competing interests.

> *Administrative and managerial competencies*. These are similar to those needed by professionals working in mental health services in general hospitals.

> *Research competencies*. These are similar to those needed by professionals working in mental health services in general hospitals.

> *Training and supervision competencies*. These too are similar to those needed by professionals working in mental health services in general hospitals.

Different professional groups working in formal community mental health services will need different competencies. For example, occupational therapists may need competencies in functional assessments and occupational rehabilitation, whereas social workers may need competencies in counselling and assisting with access to a range of other services and benefits.

**Box 7.  Formal community mental health services: Examples of training programmes, strategies and resources**

*International Mental Health Leadership Program (iMHLP)*
The iMHLP is a collaborative initiative of the Centre for International Mental Health at The University of Melbourne (Australia) and the Department of Social Medicine, Harvard Medical School (USA).  It was established in 2001 to develop and sustain an international network of leaders for policy and service development in mental health. Building on the strengths of each institution, the initiative invites young psychiatrists and other mental health professionals with demonstrated leadership potential to become iMHLP Fellows. Fellows undertake a one-year intensive programme aimed at developing their leadership and research competencies through training, mentoring and supervision of project work. The initiative also offers the opportunity to become part of an expanding network committed to responding effectively to the distinct and changing needs of regional communities. For more information, see: http://www.cimh. unimelb.edu.au/imhlp/index.html

*Mental Health Foundation (United Kingdom)*
This charity offers various training programmes for staff working with people with mental disorders. The programmes include:

> A Level 2 Certificate in Mental Health Work, which provides an introduction to newcomers. It is designed to complement or provide a framework for an employer's existing induction programme.

> A Level 3 Certificate in Community Mental Health Care, which offers comprehensive coverage of the core knowledge, skills and attitudes needed by practitioners to deliver effective and safe client-centred services across the broad spectrum of mental health services in the United Kingdom.

> Strategies for Living: Trainers' Information Pack: Learning the Lessons - Using the Lessons. The Mental Health Foundation has developed one-day and half-day workshops for people working in the mental health field, service users and survivors, carers and others with an interest or concern about improving mental health services. This Trainers' Information Pack aims to disseminate the key messages from the Strategies for Living research project into mainstream mental health services. For more information, see: http://www.mentalhealth.org.uk/

*The Sainsbury Centre for Mental Health (United Kingdom)*
The Centre provides various training programmes. Their approach emphasizes the practical application of core multidisciplinary skills. To this end, they train whole teams together in their normal work setting and link the programme to the wider organizational development agenda. This not only encourages the sharing of ideas across disciplines, but also makes it more likely that new skills will be employed, sustained and supported by the organization. Service users and carers are essential to the effectiveness of the work, and participate in curriculum development, advisory groups and training. The Sainsbury Centre works with regional confederations involved in workforce development, the National Institute for Mental Health in the United Kingdom, regional development centres and higher education providers to develop sustainable, local training programmes. Their key areas of training include, acute mental health care, assertive outreach, community care, crisis resolution/home treatment, dual diagnosis, early intervention and leadership.  For more information, see: www.scmh.org.uk

*The Fogarty Training Program in International Mental Health*
This is a collaborative effort of the Department of Social Medicine, Harvard Medical School(USA) and the Chinese University of Hong Kong (China). The project is designed to address the massive problems of mental health and neuropsychiatric disorders facing China and the region. The programme trains a promising group of mental health and mental health service researchers. It focuses on a paradigm of "culture and mental health services research" – an interdisciplinary approach that combines clinically relevant medical anthropology, social and cultural psychiatry and mental health service research which has developed as part of the Harvard Medical Anthropology Programme over the past 20 years. For more information, see: http://www.hms.harvard.edu/dsm/WorkFiles/html/education/postdoc/InternationalFogarty.html

*Rehabilitation training*
The Centre for Psychiatric Rehabilitation at Boston University (USA) has a collection of protocols and activities that guide practitioners through the psychiatric rehabilitation process. These are available at: http://www.bu.edu/cpr/catalog/training/practitioner/index.html.

*Training trainers*
*Training for Trainers*: Developed by the Hamlet Trust and the Mental Health Foundation, with funding from the Community Fund and the Department of Health in the United Kingdom, Training for Trainers is a new and innovative training resource. It is a focused, and practical resource guide aimed at enabling more people to become mental health trainers. More information on this course can be found on the Mental Health Trainers Network website at: www.mhtn.org/training for trainers.htm

*Mental Health Trainers Network website*: This website, developed by the Mental Health Foundation, with support from Pavilion and the Department of Health in England, is designed to support mental health trainers delivering mental health education and training across a range of service and educational settings. For more information, see: www.mhtn.org

*Note: These examples are provided for illustrative purposes only, and do not constitute endorsements by WHO.*

### 5.1.5  Long-stay facilities and specialist mental health services

These are usually facilities based in specialist hospitals, and offer various services in inpatient wards and specialist outpatient clinics. Examples include long-stay inpatient facilities, medium and high security units, specialized units for treatment of specific disorders (e.g. eating disorders), and related rehabilitation programmes dedicated to specific populations, such as children and adolescents or the elderly, as well as respite care units.

Examples of professionals working at this level are psychiatrists, mental health nurses, psychologists, psychiatric social workers and occupational therapists, who are likely to be specialists in the service provided, such as forensics or children and adolescents, or eating disorders.

*Long-stay facilities and specialist mental health services are usually facilities based in specialist hospitals, and offer various services in inpatient wards and specialist outpatient clinics.*

### (i) Functions

It is important to remember that such specialist units are not first-line care providers; they are usually tertiary care referral centres. They should not be confused with outdated asylums that offer custodial care. Usually, they require highly trained and skilled professional staff, and their success depends upon the quality of staff and the availability of infrastructure. Hence such services are frequently absent or inadequate in many developing countries with limited resources.

The exact functions of these services will depend on the area of specialization of the unit; for example, professionals working in forensic units will have functions and roles that are very different from those of professionals working in child and adolescent units. For these reasons, it is difficult to enumerate a common set of functions. Suffice it to say that the functions of these services include nearly all of the functions of mental health services in general hospitals and community mental health services, in addition to the specific specialist function that the particular service is designed to deliver.

### (ii) Competencies required

Professionals working at this level of service provision need specific competencies for their particular area of specialization. Thus, those working in child and adolescent units require specialist competencies in that area, while those working in forensic units require specialist competencies in forensic mental health. In addition, they require competencies that have been described under the previous levels of service provision. These include knowledge of relevant legislation, and competencies in education and training, administration and management, advocacy and research.

Not all professionals working at this level need to have all the competencies identified for the previous service levels. For example, forensic psychiatrists would need competencies in prescribing medication and authorizing fitness to stand trial, whereas forensic psychologists would need competencies in risk assessment and anger management.

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**Box 8. Long-stay facilities and specialist mental health services: Examples of training programmes, strategies and resources**

Training programmes for specialized services are normally provided through academic institutions. Since they tend to be very specialized, only one illustrative example is provided here.

*Specialist training in child mental health*
The International Child Mental Health Training Programme, run by the Department of Psychiatry, Children's Hospital, Boston, and the Department of Social Medicine, Harvard Medical School (USA), is a cross-disciplinary programme for training physicians, psychologists, social workers and health providers in basic and advanced concepts of child mental health. The goal is to develop a cadre of trained individuals, primarily from developing countries, who can aid in the development of child mental health policy, foster child mental health clinical programmes, and otherwise serve as advocates for child mental health. For more information, see: http://www.hms.harvard.edu/dsm/WorkFiles/html/research/mentalhealth/ICMHP/Training_Brochure.pdf

*Note: This example is for illustrative purposes only, and does not constitute an endorsement by WHO.*

## 5.2  Curriculum development

In many countries, achieving training goals will require a change in the way in which mental health education and training is conducted. There is often a phase lag in which clinical practice moves ahead of the content of training courses, as their curricula tend to change more slowly (Thornicroft & Tansella, 1999). Therefore, curricula that have become outdated or are not consistent with new models of community-based care need to be updated.

Evidence-based training is necessary to prepare workers who are competent to fulfil mental health service needs in the most relevant and efficient manner possible. This means that training must be conducted on the basis of the best available evidence for a particular practice or intervention.  For example, staff should be taught about the most cost-effective medications and psychosocial interventions, and the development of community-based care (Gorman & Nathan, 2002; WHO, 2001a).

The three core principles of curriculum development are:

> assessing the *current training* provision,
> assessing the *future needs* for which training is to be provided, and
> *setting targets* for transforming current training towards meeting future needs.

The development of curricula for mental health training can be undertaken through the steps set out in table 7 (further details of each of these steps, with examples, are provided in Annex 2).

*In many countries, achieving training goals will require a change in the way in which mental health education and training is conducted.*

**Table 7. Steps in developing mental health curricula**

**Stage 1. Steps for getting started**

Step 1: Plan the curriculum according to current and future mental health needs
Step 2: Consult all relevant stakeholders
Step 3: Develop a profile of the "future mental health worker"
Step 4:
  (a) Where no curriculum exists, obtain and adapt a relevant mental health curriculum;
  (b) Where a curriculum exists, assess its usefulness.
Step 5:
  (a) Where no student evaluation system exists, develop or adapt a relevant evaluation system;
  (b) Where a student evaluation system exists, assess it
Step 6:
  (a) Where no faculty and staff exist, create a viable faculty using an appropriate training group model;
  (b) Where a faculty and staff exist, review them
Step 7: Assess the organizational structure and reward system
Step 8: Estimate the chances for successful change and prepare appropriate leaders

**Stage 2. Steps for development and early implementation**

Step 1: Seek financial support
Step 2: Gather materials to develop a new curriculum
Step 3: Develop an organizational plan

**Stage 3. Steps for full implementation**

Step 1: Develop a curriculum schedule
Step 2: Establish an appropriate curriculum governance structure
Step 3: Establish an ongoing evaluation plan for the short term and the long term
Step 4: Participate in community-based mental health programmes and mental health service research

## 5.3 Continuing education, training and supervision

Continuing education and training (CET) is in the interests of both the mental health service and the staff. For the service, it ensures that care remains up-to-date with the evidence for the most effective interventions. For the staff, it ensures that their occupation remains stimulating, and that their working life can follow a trajectory of career-long professional development. Lifelong learning is a cornerstone of continued fitness to practice, and is closely tied with the quality of care and patients' safety.

Changing and growing knowledge in the field of mental health means that mental health workers are required to know more and more, compared to what they first knew when they completed their basic training (Figure 9). This knowledge gap has begun to grow faster as new interventions are developed for assessing, treating and managing mental health problems. The gap grows further if training does not continue after qualifying: people forget what they were originally taught and a retention gap develops. A combination of the knowledge and retention gaps results in an ever-widening gap in knowledge and skills. Continuing education and training is the most effective way of bridging this gap.

*Continuing education and training is in the interests of the mental health service as well as the staff.*

**Figure 9. Why continuing education is necessary for all mental health workers**
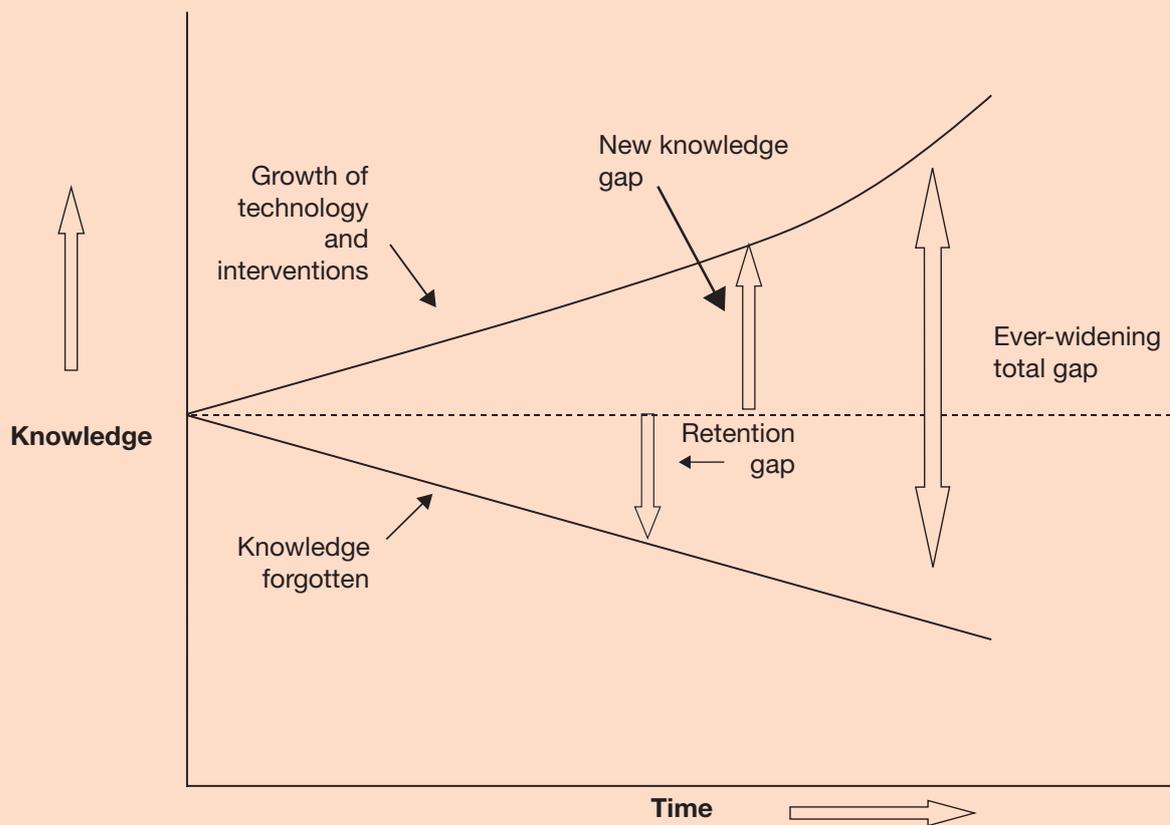


Source: adapted from WHO, 1993.

The knowledge gap refers not only to the content of a body of knowledge, but also to how knowledge is acquired, organized and applied. Continuing education is therefore necessary, not only to provide staff with new knowledge (such as new therapeutic interventions) but also to keep staff abreast of methods for acquiring new knowledge (such as through the Internet).

In order for CET to function effectively, every mental health service needs to develop a sound policy and effective method for staff development.

### 5.3.1 Developing a CET policy and plan

The first step in developing CET is to draw up the principles upon which staff development will be practised, and a plan for implementation. The policy should include the following (WHO, 1993):

> Commitment of the service to continuous career-long staff development, including the mapping of career paths.
> Self-development as the responsibility of every individual within the service, guided and supported by a manager or supervisor.
> Commitment of the service to recognize improved performance and provide appropriate recognition and rewards.
> Linking of CET to accreditation of professionals so that professionals are required to undergo continuing training in order to retain their professional registration. This may be linked to quality improvement measures (see module on *Quality Improvement*).

*Every mental health service needs to develop a policy and plan for effective staff development.*

*The first step is to draw up the principles upon which staff development will be practised.*

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> Commitment to use new competencies in service provision or service organization.
> Clear statements about who is responsible for the implementation and review of CET plans.
> Clear statements regarding the channels through which plans for continuing education are communicated.
> Appraisal and assessment methods.
> A policy on paid and unpaid leave for study during work time.
> Encouragement of an environment for staff development, ensuring that all managers are committed to CET as an ongoing process.
> Where possible, intersectoral training opportunities should be encouraged, such as using mental health workers to educate school teachers, the police and the judiciary.

## The CET plan

The continuing education and training plan should include:

(i)  a survey of training needs for existing staff
(ii)  targets for specific training programmes (dates and activities)

### (i) Training needs survey

A survey of training needs can be conducted (see Table 8 below) as part of the survey of the existing staff supply (see Situation Analysis, Step 1, discussed above). It should include the following components:

*A training-needs survey is essential for appropriate planning for CET.*

> For each service level in the mental health service pyramid, a brief description of what post-qualification training is being provided.
> This should be assessed in the light of current needs and future requirements. For example, what staff competencies are needed in this service or team to meet the identified service functions (as set out in section 5.1)?
> The training needed to develop these competencies should then be identified in the same way as for the protocol for training reform (described above).
> After that, the gaps between existing post-qualification training and the needed training should be identified.
> Finally, targets can be set for how the gaps can be filled.  This will include determining the time frame, identifying who carries out in-service training, what qualifications they will need to conduct the training, and the site of training.

An important element of the training needs survey is consultation with the staff regarding their perceived training needs. Active participation is critical not only for identifying training priorities, but also for ensuring successful delivery of training and its positive impact. Compelling staff to attend training sessions against their wishes is problematic and can waste valuable resources. For example, specialist psychiatric staff and general health staff frequently have differing perceptions of the latter's mental health training needs. Some studies have shown that primary care doctors most often want to increase their knowledge of somatization, psychosexual problems, people who present with difficult behaviour and stress management, whereas psychiatrists emphasize the need for improving their knowledge of diagnostic criteria for disorders such as schizophrenia, bipolar disorder and depression (Hodges, Inch & Silver, 2001).

*The training needs survey must be based on thorough consultation.*

Crucial to the survey of CET needs is an overview of the training methods. One of the most important variables in effective continuing education is the active participation of the learners.  Over three decades of research in North America  has shown that a high degree of involvement of primary care doctors, as a result of their learning psychiatry, is necessary to help bring about change. One-day conferences with long, didactic lectures have

*Crucial to the survey of CET needs is an overview of training methods*

minimal impact compared to interactive, longitudinal programmes that provide opportunities to practice knowledge and skills (Hodges, Inch & Silver, 2001).

Partners in CET also need to be identified as part of the training needs survey. An example is collaboration with professional societies that are often able to raise funds with support from the pharmaceutical sector. By drawing the private medical sector into CET via professional societies, planners can achieve the twin goals of gaining access to these resources and including the private sector in an effective CET programme.

A culture of lifelong learning can be developed by providing mental health workers with incentives for CET. These include rewards for participation in further training, and ongoing professional registration being contingent on the attainment of certain minimum CET points during an average year. Accreditation of training programmes that qualify for CET points is a necessary part of this latter incentive.

*A culture of lifelong learning can be assisted with incentives.*

**Table 8. Example: Post-qualification training needs survey**

| Service levels | Current post-qualification training being conducted | Staff competencies needed to meet the identified service functions | Training needed for the identified competencies | Gaps between current training and needed training | Training targets |
|---|---|---|---|---|---|
| Informal community mental health services | | | | | |
| Mental health services through primary health care | | | | | |
| Mental health services through general hospitals | | | | | |
| Formal community mental health services | | | | | |
| Long-stay hospital facilities and specialist services | | | | | |

On the basis of two sources of data – the results of the training needs survey and the targets for HR development (from earlier planning) – the CET targets for the service can be identified.

On this basis, the training commitments that will be honoured within the current and subsequent financial year can be listed. Indicators should be identified that will provide a measure of whether these training commitments have been achieved.

An example of training targets is the training of primary care workers in the detection and management of mental disorders. Training targets might include:
> number of primary care workers to be trained,
> time period of the training,
> content of the training curriculum,
> methods of training (e.g. seminars, supervised clinical practice, reading materials),
> evaluation methods for trainees, and
> methods of evaluating the success of the training programme (e.g. detection rate of mental health problems before and after training, number of mental health problems appropriately treated before and after training, and the impact of the training on mental health outcomes in the community, such as suicide rates) (see Box 9).

A CET plan should also recognize the importance of supervision, which is discussed in subsection 5.3.2 below.

### Box 9. Example: Benefits of mental health training for general practitioners

The training of general practitioners in mental health skills has been shown to have clear benefits. In Sweden, successful training led to fewer hospitalizations and to a reduction in the suicide rate among the population served by the trained general practitioners (Rutz, Walinder & Eberhard, 1989). However, the reduction in the suicide rate was not maintained in the three-year follow-up period, possibly indicating the need for ongoing training, supervision and/or support (Rutz, von Knorring & Walinder, 1992).

### Box 10. Examples: Developing a continuing education system

**Example 1: Developing a CET programme for the mental health services in Egypt**

In Egypt, a continuing education system for the mental health service was started, to be extended later to other services. Over 1000 persons were involved in the pilot programme. Before this, there was no system for HR development or continuing education for mental health in the country.

*Stages in the development process:*

1. A situation analysis was conducted concerning management systems and practices, number of personnel in different staff categories, job descriptions, educational backgrounds and training needs.

2. A multi-professional training committee was established, on which all staff categories were represented. The committee reported to the director of the service.

3. The tasks and responsibilities of the committee were defined.

4. The working practices of the committee were defined.

5. The committee developed skills in working as a team.

6. The committee members were trained to be trainers.

7. A training plan was developed and the committee members were required to go through the following steps:

   (i)    Analyse the contextual changes in the service;
   (ii)   Clarify job requirements according to job descriptions, the mission and goal(s) of the service;
   (iii)  Study personnel requirements based on data about current skills and the new skills required;
   (iv)   Prioritize the training needs;
   (v)    Make draft plans of contents for training;
   (vi)   Assess cost of training;
   (vii)  Prepare a timetable for training; and
   (viii) Make follow-up plans for different training courses.

*After developing the training plan the next stages were:*

1. Implementation of the training
2. Follow-up of the training
3. Assessment of the continuing education system

*Source: Ahmed Mohamed Heshmat, Chief Technical Adviser, Mental Health Programme, Ministry of Health, Cairo, Egypt, personal communication.*

**Example 2: Developing a CET system for a psychiatric hospital in Slovenia**

The central Slovenian psychiatric hospital employs about 60 mental health workers, who use mainly occupational therapy and psychotherapeutic techniques in their work with patients with severe mental disorders. Most of their work is done in groups, and has no clear theoretical or evidence-based foundation. Even though these therapists contribute to improving the ward milieu and, possibly, to better compliance with treatment, there is no solid evidence that their work contributes to outcome or rehabilitation goals. Since these are traditional therapeutic practices, it is difficult to change them to more outcome-oriented approaches. This group of workers is not interested in acquiring new skills and updating their approach, and there is little money available to provide them with training. Thus their outdated therapeutic approaches are difficult to tackle.

Several possible solutions may resolve this impasse:
> Negotiating with those mental health workers who are willing to update their skills.
> Development of a policy that requires participation in continuing education and training for all mental health workers, as a condition for continued professional registration.
> Setting up exchanges with other similar facilities in the country, or in neighbouring countries, to share skills and experience.
> Providing opportunities for promotion or other positive incentives for those mental health workers who are willing to update their skills.
> Offering a series of seminars on evidence-based approaches to occupational therapy and psychotherapy in groups.
> Establishment of ongoing reading groups and peer supervision.

*Source: Vesna Svab, President, Slovenian Association for Mental Health (SENT), Ljubljana, Slovenia, personal communication.*

### 5.3.2 Supervision

Supervision has been defined as "the overall range of measures to ensure that personnel carry out their activities effectively and become more competent at their work." (Flahault, Piot & Franklin, 1988) Supervision therefore includes qualities of management, leadership and the passing on of technical information.

**(i) Why is supervision needed?**

The purpose of supervision is to promote continuous improvement in the care delivered by mental health workers. This includes several aspects (Flahault, Piot & Franklin, 1988):

1. Ensuring that staff and management are in agreement about the objectives of the service.
2. Ensuring that when difficulties are encountered, staff are able to adjust to those difficulties and overcome them.
3. Developing staff motivation.
4. Helping staff improve their performance and develop the necessary competence.
5. Providing emotional support to the staff, since those involved in caring for the mental health needs of others often need emotional support themselves.
6. Improving coordination between sectors and agencies in service delivery.

When there is general agreement, mastery of difficulties, greater motivation and improved performance and competence, staff are more likely to feel satisfied and rewarded in their work.

**(ii) Who needs supervision?**

Everyone involved in the provision of mental health care requires some form of regular supervision. For a mental health worker, supervision may be provided by an immediate line manager or by peers. In turn, the mental health worker may provide supervision to other junior or less experienced staff.

It is the responsibility of all mental health workers to ensure that they are being supervised and, if appropriate, that they are providing supervision to others. Supervision also needs to be adopted as part of HR policy for mental health services.

**(iii) What activities does supervision include?**

Supervision is a continuous process that is carried out in a range of mental health settings. It may involve supervision of clinical work (e.g. discussion of difficult cases), peer supervision in the context of a team discussion, or management of the service (e.g. discussion of waiting lists). For an example of primary health care supervision in South Africa, see the *Supervisor's Manual* of the Eastern Cape Department of Health, available at: (www.equityproject.co.za).

In order to be effective, clinicians and managers need to set aside regular times for supervision. In addition, there may be ad hoc supervision activities that are organized for specific purposes (e.g. reviewing referral procedures). Table 9 outlines the three broad stages of supervision activities.

*Supervision includes management, leadership and the passing on of technical information.*

*Supervision promotes continuous improvement in care.*

*Everyone involved in the provision of mental health care should be in some form of regular supervision.*

*Supervision is a continuous process that includes a range of activities.*

**Table 9. Stages, objectives and activities in supervision**

| Stages | Objectives | Activities |
| --- | --- | --- |
| Stage 1 | Preparation for supervision | > Set goals and priorities for supervision (e.g. regular review of case-load, assistance with difficult cases, ongoing development of clinical competencies)<br>> Prepare a supervision schedule (e.g. once every two weeks for one hour) |
| Stage 2 | Conducting supervision | > Establish contact with those being supervised<br>> Review objectives and norms<br>> Observe workers as they carry out tasks<br>> Provide feedback and discuss observed tasks<br>> Discuss any other outstanding issues or concerns |
| Stage 3 | Follow-up of supervision | > Formalize feedback in reports or evaluation forms<br>> Organize training programme, if necessary<br>> Make changes to organization or logistical support, if necessary<br>> Reorganize scheduling, goals and priorities, if necessary |

*Source: adapted from Flahault, Piot & Franklin, 1988.*

## (iv) Styles of supervision

Vital to effective supervision, apart from imparting knowledge, is the style of supervision. There are broadly three main styles: autocratic (in which the supervisor tells the person being supervised to do as told), anarchic (in which the supervisor tells the person being supervised to do as s/he likes) and consultative (in which the supervisor suggests that they agree on what they are going to do) (Flahault, Piot & Franklin, 1988).

*An appropriate supervisory style is essential.*

The consultative style is preferable and most likely to lead to cooperative and motivated staff. Supervision provides a useful opportunity for teaching by example in mental health settings. A supervisor who is able to demonstrate support, and reflective and listening skills in supervision is also likely to teach those supervised how to effectively care for the people whom they serve by using the same skills.

*Supervision provides a useful opportunity for teaching by example in mental health settings.*

There may be certain areas that require a more autocratic supervision style, for example, where there are ethical concerns over the management of a service user. Conversely, a more laissez-faire or anarchic style may be required, for example, when supervising experienced, highly skilled staff.

In the context of a long-term care team, one of the objectives of clinical supervision is the shared development of emotion-management skills, particularly those leading to adequate tolerance of aggression, anxiety, sadness, powerlessness and euphoria. Emotion-management training in such a perspective becomes one of the main activities of supervision. For example, a mental health nurse confronted with a highly depressed service user during a home visit may be left feeling sad and hopeless about the

possibility of assisting that user. In this instance, discussions of the case with the team and peer supervision might improve the nurse's understanding of the user's condition, reveal various options for effective interventions and demonstrate emotional strategies for dealing with the situation. These strategies include tolerance and "normalizing" of appropriate sad feelings, reminders of positive achievements (made by both the user and the nurse concerned), and utilization of other support mechanisms, such as supportive relationships, leisure activities and other experiences of success in the workplace. For an individual mental health worker in a team, supervision provides an essential means of modifying an emotional experience.

## 5.4  Approaches to training

Recent developments in mental health training show a move away from traditional, didactic or lecture-based methods towards more problem-focused, student-centred, active learning methods. There is a greater emphasis on outcomes-oriented training, multidisciplinary learning opportunities, and an integrated systems-oriented approach to the study of mental health that includes biopsychosocial elements.

*Recent trends in training show a move away from didactic methods to active, student-centred, problem-focused learning methods.*

Mental health training reform therefore needs to keep pace with these developments, and both planners and trainers should be aware of the latest evidence for cost-effective training methodologies. Optimally, mental health training should employ a combination of training methods, such as didactic lectures, role-playing, practical experience, on-site training and supervision.

Choices about which specific methods are appropriate will depend on the training objectives, training materials, the students, the environment and the available resources. The methods should be appropriately geared to the specific training objective. For example, for training of mental health competencies in primary care settings, it is essential that an element of practical, supervised experience in a primary care setting be included in the training programme.

*Choices about which specific methods are appropriate will depend on the training objectives, training materials, the students, the environment and the available resources.*

It is beyond the scope of this module to explore the variety of approaches employed in mental health training. However, box 11 highlights some of the key training methodologies (Gage, Bisch & Orley, 1990), as well as the advantages and disadvantages of each.

*A variety of approaches may be employed in mental health training.*

### Box 11. Examples of mental health training methods

**Lectures:** a lecturer or teacher gives an oral presentation of concepts or skills to assembled students, who are responsible for note-taking.

*Advantages:*
> The content of course material (facts, concepts or skills) may be relayed to a relatively large group by a single instructor.
> Students may be encouraged to learn the material by taking notes.
> The lecturer can modify the pace and elaborate selectively, depending on the response of the audience.
> There can be advantages to meeting with a large group undergoing the same training in terms of improving morale.

*Disadvantages:*
> Learning methods are relatively passive (i.e. students are not required to actively engage with the material).
> It is difficult to evaluate the extent to which students are learning the material.
> The extent to which practical skills (such as a mental health assessment) can be learned in a lecture is limited.

**Role play/simulation:** students are assigned to portray or act out roles in a simulated care situation.

*Advantages:*

> Students are able to gain practical experience of applying a specific skill or set of knowledge.
> The simulation helps to minimize negative consequences to the public of errors.
> Students can learn through the role models of the lecturer and fellow-students.
> This method can ensure that the education is appropriate for the particular service users in an area.

*Disadvantages:*

> This method may not enable explanations of complex concepts or the memorizing of large volumes of information.
> It may provide examples of poor practices.

**Self-instruction:** students use prepared materials (e.g. programmed instruction, learning packages) that provide questions for response, feedback and testing so that they can learn with minimal teaching guidance.

*Advantages:*

> Students can work at their own pace and are given responsibility for learning.
> Low levels of teacher input and hence fewer resources are required.
> Students can receive direct feedback for work they have completed.
> These skills are important to acquire for life-long learning.

*Disadvantages:*

> Too much reliance on student motivation.
> Limited direct evaluation of learning by the teacher.

**Process recordings:** students use audio-visual or written recordings (such as logs or diaries) to depict and analyse the process of interpersonal interactions and receive feedback from the teacher.

*Advantages:*

> Low levels of teacher input, and hence resources, are required.
> Students are given responsibility for learning.

*Disadvantages:*

> Reliance on technology that may not be available in some settings.
> Evaluation by the teacher is limited as students may use only those excerpts.
> That demonstrate higher competency levels.

**Demonstration or observation of clinical settings:** the teacher uses, or students observe, examples of actual performances to illustrate specific concepts or skills.

*Advantages:*

> Students are able to gain practical experience of applying a specific skill or set of knowledge.
> They are able to observe skilled practitioners, who can serve as role models of good attitudes and "bedside manner".

*Disadvantages:*

> There may be negative consequences as a result of student errors.
> Examples of best practice rely on the skill and/or experience of the instructor.
> For the service users it can be inconvenient and time-consuming.

**Supervised clinical practice:** students are given assignments for the application of concepts or skills in real-life situations. Such practical applications are directly supervised by the teacher, or the students report back to the teacher for feedback.

*Advantages:*
> Students are able to gain practical experience of applying a specific skill or set of knowledge.
> They are able to practise specific skills in a supportive environment.

*Disadvantages:*
> There may be negative consequences as a result of student errors.
> The method may not allow for the explanation of complex concepts or the memorizing of large volumes of information.

Two approaches to training that are relevant for mental health training, particularly in situations of limited resources, are open or distance learning and train-the-trainer.

In *open or distance learning*, students use self-instruction with support via the Internet or telephone and periodic physical meetings or seminars with teachers and fellow-students. Recent innovations include interactive teaching materials such as CD-ROMs or Web-based discussion groups. The advantages of this approach are that the programmes can reach a wider student audience; students may be able to participate who might not have direct physical access to institutions of learning; outside experts who might otherwise be unavailable can be involved in teaching; and technology can facilitate interaction among students (e.g. through Internet-based chat rooms and bulletin boards). Disadvantages are that these methods rely to a large extent on student motivation; there is a limit to the practical clinical skills that can be learned at a distance; the methods depend on students having access to the required technology; and students can feel isolated and demotivated without direct physical contact with teachers and fellow-learners.

In *train-the-trainer methods*: (i) trainers learn about specific areas, such as mental health clinical skills in primary health care; (ii) they learn to teach about those areas, and their teaching is evaluated by direct observation; and (iii) trainees can be taught in such a way as to link training to clinical care by using tools common to both (Kutcher et al., 2004). Advantages are that a core group of trainers is formed; the approach is needs-based; a set of specific target competencies can be defined; trainers and trainees may be integrated into the health care system; a low level of resources is required; and it can be locally sustainable. Disadvantages are that it may require input from external experts to start the initial training process (see Annex 3 for more detail).

*Two approaches to training that are particularly relevant for mental health training, especially where resources are limited, are open or distance learning and train-the-trainer.*

# 6. Conclusion

This module has provided a set of guidelines for HR policy development, planning, management and training. It addresses issues facing a range of countries: from those with minimal mental health services, to those with relatively well-resourced services. Ultimately, the tools presented in this module should be adapted to the particular circumstances and needs of the country concerned.

Whatever the available resources, mental health services need to develop a long-term perspective by investing in the most essential assets of the service: the staff.

*Mental health services need to develop a long-term perspective by investing in the most essential assets of the service: the staff.*

"It is common when budgets are reduced to cut the training budget first. An equivalent could be stopping all routine maintenance on a passenger aircraft: it will fly on for some time, but the need for consequent major repair, if not the risk of serious adverse outcome, increases with time… If the mental health team is seen as an asset, then investment in frequent and planned minor maintenance is likely to be cost-effective in the long term." (Thornicroft & Tansella, 1999:156)

# Annex 1. Resources for training curricula

The following resources may be used to gather materials for new curricula (full references to citations are provided in the list of references).

> **A Guide to Treatments that Work** by Gorman JM & Nathan P (2002).

> **What Professionals Need to Know about Families**. Centre For Psychiatric Rehabilitation, Boston University (USA). For further information, see the following website: *http://www.bu.edu/cpr/catalog/multimedia/families.html*. The Centre also has a collection of protocols and activities that guide practitioners through the psychiatric rehabilitation process. These are available at: *http://www.bu.edu/cpr/catalog/training/practitioner/index.html*.

> **The Clinical Research Unit for Anxiety and Depression (CRUfAD)**. This is a group of researchers and academicians concerned with anxiety and depression. It works in association with the University of New South Wales School of Psychiatry (Australia), which is also a WHO Collaborating Centre. For further information, see the following website: *http://www.crufad.com/cru_index.htm*

> **Training Programme in Benefits and Mental Health, Disability Alliance (United Kingdom)**. For more information see the following website: *http://www.disabilityalliance.org/train17.htm*

> **The Fogarty Training Program in International Mental Health**. This is a collaborative effort of the Department of Social Medicine, Harvard Medical School (USA) and the Chinese University of Hong Kong (China). For more information, see the following website: *http://www.hms.harvard.edu/dsm/WorkFiles/html/education/postdoc/International Fogarty.html*

> **Helping People with Mental Illness**. A Mental Health Training Programme for Community Health Workers, KwaZakhele, Eastern Cape, South Africa. This has been developed by the University of Manchester (United Kingdom) and the University of Port Elizabeth (South Africa). Training modules are available on the WHO website and can be accessed at: *http://www.who.int/mental_health/policy/education/en/*

> **International Mental Health Leadership Program (iMHLP)**. This is a collaborative initiative of the Centre for International Mental Health at The University of Melbourne (Australia) and the Department of Social Medicine, Harvard Medical School (USA). For more information, see the following website : *http://www.cimh.unimelb.edu.au/imhlp/index.html*

> **The International Child Mental Health Training Programme**. This programme, run by the Department of Psychiatry, Children's Hospital, Boston (USA) and the Department of Social Medicine, Harvard Medical School (USA), is a cross-disciplinary programme for training physicians, psychologists, social workers and health-provider students in basic and advanced concepts of child mental health. For more information, see the following website: *http://www.hms.harvard.edu/dsm/WorkFiles/html/research/mentalhealth/ ICMHP/Training_Brochure.pdf*

> **Mental Health Foundation (United Kingdom)**. This charity offers various training programmes for staff working with people with mental disorders. For more information, see the following website: *http://www.mentalhealth.org.uk/*

> **Mental Health Trainers Network website**. This website, developed by the Mental Health Foundation, with support from Pavilion and the Department of Health (all in the United Kingdom), is designed to support mental health trainers delivering mental health education and training across the range of service and educational settings. For more information, see *www.mhtn.org*. The website also provides a training resource pack for mental health trainers, developed by the Hamlet Trust and the Mental Health Foundation with funding from the Community Fund and the Department of Health (United Kingdom). More information on this course can be found on the Mental Health Trainers Network website at: www.mhtn.org/training for trainers.htm

> **National Electronic Library for Mental Health (NeLMH)**. This project, led by the Centre for Evidence-Based Medicine in Oxford, United Kingdom, is funded by the National Electronic Library for Health and supported by the Centre for Evidence-Based Mental Health, University of Oxford Department of Psychiatry, the Royal College of Psychiatrists and the World Health Organization Collaborating Centre. The NeLMH also works closely with a number of leading mental health charities. Further information is available at: *www.nelmh.org*

> **Psychiatric Notes for Volunteer Community Workers**, Ghana. These notes are available on the WHO website at: *http://www.who.int/mental_health/policy/education/en/*

> **The Sainsbury Centre for Mental Health**, United Kingdom, provides various training programmes and resources for mental health. For more information, see the following website: *www.scmh.org.uk*. See also the Centre's following publications: *Pulling Together:* **The Future Roles and Training of Mental Health Staff (1997); and The Capable Practitioner** (2001).

> **Substance Abuse Mental Health Service Administration Training Manual for Mental Health and Human Service Workers in Major Disasters**. This manual is prepared by the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, USA. For more information, see the following website: *http://www.mentalhealth.org/publications/ allpubs/*

> **Training Manual for South African Police Services**, prepared by the National Department Directorate of Mental Health and Substance Abuse, Department of Health, South Africa. This manual is available on the WHO website, and can be accessed at *http://www.who.int/mental_health/policy/education/en/*

> **Where There Is No Psychiatrist**, by V. Patel (2003). A mental health training manual and resource material for non-specialist health workers.

> WHO publications, including: the **Annotated Directory of Mental Health Training Manuals** (WHO, 1992), the **Directory of Training Courses in Mental Health in Africa** (WHO, 1988), **Integration of the Mental Health Component in General Nursing Education** (Gage, Bisch & Orley, 1990), and **Mental Disorders in Primary Care: A WHO Educational Package** (WHO/MSA/MNH/EAC/98.1) Full details of the WHO PHC Training Kit are available at the following website: *http://www.who.int/msa/mnh/ems/primacare/edukit/index.htm*

For reviews of existing human resources for mental health globally, see the WHO **Atlas: Country Profiles on Mental Health Resources** (WHO, 2001b); (*http://www.who.int/mental_health/evidence/atlas/*).

# Annex 2. Mental health training: a protocol for change[1]

In order to assist countries in assessing their current mental health training programmes and in the implementation of necessary changes, this section provides a protocol for change in mental health education.

The protocol is designed for application in a variety of training settings, including departments within universities (for example, departments of nursing, psychiatry, psychology, occupational therapy and social work), medical schools and nursing colleges. The term "mental health training institution" is therefore used to refer to any of these settings. This may include mental health training of both general health workers and specialist mental health workers. General health workers may spend only part of their time in mental health service delivery, and specialists work exclusively in mental health. It also includes all aspects of mental health promotion, prevention, treatment and rehabilitation.

Training needs for mental health may well be identified for non-mental health workers as well. For example, teachers, police officers, prison service employees, private sector employers, home-based carers and service users are all well placed to provide mental health promotion and prevention services to the population. Their particular training needs can be evaluated and modified using similar principles to the protocol for change for mental health training institutions.

Training institutions and central or regional governments will need to liaise closely in this process of reforming mental health training. The nature of this liaison will vary significantly, depending on countries' specific organizational set-up. For example, in some countries, training institutions will function relatively independently of public sector HR planning departments. In others there will be closer relationships.

The difficulty in undertaking this task should not be underestimated. In many countries there are conflicts of interest and tensions between these stakeholders. With private health care prevailing in many countries, some universities, for example, tend to train mental health professionals oriented towards private practice in urban settings. This may contradict the policies of the ministry of health, which may wish to emphasize the mental health needs of the poor and the rural population.

In other countries, professional bodies may play a particularly powerful role. For example, in the United Kingdom, professional bodies' control over every aspect of training made the changing of basic training a complex and slow process. As a result, strategies for reform focused on postgraduate training with a view to influencing undergraduate training. This has proved to be very successful; many, if not most, higher education institutions are now reviewing their curricula to take account of the priorities of the National Service Framework for Mental Health and the Capable Practitioner Framework (The Sainsbury Centre for Mental Health, 2001).

The three core principles of this protocol for change are:

> assessing the *current training* provision,
> assessing the *future needs* for which training is to be conducted, and
> *setting targets* for transforming current training to meet future needs.

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[1] This protocol has been adapted for mental health from a protocol for change in medical education (Boelen et al., 1995)

Mental health training institutions can define their missions by anticipating the essential features of the future mental health system and the essential aptitudes that health workers must possess in that system. This forecasting implies change and risk, but a reluctance to adapt to the changes anticipated for the future runs the greater risk of training staff who are irrelevant and redundant. The task of the training institution is "to prepare graduates to function effectively in society for the next three to four decades" (Boelen et al., 1995:4).

In this protocol, the process of changing mental health training in a country goes through three stages, within which several steps are required (Boelen et al., 1995). We provide a "walk-through" example for each stage, as an illustration of the change process.  It is important to emphasize that countries or regions may need to adapt this protocol according to their own health systems, training institutions and cultural context.  Some steps may be more relevant than others, depending on the country. For example some steps (4a, 5a and 6a) are intended for countries that do not have training institutions and curricula, while other steps (4b, 5b and 6b) are intended for countries that already have training institutions and curricula.

**Stage 1. Steps for getting started**

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

Step 2: Consult all relevant stakeholders

Step 3: Develop a profile of the "future mental health worker"

Step 4:

      (a) Where no curriculum exists, obtain and adapt a relevant mental health curriculum
      (b) Where a curriculum exists, assess its usefulness

Step 5:

      (a) Where no student evaluation system exists, develop or adapt a relevant evaluation system
      (b) Where a student evaluation system exists, assess that system

Step 6:

      (a) Where no faculty and staff exist, create a viable faculty using an appropriate training group model
      (b) Where a faculty and staff exist, review them

Step 7: Assess the organizational structure and reward system

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

**Stage 2. Steps for development and early implementation**

Step 1: Seek financial support

Step 2: Gather materials to develop a new curriculum

Step 3: Develop an organizational plan

## Stage 1. Steps for getting started

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

**Goal:** To gather data regarding the mental health status and needs of the population as a basis for rational decision-making. This will ensure that present and future needs are a major factor in determining the content of the curriculum. This data may be gathered in conjunction with mental health policy and service planning (see the modules: *Planning and Budgeting to Deliver Services for Mental Health*; and *Mental Health Policy, Plans and Programmes*). It may be possible for a single survey to cover the needs assessment for several institutions or regions within a country, or indeed for the entire country, depending on the scale and diversity within that country.

**Tasks:**
> Identify sources of data.
> Prepare a plan for collecting the data (who, where, when), or coordinate a survey with service planning programmes. (see the module: *Planning and Budgeting*)
> Develop and administer a survey, where appropriate.
> If a survey is not possible, gather available information from existing expert opinion and planners regarding the priority mental health needs in the country and how this should contribute to curriculum development.
> Collate information and develop conclusions.

**Comments:**
> These data offer evidence to convince others of the need for change.
> Data sources may be qualitative or quantitative, and may use demographic or epidemiological data. Methodologies may include surveys and interviews with mental health workers, other health providers, educators and service users.
> Some data may be difficult to obtain, and it may be necessary to explore a variety of data sources and types.

**Sign of progress:**
    Baseline data are collected and conclusions are developed.

**Example:** In Slovenia, this approach has been adopted in a pilot project in the south-west region of the country. Data has been gathered on the epidemiological and mental health service situation in the region containing 24,000 inhabitants. It is proposed that the results of this research be implemented in training institutions.  Since this action is to be led by the Government, the reports will be sent to the National Council for Mental Health, which also includes a representative from the Ministry of Education. This person will be responsible for transferring the results of the survey to training institutions (Vesna Svab, personal communication).

**Step 2: Consult all relevant stakeholders**

**Goal:** To collaborate with local health authorities, professional groups, community organizations, family groups, service users, advocacy organizations and foreign donors. Mental health training institutions need to remain relevant to and in touch with the needs of the community for trained mental health workers.

**Tasks:**
> Identify individuals and organizations in the community with whom collaborative links should be established.
> Share information with these groups regarding the training institution's current and planned activities.
> Encourage collaborative arrangements.

**Comments:**
> Indicate what kinds of and how many trained mental health personnel can work in the community.
> Inquire about current or planned activities in the community with which the training institution could be associated.
> Develop a spirit of cooperation and mutual support.
> Be prepared to encounter resistance and conflicting views among various stakeholders.

**Signs of progress:**
> Discussions are initiated and sustained about linking the training institution with other organizations in the health sector and the wider community.
> Mental health faculty members sit on committees of other groups within the health sector and in the wider community. This leads to stronger links between different sectors in mental health training.

**Step 3: Develop a profile of the "future mental health worker"**

**Goal:** To determine the essential characteristics of the "future mental health worker", whether this worker is a mental health nurse, primary health care nurse, psychiatrist, psychologist, social worker, occupational therapist or general practitioner. This can be determined from the information collected so far, in keeping with the requirements of the mental health policies and plans.

As an example, such a mental health worker might be expected to fulfil several functions, including caregiver, decision-maker, communicator, community leader and manager (Boelen et al., 1995).

The specific characteristics of the mental health worker will also depend on the level of specialization. Too often mental health workers are trained in specialist institutions, managing people with severe disorders by using medication, when later they may well be placed in primary health care settings, where the majority of disorders will be mild to moderate and medication may not be required. The distinction between a specialist and primary mental health worker is extremely important here.

**Tasks:**
> After identifying the mental health needs of the population (Step 1), identify which aspects of the mental health needs will be the responsibility of which mental health workers, from the perspectives of prevention, promotion and curative services. This should also build on the needs assessment carried out earlier in this module.

> Ensure that as the curriculum is developed, the "end product" or "future mental health worker" will have acquired the knowledge, skills and attitudes to meet the newly identified responsibilities. These responsibilities will form the core profile of the "future mental health worker".

> This may require some dialogue with other training institutions regarding the relationships between professional groups and their respective roles in providing mental health care (e.g. primary care nurses and mental health nurses, nurses and doctors, psychiatrists and psychologists, social workers and occupational therapists). It may also require dialogue with institutions that train non-mental health professionals such as police officers, teachers and prison officials.

**Comments:**
> By defining the end product, training institutions can determine how the curriculum can orient the student to become a future mental health worker.

> The definition of the future mental health worker needs to be stated in behavioural terms (e.g. "The primary health care nurse should be able to…").

> Input for this task should come from a representative group of educators, mental health workers and service users.

**Sign of progress:**
A behaviour-based profile of the "future mental health worker" is developed.

**Example:** In the United Kingdom, the Capable Practitioner Framework provides a list of the practitioner capabilities required to implement the National Service Framework for Mental Health. This covers five areas: ethical practice, knowledge of mental health and mental health services, the process of care (including effective communication and partnerships), evidence-based interventions, and their application to specific service settings. This capability framework is intended to be used by professional and regulatory bodies to map competency-based exit profiles for each of the staff disciplines. It also serves to guide education and training organizations on the education and training required at pre-qualification and post-qualification levels (The Sainsbury Centre for Mental Health, 2001).

**Step 4a: Where no curriculum exists, obtain and adapt a relevant mental health curriculum**

**Goal:** To obtain a relevant mental health curriculum that can be used or adapted to meet needed mental health competencies, as defined by the needs assessment. Examples are provided in annex 1 of this module.

**Tasks:**
> Identify the health professionals who will be taught, and those competencies that they need to be taught.

> Identify the components of the curriculum that can be used to meet those needs.

> Identify the methods of teaching those competencies (eg: seminars, role-playing and/or videos).

**Comments:**
In some cases, the available curriculum will need to be modified somewhat to address specific local, regional or national realities. For example, if clozapine is not available, there is little point in providing detailed teaching on how it is to be used. If specific myths pertaining to causes or treatment of mental illness are common in the region these should be incorporated into the curriculum.

**Sign of progress:**
The curriculum is obtained and any necessary modifications are made.

**Step 4b: Where a curriculum exists, assess its usefulness**

**Goal:** To determine which parts of the present training curriculum (content and methodologies) will best serve to train the "future mental health worker", and those that must be modified.

**Tasks:**
Answer the following questions:
> In the light of the need to produce a future mental health worker, which parts of the existing curriculum should remain unchanged?
> What is acceptable about the curriculum, but could be improved?
> What is inappropriate about the present curriculum, and needs to be changed? For example, is the location of training appropriate? Often, general nurses and doctors receive mental health training in psychiatric hospitals rather than in community clinics.

**Comments:**
> In certain instances, a radical approach may be needed and the present curriculum may have to be completely revised. For example, a traditional curriculum may need to be entirely replaced with one that is problem-focused, multidisciplinary and competency-based.
> In other instances, priorities may have to be set and modifications made to the existing curriculum in a step-by-step manner, based on what is feasible.
> This analysis needs to be conducted by a group representing faculty, mental health workers, mental health service managers and students, with consultative input from service users and other relevant community organizations.
> There may be conflicts among the group regarding which aspects of the curriculum need to be retained, and which need to be omitted. Changing the content of a curriculum may be perceived as devaluing existing staff and their teaching materials. Such a situation needs to be handled tactfully and firmly.

**Sign of progress:**
The present curriculum is reviewed and suggestions are made for modification of both the content and the methodology.

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**Box A2.1. Example: Core competencies in a mental health curriculum for doctors and nurses in primary care**

Core mental health competencies in a primary care setting include (WHO, 1990):
> Assessment
> Interviewing
> Basic evidence-based counselling techniques (including listening, reflection, empathy and development of a supportive therapeutic relationship)
> Diagnosis
> Treatment of appropriate cases
> Referral of complex cases to secondary and tertiary level
> Education of service users about mental health

Research has shown that doctors in primary care settings who use "directive" rather than "closed" styles of interviewing, who know when to make supportive comments and who use questions that explore psychological problems, are more likely to make accurate assessments of psychological disorders (Goldberg & Huxley, 1992). "Directive" styles (e.g. "tell me more about the pain") leave the service user free to provide a range of information whereas "closed" styles (e.g. "does the pain wake you at night?") restrict the range of possible responses. Training in medical schools and nursing colleges therefore needs to include feedback of interview performance so that students can acquire the relevant communication skills. Teachers who have mental health competencies need to teach students by providing them with practical experience in interviewing service users (Goldberg & Gater, 1996).

**Step 5a:** **Where no student evaluation system exists, develop or adapt a relevant system**

**Goal:** To create a student evaluation system that measures the desired outcomes of the training, if necessary adapting curricula from other settings.

**Tasks:**
> Ensure that pre- and post-training tests are carried out.
> Ensure that follow-up testing is done (six months following training).
> Ensure that a practice audit on the use of clinical tools is conducted. A clinical audit on the use of the training materials is a good means of evaluating the impact of the training on actual clinical activity.

**Comments:**
For example, each training module may be preceded and followed by a written evaluation of the information presented in the module. This written evaluation can be repeated at a later date (possibly six months) to determine if the new knowledge has been retained. Additionally, the curriculum may contain clinically relevant tools that are expected to be utilized in everyday clinical care by a variety of health professionals. By linking written evaluations with practice audits, this approach provides an evaluation system that is closely tied to everyday clinical care and which should be readily accepted by the practitioners.

**Sign of progress:**
The evaluation system is in place and the follow-up testing and practice audits are ongoing.

**Step 5b:** **Where a student evaluation system exists, assess it**

**Goal:** To determine which parts of the existing student evaluation system can best serve to evaluate the knowledge, skills and attitudes expected of the "future mental health worker", and those that must be adapted.

**Tasks:**
Answer the following questions:
> In the light of the need to produce a future mental health worker, what is currently appropriate about the present evaluation system, and should not change?
> What is acceptable about the present evaluation system, but could be improved?
> What is inappropriate about the present evaluation system, and needs to be changed?

**Comments:**
> Because the system by which students are evaluated is the greatest single determinant of where they will concentrate their efforts, it is an essential part of shaping the future mental health worker.
> Recent trends in student evaluation emphasize:
- An outcomes-based approach, through which students are evaluated in terms of what they need to do once qualified; and
- Continuous assessment, whereby students are assessed by a range of methods throughout their training, as opposed to only sitting examinations at the end of their course. In this approach, outcomes are measured through continuous assessment, the methods and content of which are based on the desired outcomes.

**Sign of progress:**
The present student evaluation system is reviewed and suggestions are made for its modification.

**Step 6a:** **Where no faculty and staff exist, create a viable faculty using an appropriate training group model**

**Goal:** To create a viable faculty using a training group. Ideally this group should be multidisciplinary, comprising health professionals from both the mental health and primary care domains (e.g. psychiatrists, primary care physicians, mental health nurses, community health nurses, social workers and psychologists). It may consist of 6 – 8 individuals who have demonstrated good clinical skills, are well regarded as clinicians by their peers and are interested in being teachers. Wherever possible, some members of this group should be linked to available health institutions (such as a hospital) or educational institutions (such as a community college) or directly to the ministry of health. This will enable the trainers' group to become embedded within the health care system, and provide ongoing feedback to policy-makers and planners about the status of the training programme and the need for further training.

**Tasks:**
> A trainers' group should be trained to deliver the training programme.
> This group will need to be embedded in the health care system.

**Comments:**
Training the trainers' group (TG) to deliver the mental health training programme will require a significant amount of time. The members of the TG will need to master the contents of the training modules, some of which may be new to them. There may also be different levels of competencies among the members of the TG, which will need to be addressed during their training. Members of the TG will also be required to learn how to teach other health professionals, and be able to demonstrate that competency under observed conditions.

**Sign of progress:**
A trainers' group has been trained and is embedded in the health system.

**Step 6b:** **Where a faculty and staff exist, review them**

**Goal:** To review the ability of the present faculty and staff to train the "future mental health worker". This entails determining which additional or different staff might be needed to train future mental health workers to meet the needs of the population.

**Tasks:**
Review the current and potential competencies of the present faculty and staff, in order to determine whether they possess the qualities necessary to train future mental health workers.

**Comments:**
> Future mental health workers may require teachers and supervisors who are not presently available among the faculty of the training institution.
> If this is so, existing faculty will need to be trained to fulfil this role, or community mental health workers (in the public or private sector) should be approached to provide teaching and supervision.

**Sign of progress:**
Shortcomings of current faculty and staff are resolved and the training institution has the capacity to train future mental health workers.

**Step 7:** **Assess the organizational structure and reward system**

**Goal:** To determine whether the current organization and reward system can sustain the changes needed in the curriculum, in the evaluation and in the faculty to be able to train future mental health workers.

**Tasks:**
> Identify how the organization is structured, using an organogram.
> Identify how decisions are made as well as the major centres of power within the organization.
> Assess whether the current organization rewards change and improvement in the training of future mental health workers.

**Comments:**
> The organizational structure should allow for the optimal flow of ideas, activities and rewards for staff who participate in change towards training of the future mental health workers.
> Incentives and disincentives for change among staff and students should be identified in order to achieve the desired outcomes. There may be strong incentives for maintaining the status quo, and these should be taken into account when planning for change.

**Sign of progress:**
Assessment of the reward system and organizational structure is complete and modifications are suggested.

**Step 8:** **Estimate the likelihood of successful change and prepare appropriate leaders**

**Goal:** To determine whether existing circumstances are appropriate for change, and encourage a climate of change by identifying appropriate leaders in the change process.

**Tasks:**
> Identify one person to drive the transformation process. This may be the dean or head of the training institution, but more commonly another individual will need to be appointed specifically for this purpose.
> Assess the opportunities and the barriers to change, both inside and outside the training institution.
> Assess staff for qualities of leadership, their views on change and the degree of support they enjoy from other staff.

**Comments:**
> The institution can determine which areas will provide opportunities for change and those that will require specific effort to bring about change.
> Key heads of department and deans of faculties who provide support for appropriate change should be identified.

**Signs of progress:**
> An objective list of forces for and against change is compiled.
> The likelihood of successful change is determined.
> Leaders are identified and agree to participate in and drive the change process.

**Box A2.2. Mental health training: a protocol for change - Example of Stage 1: Steps for getting started**

The following walk-through example uses a fictitious country's training programme for nurses to illustrate the process of reforming mental health training. In this example, the

training programme includes both general and mental health nurses. The focus of the review is on mental health training for nurses in both general and mental health.

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

Based on information in the *World Health Report 2001*, it was estimated that mental disorders currently constitute 12% of the global burden of disease and that this will increase to 15% by the year 2020.  There is therefore an urgent need to expand the training capacity of the programme for the years ahead.  The planning department in the Ministry of Health within the country prioritized the following mental health needs, based on the limited epidemiological data available and consultation with expert advisers: mental health promotion and prevention, child abuse, battered women, victims of political conflict, depression, schizophrenia, attention deficit/hyperactivity, dementia and substance abuse.  Specific data regarding the number of anticipated cases per year and the number and competencies of required nursing staff were made available by the planning department.

**Step 2:  Consult with all relevant stakeholders**

The following stakeholders were asked to make suggestions regarding the way in which current nurse training for mental health could be reformed:
> Professional nursing council
> Department of Education
> Board of trustees of the training programme
> Training staff
> Student representatives
> HR planners within the Department of Health
> Advocacy organizations representing service users and families in the community

**Step 3:  Develop the profile of the "future mental health worker"**

On the basis of the consultation and the identified needs, the profile for competent future nurses was drawn up. This included the following skills, knowledge and attitudes:

**General nurse**

Skills:
> Listening
> Communication
> Diagnosis
> Counselling
> Treatment of minor mental disorders
> Referral of complex cases
> Administration and management

Knowledge:
> Classification of mental disorders
> Evidence-based treatment and management options
> Knowledge of the rights of people with mental disorders
> Service organization

Attitudes:
> Empathy
> Flexibility
> Empowerment, focusing on the strengths of the service users
> Collaborative teamwork with other disciplines

**Mental health nurse**

All the skills, knowledge and attitudes of the general nurse.

Additionally:
> Specialized skills for assessment and treatment of severe mental disorders
> Specialized knowledge regarding severe mental disorders, including diagnosis, evidence-based treatment and management options
> Knowledge of the rights of people with mental disorders
> Specialized knowledge of the service organization and referral routes
> Supervision and consultation skills for support to general health services
> Case management

**Step 4: Assess the usefulness of the present curriculum**

Investigation of the existing curriculum used in training nurses in some of the above skills, knowledge and attitudes showed shortcomings in the following areas:
> Counselling by general nurses
> Detection and diagnosis of mental disorders in primary care settings by general nurses
> Recent evidence-based interventions by all nurses
> Teamwork with other disciplines by all nurses
> Supervision and consultation by mental health nurses

In addition to shortcomings in the content of the curriculum, the following teaching methodologies required reform:
> Mental health training for nurses in primary care settings was lacking; it tended to be offered only in specialist institutions. It was therefore necessary to give them training in detection and management of mental disorders at the primary care level.
> Counselling skills had been taught in a theoretical fashion, whereas a practical approach was necessary, including problem-oriented training, role-playing and demonstration of communication styles and listening skills.

**Step 5: Assess the student evaluation system**

The current evaluation system was based on written examinations at the end of each year. This encouraged rote learning methods, whereby trainees were being tested for their ability to remember information, rather than their skills and attitudes. It was decided that a continuous evaluation system was preferable, which would enable evaluation of  trainees' demonstrated knowledge, skills and attitudes.

**Step 6: Review the faculty and staff**

A review of the faculty and staff revealed that existing staff did not have the competencies to train nurses in the identified new areas.  In particular, some general health nursing staff did not have competencies in mental health training; indeed, they indicated that they did not consider mental health to be a priority in nursing education. A plan was introduced to expose current staff to some of the new mental health training methods and to recruit staff in some areas where current staff did not have the required knowledge and skills.

**Step 7: Assess the organizational structure and reward system**

The organizational structure was shown to discourage innovation, as training staff were seldom evaluated or rewarded for their teaching skills or their research output. Furthermore, there was little scope for career development among training staff, and morale was low. Innovative teachers tended to be promoted to administrative positions, which led to little development of teaching skills.

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

A temporary post was created to spearhead the reform process; it was filled by someone who was experienced in mental health training and could garner the support of most stakeholders in the programme. Chances for successful change were expected to be high, although it was anticipated that reform of the teaching methods and training of the trainers in mental health would meet with resistance from some quarters. Those training staff who demonstrated an openness to change and a capacity to communicate the new vision to their peers were identified as potential leaders of the reform.

**Forces for change were identified as:**
> high level policy support for mental health within the Ministry of Health
> support from student representatives
> support from the department of education.

**Forces against change included:**
> some individual training staff who did not wish their training methods to be evaluated or to have a mental health component introduced into their training modules.

## Stage 2: Steps for development and early implementation

Once information is gathered from the early assessment phase, steps can be taken to initiate change in the training organization, or to establish a training group if no such training organization exists.

## Step 1: Seek financial support

**Goal:** To investigate all potential external and internal sources of financial support for the development and training of future mental health workers.

**Tasks:**
> Explore possible reallocation of existing internal resources.
> Explore government support.
> Explore support from NGOs and foreign donors.

**Comments:**
> Changes in priorities within the training organization may free some financial resources.
> Changes that are consistent with HR policy and service plans are more likely to attract government funding.
> Donors may be more interested in training on innovations that are in keeping with HR development plans in other areas or with their other general objectives.
> Proponents of reform may need to work with limited financial resources.

**Signs of progress:**
> Sources of financial support are identified and reviewed.
> Applications for planning and implementation grants are submitted.

## Step 2: Gather materials to develop a new curriculum

**Goal:** To gather curriculum materials used in other training institutions that have similar goals for training future mental health workers.

**Tasks:**
> Contact other institutions and organizations that have experience in implementing change and the development of future mental health workers, including WHO and WHO collaborating centres.
> Contact government departments and NGOs that have been through the process of reforming mental health education.

**Comments:**
> Since syllabuses, educational materials and mental health service research protocols have already been developed in many settings, these and training innovations used in other countries could be adopted; it is important not to "reinvent the wheel" in this area.
> However, this material does need to be adapted to the specific circumstances of the training institution concerned. Care should be taken to update materials in keeping with the latest evidence. Such adaptations will give the training institution a sense of ownership over the training curriculum, and it is more likely to provide training that is relevant to the country's particular needs.

**Signs of progress:**
> Contact is established with other training institutions that can offer relevant expertise and materials.
> Plans are made for the exchange of materials, competencies, students and staff.

**Step 3:** **Develop an organizational plan**

**Goal:** To identify the roles and responsibilities of all those who will participate in the change process. If there are no clear institutional organizational lines that have traditionally been used to address mental health training needs, these will need to be created.

**Tasks:**
> Develop a new organizational chart.
> Appoint committees to undertake specific tasks, and set deadlines.
> Identify new job descriptions and identify people whose qualifications fit these descriptions.
> Maintain communication with all staff throughout the change process.
> When creating new organizational lines, ensure that a training champion with a significant role in the health care system is identified (for example, a health planner, permanent secretary of health/deputy minister, senior official responsible for mental health).
> Ensure that roles and responsibilities for the training programme are clear and understood by all.
> Ensure that the policy leadership within the department of health is supportive of the initiative and will provide the needed direction for the process (whenever possible enlist the active participation of the minister of health).
> Maintain communication with administrators and workers in the mental health, primary care and institutional sectors, and ensure their ongoing support for the planned change.

**Comments:**
> It is important to allow for feelings of uncertainty and confusion during the change process.
> An organizational plan and supportive leadership will help to alleviate the confusion and engender greater certainty and clarity in the organization.
> Clear communication is essential throughout, including informing staff of their role and the goals of change, as well as hearing staff concerns about the process.
> It is essential to ensure that support for the planned change exists, including at the highest levels within the health ministry. Additionally, important decision-makers within the ministry, the mental health system, the primary care system and the health care institutions should be actively involved and supportive of the change. Ongoing participatory communication with front-line staff is also necessary to keep them informed, and, in turn, to receive from them information about progress. A process champion and an active committee to oversee the change is essential if the plan is to be put into action.

**Signs of progress:**
> An organizational chart is completed.
> Job descriptions are developed.
> Qualified persons for the new posts are identified.

**Box A2.3.  Mental health training: a protocol for change - Example of Stage 2: Steps for development and early implementation**

**Step 1: Seek financial support**

An international donor was approached to provide financial support for a temporary (two-year) post designed to spearhead the reform process.  In addition, funding was made available from the Department of Education for the secondment of training staff from a central training institution within the country for four two-week training seminars, intended to upgrade the competencies of training staff in mental health. Political momentum for reform within the mental health sector was used to lobby the Ministry of Health for funding to reform the evaluation system within the training programme. This included the funding of extra health service posts in primary care, so that primary care staff could devote a portion of their time to the supervision of trainees in those settings.

**Step 2: Gather materials to develop a new curriculum**

A literature review and Internet searches were conducted to identify training materials that could be adapted to the local training programme. WHO headquarters and regional offices were asked to provide information on available resources and useful contacts in countries.  A WHO collaborating centre in the country provided technical assistance for this process as well as suggestions regarding the content and methodologies of the new curriculum.  Visits to two other training programmes for nurses (one within the country and one in a neighbouring country) was organized to gather materials and establish relationships for future work.

**Step 3: Develop an organizational plan**

A working group was set up, headed by the new temporary appointee.  In consultation with the stakeholders listed earlier, the working group proposed a new organizational plan.  Major areas of transformation included:

> Reduction of administrative inefficiency by streamlining procedures, such as less repetition of tasks and clarification of lines of accountability;
> Supervision and support systems for all training staff, including performance reviews and rewards for innovation;
> Improvement of communication channels for staff and students, including representation and complaints procedures;
> Reform of the student evaluation system, including the introduction of new student placements in primary care and general hospital settings.

**Stage 3:** **Steps for full implementation**

Once the foundation has been laid for the development of an appropriate curriculum for future mental health workers, full implementation of the new training can begin.

**Step 1:** **Develop a curriculum schedule**

**Goal:** To establish a detailed schedule of all the components of the curriculum, including listing which material is taught to which disciplines, over what period of time, with what clinical experience and adopting what evaluation methods.

**Tasks:**
> The committees established earlier for specific tasks produce a detailed plan of action.
> Copies of the new curriculum plan are disseminated to all relevant parties.

**Comments:**
> The proposed new curriculum is presented to students, staff and administrative staff, who are given an opportunity to voice their opinions.
> Where possible, there should be opportunities for interaction between mental health workers, and interdisciplinary teaching should be encouraged. This is likely to improve an understanding of the work and role of other disciplines and encourage collaboration in later professional life.
> Clinical experience in training should be varied and should include both community and hospital settings, as well as non-clinical settings that support people with mental disorders (offering thereby an opportunity for them to see people when they are not acutely unwell); such people should be viewed not simply as "cases".

**Sign of progress:**
The new curriculum schedule is developed and disseminated.

**Box A2.4.  Example: Nursing curriculum in Poland**

A new general nursing curriculum was introduced in Poland in 1993/94. The new direction of nursing education has taken place in the context of wider health sector reform, particularly Poland's move towards an emphasis on primary health care. Mental health is one of the five principal areas of study in the nursing curriculum. Mental health service provision is therefore regarded as an essential skill for primary care nurses. The mental health component includes 60 hours of theory and 100 hours of practical experience (effectively three weeks spent in clinics and wards in psychiatric hospitals). One commentator has argued that the biological understanding of psychiatry espoused in these courses could benefit from being broadened to a bio-psychosocial model. In addition to the mental health training for general nurses, specialist psychiatric training is planned for mental health nurses as a postgraduate qualification (Welch, 1995).

**Step 2:** **Establish an appropriate curriculum governance structure**

**Goal:** To establish a curriculum governance structure that straddles departmental boundaries.

**Tasks:**
Establish a "new curriculum" committee that reflects the knowledge, skills and attitudes required to train future mental health workers.

**Comments:**
> The content, time allocation and teaching methods of the new curriculum should reflect the goal of training future mental health workers, and should not reflect political conflicts within the training organization.

> The curriculum structure should be interdepartmental, requiring active collaboration between departments in the development of the curriculum.

**Sign of progress:**
The governance structure is formed and clearly identifiable.

**Step 3: Establish an ongoing evaluation plan for the short term and the long term**

**Goal:** To evaluate the new curriculum, both in the short term and the long term.

**Tasks:**
> For the short-term evaluation, develop questions to be asked in 1-2 years' time regarding the feasibility and effectiveness of the programme.
> For the long-term evaluation, a longitudinal evaluation of students and graduates needs to be conducted. This includes an assessment of the extent to which graduates match up to the vision of a future mental health worker, and an evaluation of the impact of the new graduates on mental health outcomes, particularly consumer satisfaction. For example, it will be necessary to establish and maintain training databases to track staff training (who received what training, when, and where they were posted). This is important, as, often, staff are trained but not used in positions that require their competencies, especially when there are staff shortages.

**Comments:**
> Preliminary feedback can be used to assess whether the curriculum is functioning well, whether students are matching the required standard, and the cost of the programme.
> An external evaluation team may assist with this process.
> Both long- and short-term evaluation can be used to re-evaluate and develop the ongoing curriculum and training institution.

**Signs of progress:**
> Questions are developed and administered.
> Data are compiled and analysed.
> Appropriate curriculum changes are made.

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

**Goal:** To establish research and evaluation programmes, where appropriate; for example, population-based research to assess the need for mental health services; systems of continuing education and training for mental health personnel in the community; and evaluation of the detection and management of mental health problems in primary health care.

**Tasks:**
> Design a programme or project.
> Explore relevance for the local community and financial feasibility.
> Seek cooperation and willingness among service providers and the community for applying the research or assessing training results.

**Comments:**
> Training institutions are often well placed to conduct research. For this reason, an essential role, complementary to training, is the development of research capacity.
> Research can be conducted both by students for whom research projects are an essential part of the training curricula, and by staff as part of their job description.
> Community participation and health service research is likely to have educational benefits by exposing students to the reality of service provision, providing students with research and evaluation skills, and enabling direct contact between the community and the training institution to assist with the development of future curricula.

**Signs of progress:**
> Several projects or programmes are planned and implemented.
> Community and service provider organizations ask the training institution to assist with mental health policy and service planning.

Major changes in mental health training may encounter strong opposition (Egger, Lipson & Adams, 2000). Furthermore, changes in curricula may take some time to implement. In the words of one commentator: "effective strategies for change in medical education will likely be evolutionary, not revolutionary" (Mosley, 1994).

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**Box A2.5.  Mental health training: a protocol for change - Example of Stage 3: Steps for full implementation**

**Step 1: Develop a curriculum schedule**

A curriculum schedule was drawn up for each of the four years of the general nurse training, describing the mental health modules to be taught for each year. In certain modules of the curriculum, this required the separate teaching of mental health, for example in counselling skills. In other modules, such as problem-focused approaches to assessment and diagnosis, mental health was integrated within general health modules. In the specialist, postgraduate programme, placements were arranged in a range of mental health settings (from primary care to secondary general hospitals, to specialist institutions). Supervision and evaluation of trainees was conducted partly by qualified mental health nurses working in those settings. The complete curriculum was designed to produce mental health nurses with all the capabilities of a future mental health nurse described in stage 1.

**Step 2: Establish an appropriate curriculum governance structure**

A new curriculum committee was established to oversee implementation of the new curriculum.  In addition to the routine functioning of the committee, mechanisms were set up for dialogue with other parties, both within and outside the programme. This included feedback procedures regarding implementation, and evaluation of the new curriculum.

**Step 3: Establish an ongoing evaluation plan for the short term and long term**

An evaluation protocol was developed for the short-term, to evaluate the programme annually for the next three years. This included questions regarding the feasibility and effectiveness of the new curriculum, as well as responses from staff and students to the changes. A longer term evaluation was planned, and awaited implementation. This included an evaluation of the functioning of qualified general health nurses in their role as mental health workers, and an evaluation of specialist mental health nurses. Once again, the skills, knowledge and attitudes needed by future mental health workers were used as evaluation criteria. For the long term, in conjunction with the Ministry of Health, a mental health outcomes study was planned to assess changing practices in service delivery as a result of reform of the mental health training of general and mental health nurses. The implications of this study for future training would be evaluated.

**Step 4: Participate in community-based health programmes and health service research**

Research projects were included in the new curriculum schedule for 3rd and 4th year students as well as postgraduate students. Students were encouraged to pursue research topics relevant to the mental health needs of the local community. A list of possible research projects for the students was drawn up by local health services in consultation with community NGOs. Joint working by several students on various aspects of a single project was encouraged. In addition, research was included as an area of staff performance evaluation, and administrative support was provided for grant applications. This facilitated greater linkages between training, research and service provision activities. In certain instances, staff were able to act as consultants to specific community-run projects, such as for the evaluation of family support groups for people with severe mental disorders.

**Example 1.** **Reform of the training of mental health workers in China**

Until 1998, mental health care in China had been organized under the administration of the Department of Medical Administration of the Ministry of Health (MOH). This department was responsible mainly for the organization and administration of medical organizations in the country, rather than disease control. Since 1998, with the aim of developing mental health care, the administration of mental health care was transferred to the Department of Disease Control in the MOH.

In 2000, a special task force was established in the MOH, which, after several studies, found that the lack of human resources was the main bottleneck to developing adequate mental health care for China's 1.3 billion people. The MOH therefore established the following set of goals:

(i) Strengthen mental health education for medical students. The aim was to provide a clearer concept of mental health to the nearly 100,000 students graduating from medical colleges each year.

(ii) Strengthen continuing education for the existing 14,000 psychiatrists in the country. Continuing education should aim to upgrade the quality of service delivered and develop capacity for training other appropriate mental health workers.

(iii) Provide mental health training to staff working in general hospitals. The aim was to improve the diagnosis and treatment of mental disorders in general hospitals.

(iv) Offer basic knowledge of mental health to teachers in elementary and secondary schools, with the aim of promoting the mental health of school children.

(v) Offer mental health education to personnel engaged in epidemic prevention. There are plans to integrate the mental health service into post-disaster relief work.

(vi) Train community-based clinical practitioners with a view to making mental health care one of the major components of community health care.

(vii) Provide training to obstetric and paediatric medical personnel. It is expected that they will pass on the message to mothers that mental health is as important as physical health, and that they will encourage the next generation to make use of the mental health services when necessary.

The obstacle to these ambitious goals is that there are only 14,000 professional psychiatrists in the whole of mainland China, and less than half of these are university graduates. In addition, the limited mental health resources are mainly concentrated in the major cities. To achieve the goals, training of trainers for mental health will be a priority.

Since 2000, the MOH has launched a series of five-year training programmes for enhancing the human resources in mental health in China:

> A programme entitled the Planting Hope Project targets psychiatric clinical teachers who work in medical colleges in different parts of China. By 2004, there were 69 key teachers from 30 provinces who had received training for training others.
> Training of the seed teachers in general hospitals (sponsored by WHO).
> Training of teachers from elementary and secondary schools.

In addition to upgrading mental health knowledge, more important in the training is trying to change the trainees' mental health approach, from the conventional bio-psychiatric one to one that advocates a healthy mental life for all.

From 2002, the MOH will set out to complete the establishment of mental health training systems at various levels, in order to maximize both the use of available resources as well as coverage in terms of participants.

The top four mental health centres in China have formed the top level. Through international and domestic communication and exchange, the four centres work together to establish the training goals and teaching materials, and each has responsibility for training in 7 to 8 provinces. They will increase the number of different groups of recipients each year, and supervise each other's training work. The MOH will be responsible for general supervision, and aims to maintain the standard of training by the four centres.

The provincial mental health institutes form the second level of the training system and are responsible for training within the province. The "seed teachers" who received the training through the Planting Hope Project will become the major trainers. In March 2002, this level of training was fully launched.

The advantage of these training networks involving different levels is that they can maximize the use of the more skilled and experienced professional personnel resources in the top four centres. This will assist in raising the teaching standards of mental health in medical colleges throughout the country in the shortest possible time. The seed teachers will go back to their provinces and take responsibility for advocating mental health as well as training the local mental health staff working in psychiatric hospitals, general hospitals, community clinics and health education institutes.

*Source:* MA Hong, Deputy-Director, National Center for Mental Health, China, personal communication

**Example 2. Mental health human resource planning and training in Jamaica**

**1. Administrative and budgetary challenges in developing community psychiatric posts**

In the early 1970s, a community mental health programme was implemented in Jamaica to replace the custodial mental hospital that had been built by the British colonial administration one hundred years earlier. A handful of community psychiatric nurses (called mental health officers) and regional psychiatrists were deployed around the island to set up and implement the community mental health service. These mental health professionals were paid out of the central budget of the mental hospital. Thirty years later, in spite of the implementation of a major administrative reform process that regionalized health care delivery, many of the posts of the mental health professionals still remain under the centralized mental hospital budget. Paradoxically, 10% of the mental hospital budget finances the community mental health programme island-wide, despite the fact that this service provides care to more than 90% of the patients with

severe mental disorders in the country. Although some new mental health posts have been created in the regional health administrations, the bulk of the mental health budget continues to finance the single custodial mental hospital. In spite of a situation analysis and a specific strategic plan, which clearly identify this paradox and set out programmes for its transformation, this inappropriate budgetary system continues to hamper the development of the community mental health service in this country.

*Source:* Frederick Hickling, Head, Section of Psychiatry, Department of Community Health and Psychiatry, University of the West Indies, Kingston, Jamaica, personal communication

## 2. The Section of Psychiatry of the University of the West Indies, Mona, Jamaica

Training in psychiatry for undergraduate medical practitioners and postgraduate psychiatrists was established at the University of the West Indies (UWI), Mona, in 1965. A training and service module was established by 1972, which reflected the prevailing thinking of community psychiatry of that time. However, even at that stage, there existed an ideological dichotomy between the model of community psychiatry practised, based on the UWI training module, and the approach of the fledgling community mental health service in the government mental health service. The latter service created clear geographic catchment sectors for the country and prohibited the admission of patients from these geographic sectors to Bellevue Hospital, the single mental hospital situated in the capital city, Kingston. The university psychiatric service, on the other hand, continued to operate on the basis of the model that encouraged the referral of difficult patients to the mental hospital. It therefore perpetuated the ideology, which placed a degree of dependency on the custodial mental hospital, among an entire generation of medical and psychiatric graduates produced by the University. Thirty years later, this ideological dilemma has created an uncomfortable contradiction in the development of the mental health service island-wide, as there exists an operational gap between the general practitioners in the country and the mental health practitioners.

In an attempt to remove this contradiction, the Section of Psychiatry at the UWI established a community psychiatric service in 2001, which served a specific geographic location and prohibited the transfer of difficult patients to the mental hospital. In order to establish this service, the necessary administrative and budgetary planning processes were established with the University Hospital of the West Indies, and the necessary staff posts for mental health officers were approved in the three-year budget starting in 2003. However, general economic cutbacks in 2003 have resulted in the freezing of all new posts, which has left the implementation of this service in limbo, and has forced it to investigate alternative methods of financing to bring the service into operation. This process of readjustment has unearthed administrative practices in which the actual staffing practices for nurses in the Section of Psychiatry bear little resemblance to the formally accepted budgetary allocation of posts to that Section.

*Source:* Frederick Hickling, Head, Section of Psychiatry, Department of Community Health and Psychiatry, University of the West Indies, Kingston, Jamaica, personal communication.

**3.** **Entrepreneurial alternative to human resource development at the Section of Psychiatry, University of the West Indies (UWI)**

In order to meet the burgeoning community mental health needs, the Section of Psychiatry, UWI, has sought grant funding for novel community mental health services, that bypass the existing planning and budgetary processes, for the provision of new staff to carry out these programmes. Two new programmes that deliver community psychotherapeutic activities to children and adolescents in violence-torn inner-city communities have been established in this way. Further community initiatives have been planned using this method, that have focused on collaboration with international agencies and organizations for HR development. For example, a Memorandum of Understanding between the University of Dalhousie in Canada and the University of the West Indies, has led to the training of two psychiatrists from Jamaica in childhood and adolescent psychiatry, and the facilitation of a programme for training child and adolescent psychiatrists in Jamaica.

*Source:* Peter Lindley, Acting Director, Practice Development and Training, Sainsbury Centre for Mental Health, United Kingdom, personal communication.

**Example 3.** **Mental health training programmes in Chile**

**1.** **Masters programme in Public Health, majoring in Mental Health (University of Chile)**

This two-year postgraduate training programme for health professionals was financially supported by the Pan American Health Organization (PAHO) and the Ministry of Health (MOH), Chile, in order to assist the implementation of the first National Mental Health Policies and Plan (formulated in 1992). The training programme was started in 1993 and ran for four years. Its main goal was to train health professionals as leaders and managers of mental health initiatives in implementing the National Policies and Plan. Altogether, training was given to 26 professionals (psychiatrists, psychologists, social workers and occupational therapists), 4 to 8 people joining the programme each year. Around 50% of the trained professionals worked in health districts and the MOH, implementing the policies and plan, 30% worked in university centres and contributed to the training of mental health professionals, while 20% did not continue working in the area in which they had been trained.

This programme thus proved helpful for training people to implement the country's first Mental Health National Policies and Plan, although the retention rate of professionals in the public system was low.

*Source:* Alberto Minoletti, Ministry of Health, Santiago, Chile, personal communication.

**2.** **Psychiatric training, with an emphasis on community care and management of local mental health programmes  (University of Santiago)**

This three-year postgraduate training for physicians was financially supported by the MOH.  The aim was to develop a new model of psychiatric training tailored to the needs of the new policies of community care and decentralization. The programme has been running since 1996, with an average of five new students each year and slightly more than 20 graduates. All of the psychiatrists trained are working in the public system, which has adopted a community approach, and most of them are leading local programmes. The programmes adopt an active retention strategy, whereby health district directors nominate the candidates according to the local needs, and candidates sign contracts that require them to return to work in that particular district.

This programme has been successful in training psychiatrists with a community orientation based on the new mental health policies. The retention rate for the public system at the local level has been very high.

*Source:* Alberto Minoletti, Director, Mental Health Unit, Ministry of Health, Chile, personal communication.

**Example 4.** **Mental Health Training Program: Grenada and Saint Lucia**

**Introduction**

Over the past two years, the Dalhousie University Department of Psychiatry (Canada) has been actively engaged in initiatives in the Caribbean region that aim to enhance the development of mental health care. These have included psychiatric acute care training programmes for psychiatric nurses in Saint Kitts and Nevis, psychiatric emergency training for health professionals in Trinidad, and mental health system needs assessments as well as mental health professional training needs identification in Grenada and Saint Lucia.

These activities have been consistent with the directions developed by the Pan American Health Organization (PAHO) based on their 1990 "initiative for the restructuring of psychiatric care" as noted in the PAHO Directing Council's Resolution on Mental Health (Resolution CD43.R10). More recently, PAHO's Mental Health Division has obtained agreement from the health ministers of the Caribbean nations that mental health will be a priority for the region, particularly focusing on mental health training for health practitioners, mental health legislation and mental health services reform.

**Mental Health Training Project**

The Dalhousie Department of Psychiatry has created an innovative model for mental health training for health professionals. This model has been developed to support a national mental health care strategy and promote integration of mental health capacity into primary care, using existing health services and health care providers. The strategy aims at the development of skill-based mental health services that meet the needs of the health system, the community and patients. The model ensures that these skills can be developed and delivered in a manner that will establish an information/knowledge foundation which can evolve over time, and which is embedded within the health care system to ensure sustainability and capacity for growth.

Conventional training models that are professional-based and institutionally driven are expensive, time-consuming and not specifically designed to meet a population's mental health needs. Furthermore, they are not usually integrated into local health care systems and do not maximize the use of available human resources for health care. The model developed by the Department of Psychiatry at Dalhousie University is based on a population's needs, is skills-based, is integrated into the health care system and is locally sustainable. This model is economically effective and can be rapidly developed, delivered and integrated into existing health system infrastructures. In short, it is a model which identifies the skills needed, and trains the right people to deliver those skills to the people that need mental health services at the right time and in the most appropriate manner.

The training model was developed as a collaborative effort between the Dalhousie Department of Psychiatry, the Mental Health Division of PAHO and the Caribbean Project Coordinator (CPC), Barbados, to develop, deliver and evaluate a skills-based training programme for mental health care, for health professionals from Grenada and

Saint Lucia. The training programme is one component of a larger mental health system development model which the Department hopes to pilot in the Caribbean, pending funding and the outcome of the training programme. More information on the model is available upon request.

The objectives of this pilot programme were:

(i)    To develop and deliver two specific mental health training modules to two training teams, one each in Grenada and Saint Lucia. The modules were selected by national policy-makers, based on the priorities identified in the needs assessments.

(ii)   To evaluate the competency of the training teams to deliver these modules to local health-care professionals.

Two training teams (one from each country) consisting of four or five individuals were identified by each respective country to receive training in the modules developed by the educators at Dalhousie University using the "train the trainer" model. The training modules were delivered to Grenada where the training was conducted for both the Grenada and Saint Lucia teams. Following the training session, each of the training teams was evaluated within their own country on their delivery of the programme to selected individuals within a specific health-care district. Initial evaluation shows the pilot programme to have been effective in enhancing competencies in both the trainers' groups and among the health professionals trained by the trainers.

*Source:* Kutcher, Associate Dean, Dalhousie University, Halifax, Canada, and Jose-Miguel Caldas De Almeida, Regional Program Coordinator, Mental Health, WHO/PAHO, Washington DC, USA, personal communication.

**Education:** the process of giving intellectual, moral and social instruction (Pearsall, 1999).

**General health worker:** general health nurses and doctors who, in addition to their other health-care responsibilities, spend part of their time delivering mental health care in an integrated general health service.

**Home-based carer:** a family member, relative or friend who delivers mental health care at home.

**Mental health workers:** those working in a range of occupations that deliver a mental health service, including mental health nurses, psychiatrists, psychologists, occupational therapists and social workers.[2]

**Service provider:** an organization, mental health team or institution that delivers mental health interventions to a population.

**Supervision:** the overall range of measures to ensure that personnel carry out their activities effectively and become more competent in their work (Flahault, Piot & Franklin, 1988).

**Training:** the process of teaching a particular skill or type of behaviour through regular practice and instruction (Pearsall, 1999).

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[2] Note: the use of the term "mental health worker" is not necessarily an endorsement of the concept of a generic mental health worker. The professional identities of specific disciplines (such as nurses, psychiatrists and psychologists) remain relevant and are respected by WHO.

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