Mental Health Policy and Service Guidance Package

MONITORING AND EVALUATION OF MENTAL HEALTH POLICIES AND PLANS

"Careful monitoring and evaluation of a country's mental health policy and plan are vital for improving services, treatment and care and for guiding future policy directions."

World Health Organization

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Table of Contents

Preface

This module is part of the WHO Mental Health Policy and Service Guidance Package, which provides practical information to 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:

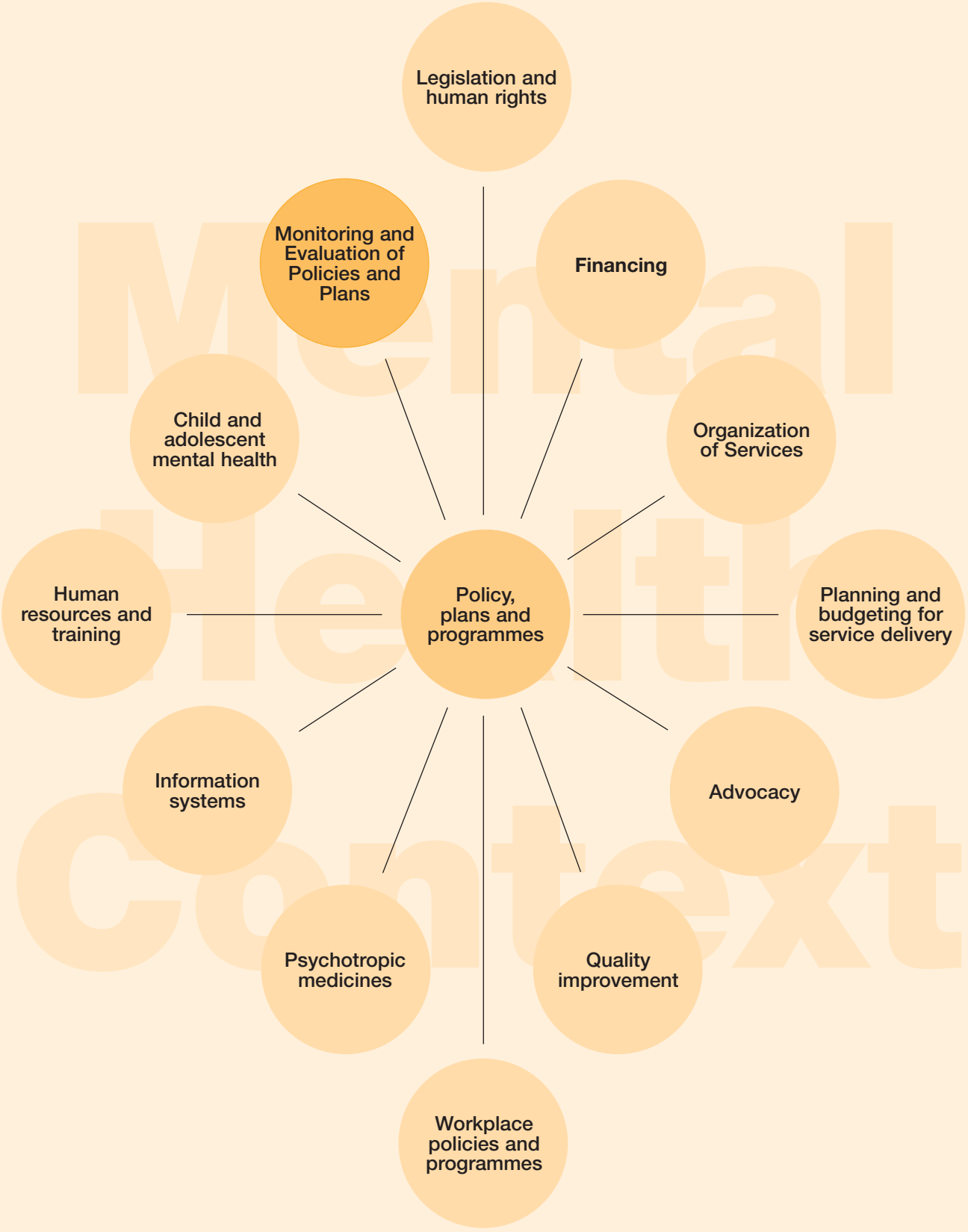
- develop policies and comprehensive strategies for improving the mental health of populations;
- use existing resources to achieve the greatest possible benefits;
- provide effective services to people in need; and
- assist the reintegration of people with mental disorders into all aspects of community life, thus improving their overall quality of life.

What is in the package?

The 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
> Monitoring and Evaluation of Mental Health Policies and Plans
> Mental Health Policies and Programmes in the Workplace


Legislation and human rights
Monitoring and Evaluation of Policies and Plans
Financing
Child and adolescent mental health
Organization of Services
Human resources and training
Policy, plans and programmes
Planning and budgeting for service delivery
Information systems
Advocacy
Psychotropic medicines
Quality improvement
Workplace 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;
- nongovernmental organizations (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 also 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.

– The modules can serve 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 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

MONITORING AND EVALUATION OF MENTAL HEALTH POLICIES AND PLANS

1. Introduction

A mental health policy provides the overall direction for mental health by *defining a vision, values, principles and objectives, and by establishing a broad model for action to achieve that vision.* To be effective, the policy should have a plan that details the strategies and activities that need to be implemented for achieving the objectives of the policy. Successful policies and plans have usually been developed through an *inclusive process*, where the content follows best practice principles and where the policy is clearly defined and appropriate to local needs and conditions.

Since governments are accountable to their citizens both for their policies and plans and for their use of public funds, it is critical that the policies and plans be carefully assessed and changes made if they are not having their desired outcomes or effects. The plan therefore also delineates the expected outputs, targets and indicators that can be used to assess whether the policy and plan have been successfully implemented as intended.

This module examines what comprises monitoring and evaluation. It explains the monitoring of a plan and the different ways of evaluating both a policy and plan. It describes a five-step process for conducting evaluations and examines how results of an evaluation can be utilized to improve policies and plans. The module then provides a detailed example of a policy and plan using a case study of a hypothetical country, and examines various ways that evaluation can be used over a period of time to assess and influence policy and the plan stemming from it.

What is monitoring and evaluation?

Monitoring refers to the *routine* tracking of a plan, whereas evaluation refers to a *systematic means of appraisal* to assess the value, worth or effectiveness of the policy or plan.

In order to understand whether the policy and plan have achieved their intended objectives, it is necessary to: (i) evaluate both, as documented; (ii) monitor the implementation of the plan; (iii) evaluate the implementation of the plan; and (iv) assess whether the objectives of the policy have been met, or to what extent they have been met. Key to evaluation is ongoing monitoring to ensure that the plan is being implemented as intended. Where possible, it is useful to measure the health outcomes. However, where this is not feasible, other forms of evaluation, such as those that assess the degree to which services have improved, are equally important. WHO has developed two checklists (annex 1 and annex 2) to assist governments to undertake evaluations of their policy and plan.

Implementation of the plan should also include an assessment of whether certain planned strategies and activities have been undertaken, and if not, why not; or whether the targets set for each strategy have been realized. For example, if a target has been to increase the number of people being treated in the community by 50%, an evaluation needs to be conducted to determine whether this target has been reached or not.

In planning an evaluation, it is important to identify the specific issues that require answers, and, based on this, to choose appropriate research methods. Moreover the method of evaluation chosen will often be determined by the time frames in which the results are needed, the financial resources available and the skills that are accessible in any given country or situation. The module describes different types of research design, including experimental, quasi-experimental and non-experimental. It also explains different forms of economic evaluation that can be undertaken and common data collection techniques.

2. Framework for setting up and conducting the evaluation of the policy and plan

There are five basic steps that are important for preparing and conducting an evaluation of a mental health policy and plan.

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

Evaluation is a "tool for decision-making". Policy-makers or administrators need to have a clear idea of what kinds of decisions they want the evaluation to help them make, and the depth and breadth of the information needed for making decisions, before commissioning and designing evaluations. For the evaluators, it is important to know who will be using the information so that they can provide their report and recommendations in an appropriate language, technical detail and form.

Step 2. Identifying the evaluators and funding for the evaluation

If the government has allocated resources for doing the evaluation, planners will need to ensure that these are appropriately distributed in terms of different priorities. If few or no resources have been allocated, strategies should be developed for securing funding from other sources such as local or international donors. The amount of money available, when it will be available and knowledge of its allocation to particular expenditure items is critical for enabling the evaluator to design and implement a suitable strategy.

Decisions must be made with respect to who will conduct the evaluation – whether it will be done by a specific individual/multisectoral team within the government or by an external agency – and what skills the evaluators will need. If an external evaluator is to be used, the mechanisms for hiring the person/team to do the work (e.g. put out on tender, request a local university or research institution, through international assistance) need to be decided.

Step 3. Assessing and managing ethical issues

The State, as the major protector of its population's human rights, needs to be especially vigilant to ensure that strict ethical practices are observed when evaluations are being conducted, especially when patients or their families are part of the process for evaluating a mental health policy and plan. There should be strict adherence to procedures for obtaining informed consent and protecting confidentiality and anonymity.

Step 4. Preparing and implementing the operational plan for the evaluation

A clear operational plan is needed for the evaluation. It should detail the evaluation method to be used, the time frame, and the type of research design and data to be collected. Depending on the size and scope of the evaluation, it may be necessary to assemble a team of people to undertake the work involved, such as field workers to conduct surveys, skilled interviewers for focus groups, a statistician, and a person with an in-depth understanding of mental health policy and planning who can interpret the results and make coherent and lucid recommendations.

Consumers and family members should be involved in the evaluation process. As the recipients of the policy/services, they are able to help identify key evaluation questions and help obtain the necessary information. Moreover, if they are involved in the evaluation, they are more likely to take ownership of the results.

Step 5. Analysis of evaluation data, including unintended outcomes, and reporting of results

Data must be collected, sorted and analysed. The analysis may involve any number of actions: from merely counting or converting to percentages, through collating themes in quantitative research, to using sophisticated computer programs. The results of evaluations, conclusions and recommendations should be clear taking into account the particular circumstances of the country concerned. In addition, governments are accountable to various constituencies, and the evaluation may be of equal relevance and importance to, for example those who voted the government into power, to opposition parties and to those receiving (or intended to receive) interventions as it is to the government.

Sometimes a policy may produce unintended outcomes, good or bad. Outcomes may even be the opposite of those intended. "Goals-free" methods of evaluation are often useful, whereby the actual effects are measured without necessarily knowing the intended objectives.

3. Case study: an evaluation of a national mental health policy and plan of a hypothetical country

This section takes the example of a hypothetical country, looks at information relevant to the development of mental health policy and then at the "actual" policy and plan that was developed. The policy is then scrutinized over the six years of implementation of the (hypothetical) plan. This case study is **not** a detailed presentation of an evaluation research methodology; rather, it is intended to provide a practical example of monitoring and evaluation of a policy and plan and what a country **may** experience over a six-year period.

The mental health policy and plan of the hypothetical country is defined by four key areas of action: organization of services; human resources and training; quality improvement and essential drug procurement and distribution. It also contains seven strategies aimed at:

(i) Reducing the number of people with mental disorders who are treated in psychiatric institutions;
(ii) Strengthening community-based mental health services;
(iii) Improving access to and utilization of mental health services throughout the country through decentralized mental health service delivery that is integrated into general health care;
(iv) Actively recruiting mental health staff, particularly in areas where staff shortages exist;
(v) Providing extensive mental health training programmes for all health staff, including general health workers and mental health specialists;
(vi) Establishing quality improvement mechanisms for mental health care; and
(vii) Improving the supply and utilization of essential psychotropic medications.

Even before implementation of the policy and plan, the five steps for setting up and conducting an evaluation (noted above) are considered, and monitoring and evaluation plans developed. Evaluations of the policy and plan are then undertaken using the WHO checklists.

Each strategy of the plan of this hypothetical country is monitored and evaluations are conducted at different stages of implementation, where deemed necessary, as well as at the end of the policy period. Additional evaluations undertaken in response to public and staff pressure are outlined. Finally, each policy objective is evaluated using both the results of previous monitoring and evaluation and additional evaluations conducted in order to assess whether the objectives have been reached.

4. Conclusions

Monitoring and evaluation are key elements of policy development and restructuring processes. First, the process of developing the policy and plan and the contents must be evaluated. Second, the plan should be monitored to ensure that its implementation proceeds according to a defined set of activities, timetable and budget and to assess whether the outputs are being realized. Third, if the plan is not being implemented as intended, an evaluation may be needed to understand the reasons for this. Fourth, at the end of a policy period it is important to assess whether the objectives set have been realized.

There are many ways of conducting evaluations; the most appropriate will depend on the human and financial resources available, the questions that need to be answered and the time frame available. Quantitative or qualitative research, and sometimes both, are important for evaluating policies and plans. In some situations a rapid appraisal may be appropriate, while in others in-depth research involving, for example an experimental design, such as a randomized controlled trial or in-depth interviews, may be preferable.

While evaluation may be perceived as an unnecessary expense and a time-consuming activity, good evaluation, on the contrary, can be money- and time-saving. Evaluations can often assist in unblocking obstacles to progress. By asking the questions “How well have we done?/How well are we doing?” and “How can we do better?” it is possible to improve mental health policy and plans and thereby improve the mental health and quality of life of people.

Aims and target audience

Aims

To present a model for the systematic evaluation of a mental health policy and plan and describe how results of an evaluation can be utilized to improve policies and plans.

Target audiences

Policy-makers and public health professionals of health ministries (or health offices) of countries and large administrative divisions of countries (regions, states, provinces).

Practitioners conducting evaluations of policy and plans.

How to use this module

The module describes what policy monitoring and evaluation are and how conducting systematic assessment of a mental health policy and plan is critical for decision making and future policy development. A 5 step framework for conducting mental health policy and plan evaluation is set out. This starts with clarification on the reasons why the evaluation is being carried out, through various steps in the evaluation process itself right through to reporting the results and using the findings of the evaluation for planning. It is recommended that planners and evaluators follow these steps in conducting policy and plan evaluation.

The module also has an extensive case example from a hypothetical country. This includes information relevant to the development of mental health policy and the "actual" policy and plan that was developed. The policy is scrutinized over the six years of implementation of the (hypothetical) plan. This example is not intended to be perfect model of evaluation but is rather an illustration of how policy evaluation may work "in the real world". Lessons of how problems may be overcome and how to use the results of planning can be gleaned from this section.

The module includes two checklists that can be used in evaluating a mental health policy and the plan that derives from it.

1. Introduction

For more than 30 years WHO has recognized the importance of having an explicit policy on mental health (WHO, 1984; 1987; 1996). A mental health policy constitutes official government guidelines for a number of interrelated strategic directions for improving mental health. It provides the overall direction for mental health by *defining the vision for the future and by establishing a broad model for action to achieve that vision*. To be effective, the policy needs a detailed plan so that its vision and directions can be implemented in a systematic and well- coordinated way. Governments are accountable to their citizens both for their policies and plans and for their use of public funds to improve mental health. It is therefore critical that their policies and plans be carefully assessed, and changes made if they are not having their desired effects. *Monitoring and evaluation* are the key processes used for determining whether the goals set in the policy and plan are being realized and for allowing decision-makers to make long – and short-term service – and policy-related decisions and changes.

A mental health policy constitutes the official government guidelines for a number of interrelated strategic directions for improving mental health. It defines the vision for the future and establishes a broad model for action to achieve that vision.

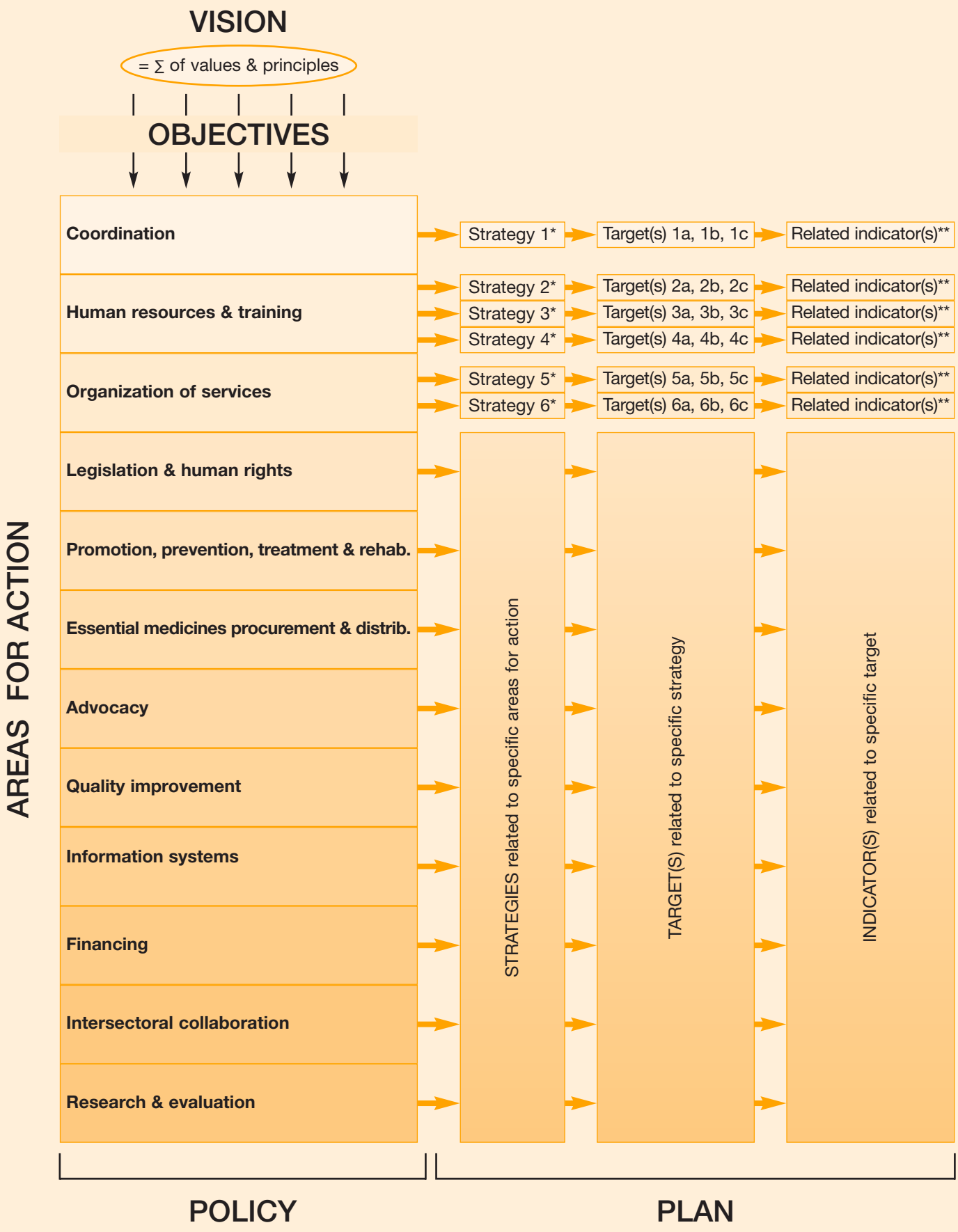
This module examines key aspects of monitoring and evaluation as they relate to a mental health policy and plan, including how to monitor a plan and the different ways to evaluate a policy and plan. It presents a five-step process for conducting evaluations and explains how results of an evaluation can be utilized to improve policies and plans. The module then provides a detailed case study of a policy and plan of a hypothetical country. It describes various ways that evaluation can be used over a period of time to assess and influence policy and the plan that arises from it, including the practical steps involved in policy evaluation and the policy decisions that can be made on the basis of monitoring and evaluations.

The relationship between a mental health policy and plan

The mental health policy and plan are interrelated elements needed to improve mental health in a country. While the policy maps out the vision, values, principles and objectives, the plan details the strategies and activities that will be implemented to realize that vision and achieve those objectives. The plan also delineates the expected outputs, targets and indicators that can be used to assess whether the implementation of the plan has been successful (see the module, *Mental Health Policies, Plans and Programmes* – (updated version), WHO, 2005a). The following diagram illustrates the relationship between the policy and plan.

The mental health plan details the strategies and activities that will be implemented to achieve the objectives of the policy.

This interrelated nature of the policy and plan also means that their monitoring and evaluation are inextricably linked.



* Strategy = ∑ activities

** Each strategy can have one or more targets and related indicators

1.1 What is monitoring and evaluation?

Monitoring refers to the *routine* tracking of a plan or a programme. In this module we use monitoring specifically to refer to the tracking of the key elements of the strategic plan. Monitoring is essential to assess how well the plan is being implemented so that any identified problems can be rectified on an ongoing basis. In addition, monitoring is crucial to ensure that any evaluation of the policy or plan is based on the *real*, rather than the *intended* (but not actual), implementation. Conducting an evaluation of the success of a policy without being certain that the plans have actually been carried out according to the design could result in incorrect or doubtful conclusions being reached about the success or "outcomes" of the policy. Areas in the plan which require close monitoring include an examination of whether:

A process of monitoring the implementation of the plan is thus vital. This needs to be done on an ongoing basis and corrective actions taken where implementation is not progressing as planned/on schedule.

Monitoring refers to the routine tracking of a plan or a programme.

- the activities outlined have been completed
- the time frames set for each activity are being observed
- the inputs planned have been realized
- the outputs of the activities have been achieved
- the targets of the various strategies have been reached

Evaluation, on the other hand, refers to a process of systematic appraisal to assess the value, worth or effectiveness of the policy or plan, and it can take a number of different forms. This module focuses primarily on the following three forms of evaluation:

Evaluation refers to a systematic appraisal to assess the value, worth and effectiveness of the policy and plan.

- Evaluation of the processes involved in developing the policy and plan, of the merits and value of the policy document itself and of the plan derived from it.
- Evaluation of the implementation of the plan. This involves not only monitoring whether the plan is being implemented, but also, if implementation is not going according to plan, assessing the reasons why.
- Evaluation of whether the policy objectives have been met.

Monitoring and evaluation are complementary and to some extent overlapping, rather than entirely distinct processes. Information collected through monitoring usually feeds into systematic evaluations that are conducted, and monitoring also involves some appraisal of information that can be used for informing the development of policy, plans and services.

Difficulties with evaluating health outcomes of a mental health policy

The decisive test of a mental health policy and plan would be an evaluation of whether the mental health of the population has improved as a *direct result* of the policy and the plan. However, for various reasons, in practice, this is difficult to achieve and measure. Significantly, mental health is determined by numerous factors, many of which fall outside the domain of a mental health policy. For instance, a war or a natural disaster may have a significant impact on a population's mental health, and may indeed have a greater bearing on the population's mental health than changes in the mental health system or mental health services.

Separating the outcomes of the policy and plan from other influences also requires sophisticated research designs and resources. However, many countries lack the skills and resources needed for this kind of evaluation. Moreover, if the policy and the plan are being implemented countrywide, it may not be possible to measure their direct impacts without also measuring the impacts of other influences. As discussed later in this module, without an appropriate research methodology, which would include a control group, any health changes measured (positive or negative) cannot be directly attributed to the policy. Moreover, the health outcomes measured may not necessarily reflect to

what extent the policy itself is good or bad; instead, they may be due to factors such as whether a comprehensive operational plan was drawn up to implement the policy and how effectively the plan was implemented.

However, the range of information relevant and useful to service and policy development that can be gained through policy and plan monitoring and evaluation need not be restricted to measures of mental health outcomes. For example, in a country where access to mental health services is very low, measurements showing improved availability of services can be considered a positive result of a policy. Similarly, if people are being kept in inhumane institutions and generally not discharged from them, a comprehensive deinstitutionalization programme may be regarded as a successful outcome of a policy that encourages the discharge of patients to community care. This section outlines and discusses different ways of monitoring and evaluating a policy and plan, and illustrates the importance of conducting monitoring and evaluation even where it is not possible to directly assess the health outcomes of the policy itself. Of course, where it is possible to measure the health outcomes that can be directly attributed to the policy, this should be encouraged.

Monitoring and evaluation of a mental health policy and plan may at times measure health outcomes. More often, though, the success of a policy and plan will be assessed through changes in health services and health systems.

1.2 Aspects of a mental health policy and plan requiring evaluation

Three important aspects of a policy and plan that require evaluation are: (i) the development process, and the merit or value of the policy and plan; (ii) implementation of the plan; and (iii) the extent to which the policy objectives are achieved.

(i) Evaluation of the development process, and the merit or value of the policy and plan

An important aspect of evaluation is assessing whether the *process* of developing the policy followed best practice principles, and whether the *content* of the policy itself is appropriate, feasible and based on best practice principles of a mental health policy.

Evaluating the merit or value of the policy itself may take place even before its implementation. This would ensure that the implementation of any subsequent action plan is based on a policy that is thoroughly prepared, practicable and sound in content. However, mental health policy is not a static entity that, once accepted and approved, remains constant. To be meaningful and relevant, policy must be responsive to various changes, such as the availability of new evidence regarding effective approaches for treatment, prevention and promotion, important social and economic changes in the country itself (e.g. internal conflicts), international best practices or a change in government; and any of these factors may prompt a policy evaluation. The government may also simply be concerned at any point that it may be not be pursuing the best possible policy path in mental health, and it may therefore wish to re-evaluate its policy.

The mental health policy and plan need to be evaluated in terms of both their process of development and their content. Based on such an evaluation, changes could be made to the policy and/or plan even before implementation.

The plan derived from the policy similarly requires evaluation of process and content. For example, have key stakeholders been involved in the development of the plan? If they have not, this may impede successful implementation. A critical aspect of the evaluation of the content is to ensure that the plan is realistic. For example, the plan needs to be checked against the available budget and human resources in the country. Trends in and outside the health service need to be noted and incorporated, where appropriate. For instance, if the public sector has been regularly losing nurses or doctors to the private sector or to other countries, this would affect the availability of human resources and would thus need to be considered when drawing up the plan. The plan may need to include ways to address the problem, but it should also be realistic with respect to the impacts of the human resource losses. Trends and plans within other sectors such as housing and labour would also need to be analysed, as these may also have a practical bearing on outputs and targets to be achieved within a mental health plan. For example, if, according to the plans of the housing ministry, people with disabilities were to be given

priority in access to housing, it may be possible to move more people from institutional to community care than if housing was not likely to be made available. The outputs and the targets of the plan would hence need to be interdependent with outputs and targets from other sectors.

(ii) Evaluation of the implementation of the plan

Where problems are experienced in the implementation of a plan, an evaluation may be required to better understand the reasons for this.

In monitoring the implementation of the plan, areas where implementation is not progressing according to the plan or where targets are not being met should be identified. In a number of instances, the reasons for this may be self-evident or relatively easy to identify and rectify. For example, inputs, such as the funding promised for implementation, may not have been provided as promised, or personnel may not have been appointed to implement the strategy as anticipated. Clearly, the activities and targets in the plan would both be hindered by such factors. However, in certain instances there may be deeper underlying problems, and an evaluation would be required to better understand why implementation was not progressing according to the accepted plan. The results of such evaluations may point to the need to revise the plan itself (for example, the strategies may not have been defined in a culturally appropriate way, or the plan may require more resources than are available in the country, or the time frames may have been unrealistic), or, for example, to the need for more effective management to be put in place.

(iii) Evaluation of the extent to which the policy objectives are achieved

An evaluation is essential at the end-point of a policy period. Any new mental health policy needs to draw on the successes or failures of the previous policy.

Policies usually have specific time frames. It is crucial that an **end-point policy evaluation** be conducted at the end of that period. Such an evaluation may examine whether, or the extent to which, the specific objectives set out in the policy have been met. Often this can be inferred from a detailed evaluation of the extent to which the targets outlined in the plan have been met. However, it is imperative to refer to the original objectives of the policy and assess explicitly whether these objectives have been met by the policy. If, for instance, the specific time frame of the policy and mental health plan had been set for a five-year period, the end-point evaluation for the policy and plan should occur at five years. If the objectives have been met, this is an indication that the strategic plan and its implementation have been successful. For this reason it is important that the objectives of the policy are clearly stated, are measurable and relate to what is strategically and practically feasible. In addition, the evaluation of the objectives may need supplementary assessments in order to determine whether the objectives have indeed been met (see section 3.6).

On the basis of the end-point evaluation, future policy directions can be made, integrating the strengths and reducing or eradicating the weaknesses. It may even be decided to set completely new policy directions.

What aspects of a mental health policy and plan need to be evaluated?

A mental health policy requires:

- **evaluation of the policy itself**
- **end-point policy evaluation of the objectives**

A mental health plan requires:

- **evaluation of the plan itself**
- **monitoring and evaluation of the implementation of the plan, including an evaluation of the targets**

1.3 Monitoring and evaluating a mental health policy and plan

Evaluation of the process of developing the policy and its content

A successful policy is usually one that has gone through an inclusive process of development, where the content follows best practice principles and where the policy is clearly defined and appropriate to local needs and conditions. An evaluation of a policy may therefore evolve around two broad questions:

(i) Was the **process** for developing the policy comprehensive?
(ii) Is the **content** of the policy in line with best practice principles (described below), clearly defined and appropriate?

The standards an evaluator uses to assess the policy need to be linked to local conditions, priorities, needs and resources. For example, the constitution of the country, the health financing system, finances committed or obtainable for mental health, and the importance of traditional practitioners in health care all need to be considered. In addition, the evaluation should be guided by standards such as a commitment to evidence-based mental health care and internationally accepted best practices.

WHO has developed a checklist to assist governments in undertaking an evaluation of their policy (see annex 1). This checklist can also serve as a best practice guide for how policy should be developed from the start.

The checklist delineates and considers a number of critical process and content issues. For example,

From a **process** perspective, is the policy based on
- A thorough consultation process, including consultation with all relevant/key stakeholders such as consumers of mental health services and their families?

From a **content** point of view, does the policy take into account
- Relevant and available data regarding the mental health care needs of the population?
- Evidence of effective policies in other countries with similar cultural and demographic patterns?
- Respect for and promotion of human rights?

And does the policy have

- A clear vision?
- Explicit values and principles?
- Clear and realistic objectives that have been thoroughly considered and discussed?
- Areas for action clearly linked and relevant to the main objectives (financing, legislation and human rights; organization of services; promotion, prevention and rehabilitation; procurement and distribution of essential medicines; advocacy; quality improvement; information systems; human resources and training; research and evaluation; and intersectoral collaboration)?

The WHO checklist assists governments in evaluating the process *and* content *of their mental health policy and plan.*

Evaluation of the plan

As with policy, a mental health plan needs to be considered in terms of both **process** and **content**. For example, in the same way a policy needs inputs from and consultation with key stakeholders, so does the plan. The extent to which this is done is likely to have a major bearing on the implementation and success of the plan.

WHO has also developed a checklist to assist governments in undertaking an evaluation of a mental health plan (see annex 2). Some of the key issues to be assessed in the plan are:

- Does the plan conform with the values, principles and objectives specified in the policy?
- Are clear and relevant strategies specified, with the appropriate target population linked to the areas of action identified in the policy?
- Are clear and relevant activities required for the implementation of each strategy listed in the plan?
- Are there specific and measurable outputs for each activity?
- Are targets and indicators specified to measure achievement of strategies?

Monitoring and evaluation of plan implementation

A good mental health plan is likely to have a number of strategies, each with targets and indicators against which the strategies can be measured. To achieve the objectives of these strategies activities need to be completed, human resources committed, and budgets allocated and spent according to the plan and time frames within which each of the activities must be completed. Each activity in a plan also requires a specific "output", which is a tangible result expected to be achieved from the activities. All these need monitoring.

Policy-makers and planners should never assume that the plan, as accepted, is being implemented as intended. Ongoing monitoring is essential so that where problems are identified corrective actions can be taken. If activities have been planned on a monthly basis, monitoring should probably take place monthly. The longer the time lapse between monitoring the more difficult it is to get the plan back on track if problems are identified. The outputs need to be monitored on completion of each activity.

Ongoing monitoring is essential so that where problems are identified corrective actions can be taken.

Evaluation of the plan's implementation should include an assessment of whether the targets set for each strategy have been realized. For example, if one of the targets is to increase the number of people being treated in the community by 50%, an evaluation needs to be conducted to determine whether this target has been reached. Generally, if a plan has been carefully thought through and if all the outputs have been achieved, it might be expected that the targets set will be realized; however, this may not always be the case. Evaluation of the plan may thus include an assessment of why the targets have not been met.

The degree to which the inputs, outputs and targets of a plan can be evaluated depends to a large extent on how clearly they were initially specified in the plan itself. Nevertheless, evaluations are possible even where these have not been clearly specified, though the results will only be able to say what has been achieved rather than whether specific predetermined goals have been met or not.

In some instances, the reasons why a plan is not being implemented as agreed upon, or the targets set are not being reached are complex. Research may then be needed to establish not only *what* is occurring in different situations but also *why*, *or why not*. As discussed later in this module, the research methods that may be used to achieve this may be quantitative or qualitative – or both. In some situations where results are needed in a very short space of time, "rapid appraisal" may be an appropriate research approach. However, in other instances, longer term, more detailed and more expensive research methods may be necessary.

Research may be needed to establish not only what is occurring in different situations but also why, or why not.

Monitoring and evaluation are important to assess whether:

- The relevant inputs (e.g. human and financial resources) to implement each activity delineated in the plan were actually provided (input evaluation);
- The major defined activities were actually implemented as intended (process evaluation);
- The outputs tied to each of the major activities were achieved (output evaluation); and
- The targets for each strategy were achieved using the indicators specified in the plan (impact evaluation).

Evaluating whether the objectives of the policy have been achieved

The objectives of the policy need to be evaluated at the end of the policy period.

While it is extremely difficult to measure the realization of the vision of the policy and its direct mental health outcomes (and the corresponding plan), the *objectives* of the policy nonetheless need to be evaluated at the end of the policy period. This evaluation task is easier if the objectives have been set out in clear terms in the policy and if evaluation was planned at the beginning of implementation of the policy. Moreover, if the objectives have been closely aligned with the targets of the plan, and these targets have been monitored and evaluated, evaluating the objectives is made significantly easier. However, evaluation of the extent to which policy objectives have been achieved involves more than monitoring and evaluation of the strategic targets, and it needs to be done irrespective of whether the evaluation was planned at the beginning of the implementation period or not. For example, if an important objective of the policy was to improve people's lives through the development of community mental health services, and the targets stipulated were indeed met, as part of assessing the objective, the government may also wish to know whether the mental health or quality of life of those people using these services has improved, and this is likely to require further investigation.

Where any evaluation is to be undertaken, it is necessary to consider the methodology to be used. The following section outlines various research methods useful for policy and plan evaluations.

1.4 Research methods for evaluating a mental health policy and plan

No single research method or design can answer all evaluation questions relating to the mental health policy and plan. Therefore, in planning the evaluation, it is important to understand clearly the specific issues that need answers, and choose the appropriate research methods accordingly. For example, in adopting a policy of deinstitutionalization policy-makers may not only wish to know whether the targets for community care have been met, but also whether patients are satisfied with the new arrangements and whether the mental health and quality of life of the patients who have been deinstitutionalized has improved with respect to standardized measures. Different research methods are required to answer these very different kinds of evaluation questions.

In addition, the kind of evaluation method chosen will often be determined by the time frames in which the results are needed, the financial resources available and the skills that are accessible in any given country or situation. While it is always important to conduct research that provides credible results on the basis of which good policy or service decisions can be made, it is not always necessary to spend large amounts of money or time on evaluation. For example, policy evaluations may usefully utilize secondary data, the questions framed may be modified to accommodate limited resources, and instruments themselves may be adapted to allow for resource constraints (for example, the nature and number of research instruments used, and the sample size and time period may all need to be limited). On the other hand, certain policy questions *require* methods that

take longer and tend to be more expensive. While not essential for all policy evaluation research, it can be extremely beneficial to start the process of evaluation at the beginning of the implementation process rather than at the end. For example, if changes over a period of time are to be monitored and differences noted between the beginning of the policy and its implementation, it is necessary to have measures against which to assess the changes and to collect the information at the start of the policy and at (various) stages thereafter.

Numerous textbooks and publications are available on research methods (see list of further reading at the end of this module) and the following illustrations do not attempt to provide a comprehensive explanation of when or how to use different research approaches. Rather, this section briefly describes different approaches and methods for evaluation in relation to broad questions that are often asked concerning policy and plan evaluation.

1.4.1 Experimental designs

A randomized controlled trial can link measured change directly to the policy or plan intervention. At times, though, the use of an experimental design in policy and plan evaluation is neither feasible nor ethical.

Experimental research attempts to link any measured differences with a particular intervention. A true experimental design, that is, a randomized controlled trial (RCT) in which subjects are randomly assigned to groups who either get the intervention or do not, is the most effective method for assessing causality. When utilized to evaluate aspects of a mental health policy or plan, it becomes possible to link any measured change directly to the "policy" or "plan" intervention. However, often the use of an experimental design is neither feasible nor ethical. For example, once a national policy has been adopted for a whole country, it is difficult (and perhaps even unethical) to randomly assign only some people to an intervention. Moreover, RCTs are usually quite expensive and require skilled researchers. They are thus seldom used in countries to evaluate the success of a policy or plan.

Quasi-experimental designs may be a more viable option for measuring the outcomes of a policy intervention. They also measure the success of an intervention but differ from experimental designs in that subjects are not randomized to the intervention and control groups. Although more practical, it is much more difficult to attribute any observed effect to any particular policy intervention. There are many variations of designs that would be classified as quasi-experimental, and the degree of confidence in attributing change to the implementation of the policy will depend on whether an adequate control group was used as well as a number of other variables that are discussed in various textbooks (see references).

In summary, the main advantage of using an experimental design is to understand the degree to which the policy intervention itself had a real impact on any outcome achieved. The challenge, however, is to overcome all the practical problems in setting up a research design in real environments that is rigorous enough to enable an attribution of causality to the policy intervention. Furthermore, although capable of demonstrating causality, experimental designs cannot go beyond this in describing the phenomenon that led to the causal relationship; other, "non-experimental" methods might be needed to supplement this type of research.

1.4.2 Non-experimental designs

Non-experimental designs may make use of quantitative and qualitative research methods.

Non-experimental designs do not make use of a control group or of repeated measurements for comparison over time. They can make use of quantitative and/or qualitative data. For example, quantitative data collected to answer questions relevant to mental health policy evaluation may include information such as the percentage of general clinics and hospitals providing mental health services, which mental disorders are being treated in the country and in what proportions, what medications patients are receiving and how this matches

their diagnoses, the relapse rate of patients who are receiving community care, the availability, or not, of medicines in clinics for patients who need them, the doctor-to-patient ratio in different regions, and the percentage of people who have negative attitudes towards and beliefs about people with mental illness.

Other common non-experimental designs make use of qualitative research methods, including surveys (which can be qualitative or quantitative), case studies, ethnography, participant observation and focus groups. They are helpful when it is necessary to understand points of view or life experiences as understood by people themselves. They can provide a "richness" and depth which quantitative research cannot. Non-experimental designs can also be used for capturing or describing naturally occurring phenomena in their real-life context. Qualitative non-experimental designs enable an understanding of social or human behaviour and the meanings that people attach to their actions.

Qualitative research can provide a "richness" and depth which quantitative research cannot

The main weakness with non-experimental design is that it does not provide information on the cause of the measurements found. However, hypotheses about causal relationships can be derived, particularly if there is consistent evidence from a number of different sources.

Some of the more common non-experimental designs are briefly described below, together with their main use.

Surveys: Surveys can be used to collect standardized information from a selected sample of people or households. They are often employed when it is important to understand characteristics about populations at a given point in time. Surveys can be done through written questionnaires or by interviews.

Case studies: A case study involves the observation of a single unit, which could range from an individual or community to a whole culture, in which the researcher gains an in-depth understanding of the entity being studied. While case studies may make use of either qualitative or quantitative methods (or both), most use qualitative methods. The main techniques used are observation, interviewing and document analysis. Case studies are useful when trying to find out what goes on within a complex, bounded system (Burns, 2000). However, such studies cannot necessarily be considered applicable to the whole population.

Phenomenology: Phenomenology focuses on subjective experiences and people's interpretation of the world. In-depth interviews are conducted which may last hours, or a number of interviews may be needed over a period of time. If, for example, there is the need to understand how people are coping with their lives after being deinstitutionalized and what meaning they are giving to this existence, phenomenology may be the best research method to use. However, this method is time consuming and the results cannot be generalized as relevant for the whole population.

Participant observation: In this approach, the researcher becomes immersed in the culture as an active participant while observing and understanding that culture or organization. Impacts of a mental health policy on patients and families within a community may be very effectively assessed through this approach. However, such an approach cannot attribute changes directly to a policy intervention.

Focus groups: A focus group is basically a group interview, but rather than having the interviewee answer direct questions, group discussion and interaction are generated centred on a topic or topics supplied by the researcher. Focus groups enable quick generation of information and promote the production of ideas through interaction with others. A limitation of this approach is that people may be influenced by others in the group and may be afraid to express their true views and beliefs.

Ethnography: Ethnography provides a multifaceted approach to understanding a particular social phenomenon, and includes the use of one or more of the above qualitative methods.

1.4.3 Economic evaluation

There is an increasing need to generate evidence on mental health care strategies that are not only effective and appropriate but also cost-effective and sustainable. Economic analysis provides a set of principles and analytical techniques that can be usefully employed to assess the relative costs and consequences of different mental health strategies and interventions. Economic evaluation is becoming increasingly important in the context of a resource competitive environment.

Economic analysis provides a set of principles and analytical techniques that can be usefully employed to assess the relative costs and consequences of different mental health strategies and interventions.

Broadly, there are four types of economic evaluation; the choice of a particular method depends on the main objectives of the study and on underlying data considerations. The major types of economic evaluation are cost-minimization analysis, cost-effectiveness analysis, cost-utility analysis and cost-benefit analysis (Drummond et al., 2005).

Cost-minimization analysis

This mode of evaluation is appropriate if it is well established that the outcomes will be identical. In that case, the task is merely to identify the least costly method of achieving these outcomes. However, a cost-minimization approach should not be used unless it is established beyond reasonable doubt that the outcomes will indeed be identical.

Cost-effectiveness analysis

This is a widely used form of economic analysis, which compares the relative costs of two or more interventions to a chosen measure of outcome, such as cost per reduction in symptom level or cost per life saved. The intervention with the lower incremental cost for a unit of effect is the more efficient choice. Where more than a single measure of outcome is being investigated, as is often the case in psychiatry and related fields, this type of study is also sometimes labelled a *cost-consequences analysis*.

Cost-utility analysis

This is a particular form of cost-effectiveness analysis, where the outcome measure is a combined index of the mortality and quality of life or disability effects of an intervention, such as the quality-adjusted life year (QALY) or the disability-adjusted life year (DALY). This mode of evaluation has considerable appeal for decision-makers since it generates equivalent, and therefore comparable, study data for different populations or health conditions.

Cost-benefit analysis

The final mode of analysis attempts to place monetary values on the outcomes of a policy or strategy, thereby allowing assessment of whether a particular course of action is worthwhile. It is based on a simple decision rule, that the monetary value of the benefits must exceed the costs of implementation. This approach is difficult to undertake because of the requirement to quantify outcomes in monetary terms.

1.4.4 Common data collection methods

Most policy research and evaluation will make use of a mix of quantitative and qualitative data in order to understand the effects of interventions. In some instances the data required may be readily available and may merely require collation and analysis, whereas in other circumstances data may need to be specifically collected in order to answer the research question.

Data can be obtained from a number of sources, including those discussed below.

Routine data from health information systems: Data collected on an ongoing basis through mental health information systems can be a valuable means to evaluate policy interventions. However, the data collected needs to be appropriate, reliable and relevant to the policy question. Where this is not the case, alternative data collection mechanisms need to be used. Indeed, WHO recommends that mental health information systems be set up to collect data in a way that informs policy development and evaluation. A few well-chosen, yet accurately collected data items are invariably more helpful than large amounts of poorly collected data (WHO, 2005b).

Data collected on an ongoing basis through mental health information systems can be a valuable means of evaluating policy interventions

In Chile, an evaluation of the National Mental Health Plan is conducted every two years using data from the information system. From this, it is possible to assess whether targets set have been realized, and it helps with making improvements to the implementation process. Where problems are identified, new strategies are drawn up to complement the existing plan.

Source: Minoletti (2005).

Standardized instruments: Much research needs highly specific collection of data. Standardized instruments that have been tested for reliability and validity have been developed in a number of areas relevant to mental health policy evaluation. For example, the World Mental Health version of the World Health Organization Composite International Diagnostic Interview is a comprehensive, fully structured diagnostic interview for the assessment of mental disorders (Kessler and Usten, 2004). WHO has also developed instruments to measure quality of life (WHO-QOL). Such instruments are not only useful for measuring general prevalence of mental disorders and quality of life, they can also be used in experimental designs to measure pre- and post-intervention of mental health status and quality of life. Many other standardized instruments, several of which have been tested for use across cultures, are also available. When using standardized instruments in countries where the language is different from that used in the development of the instrument, a thorough translation process, including back translation, is needed.

Standardized instruments that have been tested for reliability and validity can be effectively utilized in evaluating a mental health policy and plan

Structured, semi-structured and unstructured interviews: At times, information is needed which cannot be collected through existing standardized instruments, and more tailored interview schedules need to be drawn up for the particular evaluation. Sometimes answers are needed to highly specific questions, for which direct structured interviews are more appropriate. In other instances, greater elaboration of views and perspectives may be required, but within a defined domain, for which semi-structured interviews may be appropriate. Finally, an unstructured interview could be used when an interviewee may be required to respond in a less defined manner. It is important to test the interview schedules to ensure that the questions are clearly understood and phrased in a way that does not lead the interviewees to provide what they perceive to be the "correct" answers rather than giving their own thoughts, views and opinions. The interview designers must also make sure that the specific questions provide answers to the evaluation questions being asked.

At times, tailored interview schedules need to be drawn up for evaluations. Depending on the particular requirements, structured, semi-structured or unstructured interviews may be appropriate.

Documentation review: At times, expert analysis by people who have a clear understanding of issues is important. For example, in policy analysis it is often useful to thoroughly assess documentation to determine whether best practices are being followed and whether proposed interventions are likely to produce the desired outcomes. It may also be necessary in monitoring and evaluating a policy and plan to examine such aspects as patients' records or staff establishments.

1.4.5 Low-cost/quick research

Rapid appraisal: Countries often require information quickly or do not have significant finances to obtain the information they need. Rapid appraisal is a quick and low-cost means of gathering information and often uses a combination of qualitative and quantitative research methods. Some of the ways of conducting rapid appraisal are key-informant or stakeholder interviews, focus group discussions, community group interviews, direct observation and mini-surveys. While research or evaluation done within this framework may not always reach the standards of scientific rigour, if done well, rapid appraisal can be an adequate means of collecting data to help make policies and plans more effective.

Rapid appraisal is a quick and low-cost means of gathering information,which often uses a combination of qualitative and quantitative research methods

In Chile, the Ministry of Finance commissioned an independent three-person team of experts (two from the mental health field and one with financial experience) to assess whether the money spent on mental health was benefiting the population the most effectively. Information was gathered from the Ministry of Health, district health information systems and from interviews with several stakeholders. While the team arrived at an overall positive conclusion, the rapid evaluation method allowed important recommendations for service improvements to be made to the Ministry.

Source: Dr Alberto Minoletti, Director Mental Health Unit, Ministry of Health, Chile, personal communication.

2. Framework for setting up and conducting the evaluation of the policy and plan

This chapter maps out a five-step approach to conducting an evaluation of a policy and plan. This includes a range of processes, from deciding why the evaluation is being done to using the results to improve mental health services and systems in a country. While not all evaluations will follow each of these steps exactly, all five of them are pertinent to most policy and plan evaluations. Moreover, as stated previously, policy and plan evaluations are greatly facilitated by planning the evaluation at the beginning of the implementation of the plan. However, these steps can also be used where evaluation is planned later in the process. The process of deciding the purpose and scope of the evaluation can at times be quite involved and "political". Different people may have different points of view on what the issues are and what needs to be done; stakeholders may have diverse interests in wanting the evaluations done, and there may be conflicting agendas which may or may not be specifically expressed. The political context needs to be kept in mind when navigating through each of the steps.

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

Step 2: Identify the evaluators and funding for the evaluation

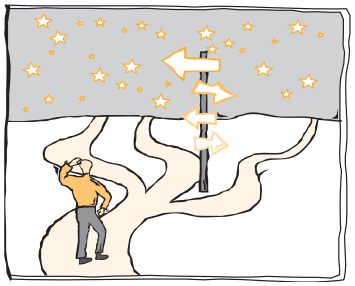
Step 3: Assess and manage ethical issues

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

Step 5: Analyse evaluation data, including unintended outcomes, and report the results.

Steps in setting up and conducting a mental health policy and plan

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



Step 2. Identify the evaluators and funding for the evaluation

Step 3. Assess and manage ethical issues

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

Step 5. Analyse evaluation data, including unintended outcomes, and report the results

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

Chapter 1 suggested numerous reasons why monitoring and evaluation are important. Perhaps, most critically, evaluation is a "tool for decision-making". However, policy-makers or administrators need to have a clear idea of what kinds of decisions the evaluation should help them make. For example, they might want the monitoring and evaluation to assist them in deciding to:

- Continue, modify or discontinue the policy or plan;
- Improve practices and procedures that are already in existence;
- Modify elements of the mental health plan such as the strategies, activities and time frames;
- Expand the sites where the policy and plan will be implemented;
- Allocate resources among competing policies, areas or programmes;
- Provide information to interested parties, such as consumers or family members, regarding progress towards improved mental health.

Policy-makers need to have a clear idea of what kinds of decisions the evaluation can help them make. They must also be clear as to the required "depth" and "breadth" of the evaluation before it is commissioned.

When the purpose and scope of the evaluation are well understood, the person/department assigning or commissioning it is better able to draw up clear and unambiguous briefs or terms of reference for the evaluation, and for those conducting the evaluation to provide relevant and precise information that responds directly to the requirements of the evaluation.

It is necessary at an early stage of monitoring and evaluation to decide on the breadth and depth of what needs to be done. For example, is the intention to examine the full objectives of the policy and plan or perhaps just certain strategies? Will the monitoring and evaluation look at whether the inputs outlined in the plan have been provided or will they examine the processes and outputs? Will the targets of the strategic plan or the health outcomes be evaluated? To give two vastly different examples, one evaluation may have the broad aim of establishing whether there were changes in the mental health status of the population, while another may simply look at whether the processes for developing policy followed best practice principles. What is being evaluated will be determined by such factors as the reasons the evaluation is taking place, the capacity in a country for carrying out the evaluations and the financial resources available.

It is also important to determine who will be using the information gathered through the evaluation, as this will assist the evaluators in providing their report and recommendations in the appropriate language, technical detail and form. Moreover, setting time frames for the start and completion of an evaluation is crucial. While some kinds of evaluation will inevitably take longer to complete than others, whatever project is being undertaken must have a reasonable, but not excessive, time frame to complete the work. It should be remembered that an extended evaluation might delay decisions that have a direct impact on people's lives and well-being.

Step 2. Identifying the evaluators and funding for the evaluation

If resources have been allocated for an evaluation, planners will need to make sure that these are well distributed in terms of different priorities. If no or very few resources have been allocated, strategies for funding will need to be developed, with funding sought from other sources.

Funding evaluations is usually cost-effective, as future interventions can be misdirected if no evaluations are conducted.

Sometimes evaluation is considered a burdensome requirement or an unnecessary luxury (Duncan & Arntson, 2004). However, without monitoring and evaluation, interventions can be misdirected and far more funds could be wastefully expended due to a lack of evaluation than those required to do the evaluation itself.

How much money is available, when the funding will be available and how particular expenditure items have been allocated are critical to enable the evaluator to design and implement a suitable strategy. Signing a contract, which clearly describes the expected outputs for the amount provided is essential to avoid misunderstandings.

National and international nongovernmental organizations (NGOs) may at times put out calls for proposals for policy research and evaluation. For example, in 2005 the Pan American Health Organization called for proposals "that address the analysis and evaluation of modalities of community care services for persons with severe mental disorders", which would require research that inter alia involves:

- Evaluation of quality of life of persons with severe mental disorders treated in the community compared with those treated at the hospital level.
- Analysis and evaluation of innovative service models and psychosocial interventions in the community.
- Evaluation of strategies to improve access to services and the quality of care.
- Evaluation of the effectiveness and cost-effectiveness of services, programmes and care interventions.
- Evaluation of the implementation of mental health policies and plans designed to promote the development of services in the community.

Source: Pan American Health Organization, 2005

Decisions then have to be made with respect to:

(i) Whether the evaluation will be conducted by a specific person/multisectoral team within the government by or an external agency;
(ii) What skills the evaluators will need; and
(iii) If an external evaluator is to be used, what mechanisms will be employed to get such a person/team to do the work (e.g. put out tenders, request a local university or research institution or seek international assistance).

Using a person or team within the ministry of health (MOH) and other departments to conduct the evaluation is usually cheaper than contracting an outside body or organization. Processes for starting and completing the work are usually also less protracted. Moreover, evaluators working within the government are more familiar with the procedures, processes and limitations involved in public health care, and this can facilitate their investigations. For example, they may know where to find information and have a better understanding of the reporting mechanisms that influence delivery. On the other hand, independent evaluators are, crucially, less likely to be biased by a need to show positive results. An "outsider's" perspective may cause an evaluator to see aspects that are not evident to people within the ministry. In addition, people, including staff members employed within the public sector, may be more open and honest with an external evaluator, as they are less likely to worry about personal repercussions if they are critical of the ministry. Finally, many governments do not employ people with evaluation skills, or if they do have these skills they may not have the time to conduct evaluations.

It is critical to have trained and competent people to conduct evaluations, as the results have significant long-term impacts. Poor evaluations can lead to inappropriate decision-making for the future.

The competencies of the evaluators are critical. Results of mental health policy evaluations are likely to have significant long-term impacts. The evaluators must therefore be skilled in the form of evaluation they are undertaking. For example, conducting randomized controlled studies, economic evaluations, in-depth qualitative research or quasi-experimental evaluations requires researchers who are adequately trained in these techniques and able to undertake relevant statistical or other analyses of the data collected. Results of poorly conducted or poorly analysed mental health policy research can have seriously negative outcomes, as major decisions, often affecting millions of people and employing enormous resources, are made on the basis of this research.

While many countries have only limited resources for training people in mental health research/evaluation and for undertaking such research, deploying resources for this is likely to be cost-effective in the long term. In the short term, if countries do not have internally skilled evaluators it may be possible to seek assistance from WHO or other outside consultants, and pair them with local trainees to complete the research and at the same time build local capacity.

Evaluating the quality and cost of mental health care at State and private institutions in South Africa.

For many years South Africa had a policy of contracting out the accommodation and care of chronic psychiatric patients to a private company. The Department of Health wished to decide whether this policy should continue or whether the State should take over this function. Through a tender process, it contracted an independent research organization based at a local university to assess the quality and cost of care provided at both State and privately contracted institutions. This particular organization was chosen for its record of conducting health systems and health economics research. In choosing the organization to conduct the study, the Government needed also to ensure that there was no conflict of interest between the chosen researchers and the private company providing the services. It also needed to ensure that the researchers would not be biased by prior ideological positions, either for or against contracted health care. These requirements were all satisfied in choosing the evaluator.

It is interesting to note that the results were inconclusive, as they indicated that the quality of services provided was directly related to the funding provided. State hospitals that were receiving similar rates per patient per day as the contracted hospitals were providing similar quality of care. However, the researchers pointed out that in deciding which alternative to choose, the Government's deinstitutionalization policy should be taken into consideration. In particular, the contracted institution had a disincentive to discharge patients, as this would affect their profits. In light of this research, certain provinces in South Africa discontinued contracted mental health care, while others, who did not have the capacity to take over the care themselves, renegotiated their contracts to get better value for money and to ensure that no patients were kept in the hospital if they could be discharged (Porteus et al., 1998).

Step 3. Assessing and managing ethical issues

When conducting evaluations strict ethical codes should be observed. It should not be assumed that, because an evaluation is being conducted by a government or for a government, research ethics can be bypassed or weakened. On the contrary, the State is the major protector of the population's human rights, and therefore needs to be especially vigilant to ensure that ethical practices are upheld. Moreover, when conducting research/evaluation involving people with mental disorders, special precautions need to be taken to ensure that their rights are protected.

The State as the major protector of the population's human rights, and those undertaking evaluations on behalf of the State, need to be especially vigilant to ensure that ethical practices are upheld.

Informed consent: As in any research using human subjects, when conducting studies with people with mental disorders informed consent must be obtained. Only in exceptional circumstances, and where processes have been undertaken whereby it is established that a person is unable to consent, may it be possible to proceed without the person's personal consent – and then only with some form of proxy consent such as the permission of a next of kin or a specifically constituted panel. This is true of all research involving people with mental disorders, but needs to be applied particularly strictly when undertaking clinical or experimental research.

Mental health evaluation *can* involve clinical research, for example if the efficacy of one treatment regime over another needs to be established; but it may also be service or health systems related and involve, for example, interviews with patients, focus groups, or other means of collecting information. For instance, research may be done to find out patients' views of a particular service provided or of their quality of life. Such research may be intrusive, and should only be done with the person's consent or by observing correct consent procedures.

Confidentiality and anonymity: Confidentiality or anonymity is essential for most research, including evaluations, and attention should be given to ensuring that a person's identity or information provided is not divulged, unless they give specific permission to be identified. This is important for a number of reasons. For example, in evaluation research a person may be critical of the services provided and if they can be identified the service providers may victimize them. It would be highly unethical of the researchers to identify them. In other cases, people may not want to have information about themselves divulged to fellow community members for fear that it might cause them to be stigmatized, but they may still be prepared to give the information for research purposes. Moreover unless confidentiality or anonymity is guaranteed to the subject(s), it is unlikely that the information they provide will be honest and represent the "full truth". As policy decisions will be made on the basis of the evaluation, this could have negative consequences for future service provision.

User involvement in research design, implementation and feedback: Researchers need to make sure that in conducting the research they do not simply "take away" something (new knowledge) from the subjects of the evaluation; it should be a shared activity with local benefit. It is good research practice to involve users in the design and implementation of the research, wherever possible, and to ensure that research results are fed back to them so that they can be "empowered" by it. This needs to be built into the protocol for the evaluation.

Effects of the evaluator: While researchers may strive towards objectivity, the evaluators themselves have an impact on the results obtained. For example, if a service provider, a consumer or another stakeholder believes that they may benefit or be prejudiced by certain answers, they may distort their responses in favour of what they believe the evaluator may want to hear. Therefore it is particularly important for the evaluator to be extremely careful not to bias people's answers towards preconceived notions that the evaluator may have of the services or of people with mental disorders.

Moreover, if the evaluators are government-dependent, they may feel pressure to produce results that favour government policy. The researchers need to be aware of such a bias and take it into account in their interpretation of results.

Step 4. Preparing and implementing the operational plan for the evaluation

The evaluator should plan each step of what needs to be done to complete the evaluation. This includes a clear plan of the methods to be used, the research design, time frames for different activities, the inputs required, and the expected outputs and outcomes of the research. In many respects, the elements that go into a plan for an evaluation are very similar to an operational plan for implementing strategies developed from the mental health policy.

The evaluator needs to plan each step of the evaluation, including the methods to be used, the research design, time frames for different activities, the inputs required, and the expected outputs and outcomes of the evaluation.

Depending on the size and scope of the evaluation, it may be necessary to assemble a team of people to complete the work. For example, completion of the evaluation may require field workers for carrying out surveys, interviewers skilled in running focus groups, a statistician, as well as people with an in-depth understanding of mental health policy and planning who can interpret the results and make coherent and lucid recommendations.

Decisions also need to be made with respect to how to involve consumers and family members in the evaluation process. As the recipients of the policy/services, they are able to help identify key evaluation questions and are an important means of obtaining information. In addition consumers and family members are more likely to take ownership of the results if they were involved in the evaluation.

Step 5. Analysing the evaluation data, including unintended outcomes and reporting the results

Data must be collected through, for example, existing health information systems, interviews, direct observation or other means (described in subsection 1.4.4). The data then needs to be sifted, sorted and analysed. The analysis may involve a range of processes, from merely counting and converting to percentages or collating themes from qualitative research, to using sophisticated computer programs for statistical analysis.

Once the raw data has been processed and analysed, the results need to be interpreted and recommendations made. Evaluations are seldom unambiguous, and conclusions should be reached and recommendations made on the basis of a clear and broad understanding of public mental health as well as the particular circumstances of the country concerned. Any limitations of the evaluation should be made clear in the report. Recommendations should be motivated as far as possible by the information available, but where data is lacking or is inconclusive it should be made explicit. Evaluators need to present their findings in a manner that facilitates clear decision-making.

Once the raw data has been processed and analysed, the results need to be interpreted and recommendations made.

It is important to know the audience(s) of the evaluation. While the ministry of health, and particularly the mental health section within it, needs to know whether its policies and plans are successful or not, and whether they are being implemented efficiently and effectively, local health authorities and practitioners providing services would similarly be interested in results as they pertain to their level of the health service.

In addition, governments are accountable to various constituencies, and the purpose of conducting the evaluation may be of equal relevance and importance, for example to the people who voted the government into power, opposition parties, and to those receiving (or targeted to receive) interventions. Moreover, depending on the country, parliament or some kind of governing council will have passed the policy and will want to know firstly, how effectively the policy is being implemented, and secondly, whether the policy is meeting the set objectives. Donors, NGOs and bilateral agencies may also commission evaluations or be interested in their results.

In addition, pressure groups with an interest in successful outcomes, including consumers and family members, may also wish to know how well the policies are being pursued and whether they are having the desired outcomes. Furthermore, countries with similar populations, cultures or economic status may be interested in evaluations from other countries, as these could influence their own policy and planning decisions. Finally, the academic community may have an interest in the findings as the results may add to the knowledge in the field and may act as a catalyst for further research and development.

In a number of instances the evaluators may present more than one written form of the findings as well as use other means to present and discuss the evaluation. For example, the evaluator may need to produce a full technical report for senior mental health officials who might want to scrutinize the methods used and examine each result and recommendation very carefully; an executive summary may be more appropriate for senior (non-mental health) officials within the health department and possibly for the minister of health who might wish to understand the methods and results more broadly; while a policy briefing document may be the preferred format for parliamentarians or other policy-makers. In addition, the evaluator may plan verbal feedback sessions, present slides or videos, post results on a website, use the media, or promote the results of the evaluation in other ways.

Knowing who will be using the information gathered through the evaluation will assist the evaluators to provide their report and recommendations in the most appropriate language, technical detail and form.

Returning to the people who have been involved in the evaluation (without giving away their identity) and sharing findings is also very important. While it is true that the evaluation is usually done to inform policy and service direction, the knowledge that communities could gain about themselves and the services provided to them would help them feel more empowered. For example, it could be used for advocacy and lobbying for better care and treatment (see also Step 3).

Most evaluation, and certainly most academic research, is published in the public domain and can be utilized as anyone who wants to use it sees fit. Openness is an important element of evidence-based policy development. However, sometimes a government may wish to understand certain issues, and, on the basis of an evaluation, make changes or modifications to its policies, plans or programmes, or change certain processes that have been started without making the information public. They may therefore place an embargo on research results for a certain period of time, or in some cases not make results public at all. Countries' rules regarding access to government information tend to differ.

Sometimes a policy may produce unintended outcomes – either good or bad. Outcomes can even be the opposite of those intended. "Goals-free" methods of evaluation are often used, whereby the actual effects are measured without necessarily knowing the intended objectives. Often, qualitative methods of evaluation are used to determine the actual outcomes.

Unintended outcome of deinstitutionalization

One of the intentions of worldwide deinstitutionalization programmes has been to integrate people previously stigmatized and isolated in custodial care into communities and society. However, in a number of countries, the resources allocated to community care have been inadequate, with the result that some people have ended up homeless and others have become disruptive within communities. Rather than reducing stigma, this has in fact resulted in increasing it! Following a review of the literature on the subject, Arboleda-Florez (2001) notes that "...deinstitutionalisation initiatives have to be implemented together with the development of adequate community systems to house those with mental illness and to provide their successful reintegration into the community. *Often, the lack of these community systems worsens the stigma held against persons with mental illness...*"

The unintended outcome of increased stigmatization does not imply that custodial care is a preferred policy option, but rather that not providing proper community care entails severe risks. Reducing stigma does not occur simply by discharging people; it must be addressed through comprehensive deinstitutionalization programmes that work together with communities. Finding out any intended outcomes is crucial to a review of policy.

3. Case study: evaluation of a national mental health policy and plan of a hypothetical country

This chapter takes the example of a hypothetical country, examines the information relevant to the development of mental health policy and finally to the "actual" policy and plan that was developed. The policy is then scrutinized over the six-year period in which the plan was implemented. *It should be noted, however, that the selection of evaluations used here are not the only ones that could have been conducted over this period. Similarly, the methods used here are not the only ones that could have been utilized to conduct either these or other evaluations.*

This case study is **not** a detailed exposition of an evaluation or research methodology (the list of further reading at the end of this module provides useful textbooks and manuals on this subject); rather, it is a practical **case study** of an evaluation of a policy and plan and what a country **may** experience over a six-year period. By examining the reasons and processes that went into evaluation decisions and by looking at how policy-makers used the information provided to them in this example, it is hoped the case study will provide countries' policy-makers with some guidance on how to identify the kinds of evaluations *they* would require and how they could carefully plan and implement assessments of their own policies, plans and programmes.

What specific countries will be able to evaluate and the depth of their evaluations will vary considerably depending on available resources and priorities for evaluation. It is unlikely that most developing countries would be able to undertake **all** the examples of evaluations presented in this case study within a six-year period; as stated earlier, these are merely examples. However, over a slightly longer period, or perhaps with some outside financial and technical assistance, many of these as well as other important evaluations could be undertaken.

3.1 The policy and plan of the country

This section summarizes key features of the country's mental health policy and plan.

The Mental Health Policy

(i) Situation analysis

Demographic and background information of the country: The country has a population of about 20 million, of which about 70% lives in rural areas. Unemployment is estimated at 40%. An increasing incidence of alcohol abuse, domestic violence and crime is reported among the growing number of unemployed workers.

Prevalence of mental disorders: In the absence of population-based data, clinic and hospital data have been used as an indicator of the mental health status of the country. These data reflect patterns of illness, the services offered and utilization patterns in the country.

Prior to the development of the policy, a review of 500 patients at the main psychiatric hospital revealed that 29% were admitted for cannabis-related mental disorders, 20% had unspecified psychotic disorders, 17% schizophrenia, 9% organic mental disorders, 7.2% bipolar mood disorders, 6.4% depression, 6.1% alcohol-related disorders and the rest constituted 5.1%.

The following information was available from routinely collected information from a selection of outpatient services. Broadly, it was estimated that 15-35% of government general health OPD attendance were due to mental disorders such as anxiety, depression, psychosomatic disorders and psychosocial stress.

Condition	Male	(%)	Female	All
Epilepsy	21.0		14.7	*35.8*
Depression	2.8		14.4	*17.2*
Schizophrenia	7.1		7.7	*14.6*
Alcohol-related disorders	4.2		2.23	*6.5*
Drug-related disorders	2.7		0.16	*2.8*
Psychoneurosis	0.4		1.7	*2.1*
Other conditions	9.2		11.6	*21.0*
Total OPD attendance	***47.5***		***52.5***	***100***

General health services: The country is divided into 10 regions, each with a designated regional hospital. Within these 10 regions there are health service areas, each of which has a number of health care centres. No person lives further than a two-hour walk from a health service. There are also village health workers at community level.

Mental health services: Before the colonization of the country, traditional healers treated mentally ill people in their communities. However, during the early/mid-twentieth century, four psychiatric hospitals were built with a total bed capacity of 2,000. A section in a large prison was also designated for detention of mentally ill prisoners and mentally ill offenders. In the late 1950s, the first outpatient psychiatric clinics were started at the main general hospital in the capital and at two district hospitals. The country's Mental Health Act came into force in 1960. Since then, psychiatric units have been established at three of the 10 district hospitals in line with the primary health care policy adopted. These are integrated within the primary health care service and provide inpatient (20-39 beds each), outpatient and community mental health services for the district.

Psychiatric beds per 100,000 population

Total psychiatric beds	**8**
Psychiatric beds in mental hospitals	**5**
Psychiatric beds in general hospital	**3**
Psychiatric beds in other settings	**0**

Human resources and training: There are few trained mental health professionals in the country. Most of the available skilled professionals are psychiatric nurses, but even they are in short supply and local laws do not allow them to prescribe most of the psychiatric medication. General medical practitioners write most of the psychiatric prescriptions, but by and large they are not well trained in psychiatry and are reluctant to deal with psychiatric patients.

The local nursing college includes a module on mental health in the training of general nurses and a specialist diploma for psychiatric nurses. However, there is concern regarding the low number of applicants for psychiatric nursing and the decline in enrollments for this diploma in recent years.

Mental health professionals per 100,000 population

Psychiatrists	**0.05**
Psychiatric nurses	**0.2**
Psychologists	**0.1**
Social workers	**1.2**

Psychotropic medicines: A limited range of psychotropic drugs featuring in the Essential Drugs List (EDL) is available at primary, secondary and tertiary levels of health care.

(ii) Vision

To achieve improved mental health for all and a high standard of care within 20 years through the provision of integrated, comprehensive, equitable and accessible community-based mental health care for all, regardless of class, status and political affiliation. Services will uphold and protect the human rights of people with mental disorders.

(iii) Values and principles

The following values and principles form the foundation of the mental health policy:

Values	Principles
Human rights	• People with mental disorders should enjoy full human rights, including the right to appropriate health care and freedom from stigma in society. • The rights and needs of mental health workers should be upheld.
Mental health is indivisible from physical health	• Mental health care should be integrated with holistic general health care throughout the country. • All health workers should be trained to detect mental disorders, provide basic assessment and treatment, and refer to specialist mental health services when necessary.
Community care	• Mental health care should be provided in the community whenever possible. • Communities and families should take an active role in the care of people with mental disorders.
Quality	• Mental health care should be of high quality. • Services should be provided according to established protocols. • Mental health services should be delivered efficiently, with minimum wastage of valuable resources.
Intersectoral collaboration	• Mental health is an issue that cuts across traditional sectors and includes health, welfare, justice, education, housing, communities and NGOs. These sectors therefore need to collaborate for improved mental health care of the population.
Respect for local culture	• Traditional healers should be involved in mental health care. • The beliefs and traditions of people with mental disorders should be respected.
Protection of vulnerable groups	• The mental health needs and rights of vulnerable groups should be upheld, including those of women, children, adolescents and the elderly.

(iv) Objectives

1. Reduce the emphasis on institutional care for people with mental disorders.
2. Expand community-based mental health services so that they become accessible to all people in need.
3. Integrate mental health into general health care.
4. Promote and protect the human rights of people with mental disorders.
5. Ensure the delivery of high quality, evidence-based interventions for mental health promotion, prevention, treatment and rehabilitation.

(v) Areas for action

In keeping with the vision, values, principles and objectives outlined in this policy, a number of areas for action were identified as priority areas. However, as it was acknowledged that not all of them could be tackled at the same time, the following where chosen.

Organization of services: The mental health services will be reorganized to be more accessible to people in need, in accordance with the human rights of people living with mental disorders, and they will be provided in the least restrictive environment. To achieve this, services will be integrated, wherever possible, into general health care, including at primary care facilities and general hospitals. People kept in institutional facilities who can be discharged into comprehensive community care programmes will be discharged, and any people who do not indisputably require long-stay psychiatric care will not be sent to institutional care.

Human resources and training: An effective workforce for mental health will be established. Additional personnel will be recruited so that effective mental health services can be provided. In addition, training of both existing health staff and new recruits will be provided so as to establish a comprehensive and multidisciplinary mental health workforce.

Quality improvement: The quality of mental health services at the different levels of health care will be improved mainly by developing quality standards, clinical practice guidelines, accreditation of facilities and regular inspections.

Essential drug procurement and distribution: Psychotropic drugs will be available for those in need of medication at the different levels of the health service. To achieve this, the Essential Drugs List (EDL) will be regularly reviewed and the procurement and distribution mechanisms improved so that patients receive an uninterrupted supply of cost-effective drugs.

The Mental Health Plan

(i) Strategies linked to the areas for action

The mental health plan elaborated a number of strategies for each of the areas for action identified in the policy, as listed in the table below.

Area for action	Strategy
I. Organization of services	• Reduce the number of people with mental disorders treated in psychiatric institutions. • Strengthen community-based mental health services. • Improve access to and utilization of mental health services throughout the country through decentralized mental health service delivery that is integrated into general health care.
II. Human resources and training	• Recruit additional mental health staff, particularly in areas where there are currently staff shortages. • Undertake extensive mental health training programmes for all health staff, including general health workers and mental health specialists.
III. Quality improvement	• Establish quality improvement mechanisms for mental health care.
IV. Essential drug procurement and distribution	• Improve the supply and utilization of essential psychotropic medicines.

For each strategy, detailed activities were formulated indicating the person responsible for each activity, a time frame for implementation, the necessary resources and budget, as well as the targets and indicators to enable measuring implementation of each strategy. The indicators used were adapted from the WHO-AIMS instrument (WHO, 2005e; see also annex 3). The time frame was set as a five-year period.

Costs were calculated in terms of a hypothetical monetary unit (MU) and are included for illustrative purposes only. In some instances where the costs related to staff, these were calculated on the basis of full-time equivalents (FTEs) rather than in monetary terms. Functions to be carried out by staff already employed and paid out of an existing budget were considered under “existing staff time”.

Area for action: Organization of services

Strategy 1. Reduce the number of people with mental disorders treated in psychiatric institutions.

Target:
A 50% reduction of beds in psychiatric institutions by year 5.

Indicators:
Number of beds in mental hospitals per 100,000 population over the next five years.

Activity	Responsible person(s)	Year 1	Year 2	Year 3	Year 4	Year 5
Undertake pilot study in the psychiatric hospitals to assess level of disability of patients, and MH needs for community-based care, including residential facilities	Director of Mental Health, social workers, psychiatric nurses	X				
Prepare patients for community life through rehabilitation programmes	Social workers and psychiatric nurses		X	X	X	
Discharge patients to community-based facilities	Hospital staff, in collaboration with Director of Mental Health		X	X	X	X

Cost of activity	Available budget for activity	Additional resources required	Outputs
5 000 MU (organization to assist with evaluation)	5000 MU	If pilot successful, additional funds promised by Ministry of Finance	Identification of people with mental disorders who need accommodation and community MH care identified
10 FTEs (to be conducted by existing staff of establishment)	Within existing staff time	None	
Potential **savings** of 200 000 MU per annum from the hospitals by end of year 5		None	Reduction in number of people in long-stay in-patient psychiatric facilities

Area for action: Organization of services

Strategy 2. Strengthen community-based mental health care services.

Target:
Create 10 additional community mental health care facilities, subject to the evaluation of the four pilot community mental health care facilities.

Indicators:
Number of community mental health care facilities.

Activity	Responsible person(s)	Year 1	Year 2	Year 3	Year 4	Year 5
Negotiate with Ministry of Local Government to collaborate in re-establishment of community-based residential facilities	Director of Mental Health, social workers (MOHSW), Ministry of Local Government		X	X		
Establish four pilot community mental health centres in rural and urban areas (two in each)	Director of Mental Health, social workers (MOHSW), Ministry of Local Government			X	X	
On the basis of an evaluation of the pilot facilities, establish community mental health centres in all areas	Director of Mental Health, social workers (MOHSW), Ministry of Local Government					X

Cost of activity	Available budget for activity	Additional resources required	Outputs
10% of FTE	Within existing staff time	None	Feasibility and plans for collaboration established
400 000 MU per annum (human resources, furniture, medication, transportation, other)	400 000 MU per annum. An NGO has agreed to cover the total costs of this pilot activity	200 000 MU per annum to be transferred from savings in hospital budget (see Strategy 1)	Four pilot residential facilities established with community MH care
600 000 MU per annum (human resources, furniture, medication, transportation, other)	400 000 MU	To be funded from savings in hospital budget from year 5 onwards (See Strategy 1)	Pilot facilities evaluated. New facilities initiated in each region

Area for action: Organization of services

Strategy 3. Improve access to and utilization of mental health services throughout the country, through decentralized mental health service delivery that is integrated into general health care.

Target:

a) Double the number of people seen with epilepsy and psychosis in regional hospitals and health care centres by year 5.

b) Increase the number of beds available at this level by 20%.

Indicators:

Number of people treated in regional hospitals and health care centres per 100,000 general population.

Activity	Responsible person(s)	Year 1	Year 2	Year 3	Year 4	Year 5
Provide training and orientation of district management team (DMT) in mental health service management	Director of Mental Health		X			
Review and develop referral systems between primary, secondary and tertiary care, and increase number of people seen at outpatient and inpatient community facilities	Director of Mental Health		X	X		
Ensure regular supportive and supervisory visits at all levels. Write supervisory reports	Director of Mental Health, District Mental Health Coordinator			X	X	X

Cost of activity	Available budget for activity	Additional resources required	Outputs
5 000 MU (trainers, venue, materials)	5 000 MU	None	DMTs are trained and oriented towards mental health planning
20% FTE	Within existing staff time	None	Referral systems are established. Number of MH patients seen and referred between levels is regularly monitored and reported
20% FTE per annum	Within existing staff time	None	Supervisory visits are conducted at all levels. Supervisory reports are available

Area for action: Human resources and training

Strategy 4. Recruit additional mental health staff, particularly in areas where there are currently staff shortages.

Target:
A 30% increase in the number of dedicated mental health staff in each major mental health profession by year 5.

Indicators:
Number of full-time equivalent staff working in or for mental health facilities per 100,000 population by mental health profession.

Activity	Responsible person(s)	Year 1	Year 2	Year 3	Year 4	Year 5
Review of existing staff	Director of Mental Health, Director of Human Resources in MOHSW	X				
Recruitment to fill 35 key target posts	Director of Mental Health, Director of Human Resources in MOHSW		X	X	X	X
Appoint 10 district mental health coordinators (DMHCs) (mental health nurses) in each district and include on district health management team (DHMT)	Director of Mental Health, Director of Human Resources in MOHSW		X			
Review of staff who have left service in last two years, investigating reasons for departure	Director of Mental Health, Director of Human Resources in MOHSW	X				
On the basis of review, develop and implement staff retention strategies, especially in the rural areas, through incentives (e.g. rural allowances, danger allowances, supervision and support to rural areas)	Director of Mental Health, Director of Human Resources in MOHSW, district management team		X	X	X	X

Cost of activity	Available budget for activity	Additional resources required	Outputs
10 000 MU (contract an external organization)	10 000 MU	None	Review completed and number of filled and vacant posts identified
300 000 MU per annum (advertising, interviewing, relocation expenses, salaries)	150 000 MU per annum from Ministry of Finance. 150 000 MU per annum through agreements with bilateral donors until enough capacity is built in the country	10 000 MU	Targeted posts filled
10 000 MU per annum (Office space, furniture and equipment) Salaries accounted for under previous activity	10 000 MU	None	DMHCs appointed and included on DHMT
5 000 MU (contract outside organisation)	5 000 MU	None	Review completed and main reasons for staff leaving identified
70 000 MU per annum (incentives, rural allowances, supervision)	70 000 MU	None	Incentives provided Staff turnover monitored and reduced

Area for action: Human resources and training

Strategy 5. Undertake extensive mental health training programmes for all health staff, including general health workers and mental health specialists.

Target:

(a) Training in mental health provided to 50% of generalist staff in regional hospitals and health care centres by year 5.

(b) All mental health staff to undergo at least two days of in-service training each year.

(c) All nurses and doctors to spend six months in psychiatry as part of their general training by year 5.

Activity	Responsible person(s)	Year 1	Year 2	Year 3	Year 4	Year 5
Review of mental health component used in existing under-graduate training centres and reform of the MH training programme, where necessary	Director of Mental Health, Heads of training centres	X				
Training of undergraduate health students in MH: • Identification of training needs • Selection of trainees • Conduct training	Director of Mental Health, Heads of training centres		X	X	X	X
Review of post-graduate mental health specialist programmes and reform of the MH training programme, where necessary	Director of Mental Health, Heads of training centres	X				
Recruitment and training of post-graduate mental health specialists: • Identification of training needs • Recruitment and selection of trainees • Conduct training	Director of Mental Health, Heads of training centres		X	X	X	X
Development of in-service training modules for health workers or adaptation of existing WHO modules	Director of Mental Health	X				
In-service training of health workers at all levels: • Identification of training needs • Selection of trainees • Conduct training	District supervisors		X	X	X	X
Include psychiatry on rotation of medical interns	Consultant psychiatrist	X	X	X	X	X

Indicators:

(a) Proportion of generalist health staff in primary care clinics trained in mental health.

(b) Proportion of mental health staff working in or for a mental health facility with at least two days refresher training in an area relevant to the new mental health organizational structure.

(c) Proportion of undergraduate (1st degree) training hours devoted to psychiatry and mental-health-related subjects in medical schools (doctor training) and in nursing schools.

Cost of activity	Available budget for activity	Additional resources required	Outputs
10% FTE	Within existing staff time	None	Curriculum for nurse training reviewed and improved to integrate MH
2 FTEs	Within existing staff time	None	Undergrad health students receiving mental health training
30% FTE	Within existing staff time	None	Curriculum for post-grad nurse training reviewed and improved
20 000 MU per annum (advertising, interviews, training), staff salaries already accounted for in strategy 3.)	10 000 MU	10 000 MU per annum	Post-graduate students recruited and receiving mental health training
3 000 MU (employment of educator)	3 000 MU	N/A	Training modules in mental health developed and available
50% FTE 10 000 MUs	50% FTE can be absorbed within existing budget 10 000MUs	None	Health Workers trained at all levels. pts with mental disorders treated by trainees before and after training
1.5 FTE	Within budget of medical school	None	Medical interns currently working on psychiatry rotation

Area for action: Quality improvement

Strategy 6. Establish quality improvement mechanisms for mental health care.

Target:

(a) Full quality standards for different levels of mental health services set and three monitoring boards appointed and trained by year 3.

(b) Quality assessments conducted annually in 50% of community and general hospital services and in all psychiatric hospitals.

Indicators:

Proportion of mental hospitals and community-based mental health facilities with at least one annual external review/inspection of human rights of patients and quality of care.

Activity	Responsible person(s)	Year 1	Year 2	Year 3	Year 4	Year 5
Develop standards for mental health services	Director of Mental Health, Consultant psychiatrist		X	X		
Establish quality assurance monitoring boards to evaluate and accredit facilities and staff, using the standards	Director of Mental Health, Consultant psychiatrist			X	X	X
Develop clinical practice guidelines (CPGs) for mental health interventions at all service levels, if necessary adapting CPGs from other countries or WHO	Consultant psychiatrist			X		
Orientation and training of all health service staff in CPGs, as part of routine in-service training	Consultant psychiatrist				X	

Cost of activity	Available budget for activity	Additional resources required	Outputs
15 000 MU (contract external organization)	15 000 MU	None	Development of national MH standards checklist
20 000 per annum (payment of Board members, admin. assistance, printing and equipment)	20 000 per annum	None	Visits to MH facilities Accreditation of facilities Compliance with standards
1 FTE	Within existing staff work time	None	Clinical practice guidelines are established
20 000 MU per annum (employment of trainers, training venues)	10 000 MU	10 000 MU	Staff have received orientation and training in CPGs

Area for action: Access and use of psychotropic medicines

Strategy 7. Improve the supply and utilization of essential psychotropic medications.

Target:
Psychotropic drugs on the revised Essential Drugs List (EDL) to be available at the appropriate primary and secondary level health facilities 100% of the time by year 3.

Indicators:
Proportion of mental hospitals, community-based inpatient and outpatient/clinic facilities having the psychotropic drugs, as listed on the EDL, available at the facility or in a nearby pharmacy throughout the year.

Activity	Responsible person(s)	Year 1	Year 2	Year 3	Year 4	Year 5
Review of the EDL to ensure that the psychotropic drugs recommended by WHO and any additional drugs with demonstrated cost-effectiveness are available	Director of Mental Health, consultant psychiatrist	X	X			
Orientation and training of staff at all levels to new EDL and rational use of psychotropic medication	Director of Mental Health, consultant psychiatrist		X	X	X	
Review of the procedures for ordering of psychotropic medication	Director of Mental Health, consultant psychiatrist, district management teams		X			
Ensure that psychotropic medicines are available at all relevant facilities and that timely reminders are available for ordering medications	Director of Mental Health, District health managers			X	X	X

Cost of activity	Available budget for activity	Additional resources required	Outputs
5 000 MU (meeting of experts)	5 000 MU	None	EDL review report available. EDL specifies the service levels that will deliver the drugs
50 000 MUs (Trainers, Venue, Materials)	25 000 MUs	25 000 MUs committed by NGO	Staff provided with orientation. Prescriptions drugs available Audit of prescribing patterns (before and after orientation)
5% FTE	Within existing staff work time	None	Procedures are reviewed
30 000 MU (contract assistance to improve the procurement and distribution system) Purchase of medicines	30 000 MU	None	Availability of psychotropic drugs. Reminders in place at all relevant facilities

3.2 Applying the framework for setting up and conducting the evaluation of the policy and plan

In this section we describe the five steps for conducting an evaluation of a policy and plan outlined in Chapter 2, and how and why, at the start of the policy process in this hypothetical country, the Government decided to monitor and evaluate the mental health policy and plan.

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

The Ministry of Health wanted to examine the degree to which the policy and plan followed best practice principles, and whether the policy and plan were feasible and appropriate for the country. Secondly, on an ongoing basis it would want to know how well the plan was progressing (i.e. according to the activities outlined in the strategy). Thirdly, in the event that the plan was not being implemented as expected, the Ministry proposed an investigation be conducted to examine the reasons for this. While the Ministry indicated that it would do everything in its power to ensure that all the strategies of the plan were implemented according to the schedule, it was also realistic in allowing for unforeseen obstacles, and it allocated some resources for investigating such an eventuality. Fourthly, it realized that it would be important to assess whether targets for each strategic plan were reached. Fifthly, it planned to investigate whether at the end of the policy period the objectives of the policy had been met. Finally, the Ministry realized that in all likelihood there would be additional and unpredictable reasons to conduct other evaluations during the course of the policy period, and hence decided to allocate some resources to this unknown factor.

Discussions took place concerning the depth and breadth of the evaluations to be undertaken (see Step 4) and it was decided that it would be important to hire appropriately skilled evaluators for some specific evaluations.

Step 2. Identifying the funding and evaluators for the evaluation

The Ministry understood that monitoring and evaluation are important in order to improve mental health services. It also realized that it is generally cost-effective to invest in monitoring and evaluation. However, being a relatively poor country, it would not be possible to conduct all the evaluations wished; therefore it would be important to seek international donors and research organizations to fund some of the planned evaluation research. It was hoped that some of the evaluations, particularly the more expensive ones, would enable other countries with a similar culture and level of economic development to learn from its experience.

The evaluators of the policy and plan included people within the Ministry of Health, local university and private researchers who would tender for work, and international NGOs and researchers who would partner with local evaluators in conducting the research.

Step 3. Assessing and managing ethical issues

The Government was careful to require that strict ethical standards be observed in all the evaluations. Where the research involved human subjects, this would be reviewed by the relevant ethics committees. Where international researchers might be involved, the research protocol would also be reviewed by international ethics committees.

Research would only be conducted with the informed consent of the participants. Results of research involving human subjects would be shared with the communities/people on whom the research had been conducted.

Step 4. Preparing and implementing the operational plan for evaluation

Aware of the need to conduct monitoring and evaluation, the Ministry of Health planned to collect baseline information wherever possible and set up evaluation mechanisms from the beginning of the policy and plan. Before starting the implementation of the policy and plan, the WHO checklists (see annexes 1 and 2) were used against which to assess the development process and content of the policy and plan.

It was decided that if any major problems were identified through the monitoring phase of the mental health plan, evaluations would be commissioned to understand the difficulties experienced. Moreover, any major problems identified by staff or problems brought to the Government's attention by the public would be taken seriously. It was also planned to conduct a complete assessment of the objectives set out in the policy at the end of the policy period.

At the beginning of the policy implementation period, the Government planned for monitoring and evaluation to be done (at least) with respect to the objectives of the mental health policy and to the seven strategies identified in the mental health action plan.

Evaluations that required different preparation and operational strategies were also planned. Some evaluations were to be conducted through rapid appraisal, whereas others would require a longer period of time and more in-depth coverage. Both quantitative and qualititative methods were to be utilized.

It was planned to use a variety of data collection methods, including information available from existing health information systems, standardized assessment instruments, patient and family interviews, checklists and focus groups.

Operational plan - monitoring and evaluating the strategies

Strategy	Type of monitoring/ evaluation planned	Time frame
1. Reduce the number of people with mental disorders treated in psychiatric institutions	(a) Monitor each activity in the strategic plan	Yrs. 1-5
	(b) Assess the number of beds in psychiatric institutions in year 5	End of policy period
2. Strengthen community-based mental health services	(a) Monitor each activity in the strategic plan	Yrs. 3-5
	(b) Assess the effectiveness of the community mental health facilities	Yr. 3
	(c) Assess whether the requisite community facilities have been set up	End of policy period
3. Improve access to and utilization of mental health services through decentralized, integrated mental health service delivery	(a) Monitor each activity in the strategic plan	Yrs. 2-5
	(b) Assess the number of people seen with mental health problems in health care centres	End of policy period
	(c) Evaluate integrated mental health care	End of policy period
4. Recruit mental health staff, particularly in areas with current staff shortages	(a) Monitor each activity in the strategic plan	Yrs. 1-5
	b) Review number of graduates	End of policy
5. Undertake extensive mental health training programmes for all health staff, including general health workers and mental health specialists	(a) Monitor each activity in the strategic plan	Yrs. 1-5
	(b) Assess training of generalist and specialized mental health workers	End of policy period
6. Establish quality improvement mechanisms for mental health care	(a) Monitor each activity in the strategic plan	Yrs. 2-5
	(b) Assess utilization of quality-of-care standards	End of policy period
	(c) Establish levels of quality of care	End of policy period
7. Improve the supply and utilization of essential psychotropic medications	(a) Monitor each activity in the strategic plan	Yrs. 1-5
	(b) Establish the availability of psychotropic medication	End of policy period

Research/collation required	Sources/methods of data collection
Assess whether the planned activity has been completed	Observation Interviews Document review
Comparison of bed numbers pre- and post-intervention (quasi- experimental design)	Health information system Survey
Assess whether the planned activity has been completed	Observation Interviews Document review
Quality-of-care assessment (non-experimental design)	Checklist using standardized instruments Observation Interview
Collate information	Observation Health information systems
Assess whether the planned activity has been completed	Documentation review Interviews
Collate available information (non-experimental design) Collect information on qualifications of health workers (non-experimental design)	Health information systems Survey Documentation review
Assess number of mental health beds in general hospitals (quasi-experimental design)	Documentation review Survey
Assess whether the planned activity has been completed	Interview Health information system
Collate information on number of mental health graduates (non-experimental design)	Documentation review Survey
Assess reasons for staff leaving the service (non-experimental design)	Interviews Survey
Assess whether the planned activity has been completed Conduct a review of all training done (non-experimental design)	Documentation review Health information system Survey Observation Interviews
Assess whether the planned activity has been completed Assess utilization.	Document review Interview survey
Collate all quality-of- care assessments for review	Standardized quality-of-care instrument
Assess whether the planned activity has been completed Assess availability of drugs at different levels (non-experimental design)	Observation Documentation review Interviews

Operational plan - monitoring and evaluating the objectives

Objectives	Type of monitoring/ evaluation planned
Reduce the emphasis on institutional care for people with mental disorders	Availability of beds in psychiatric institutions User/family satisfaction with deinstitutionalization
Expand community-based mental health services so that they become accessible to all people in need	Availability and accessibility of community- based facilities Assess progress in other sectors for promotion of community mental health care
Integrate mental health into general health care	**Percentage** of facilities that have integrated mental health care Placement of human resources Attitudes of health workers
Promote and protect the human rights of people with mental disorders	Assess human rights in psychiatric facilities
Ensure delivery of high quality, evidence-based interventions for mental health promotion, prevention, treatment and rehabilitation	Assess quality of treatment and care

Research/collation required	Sources/methods of data collection
See evaluation of strategy 1 Patient/family interviews (non-experimental design)	 Semi-structured interview
See evaluation of Strategy 2 Review of existing databases	 Documentation review
See evaluation of Strategy 3 Pre- and post-policy assessment (quasi -experimental design) Attitude assessment	 Health information system Survey
Pre- and post-intervention assessment (quasi- experimental design)	Standardized instrument
Focus group	Focus group interview

Step 5. Analysing the evaluation data, including unintended outcomes, and reporting the results

The data would be analysed on an ongoing basis and reports made to a number of stakeholder groups. The Ministry of Health would be the main recipient of the monitoring and evaluation results, but it intended to make the results public and open to scrutiny and comment. It also planned to make reports on the evaluation available to district authorities and service providers as well as to the donors who funded different aspects of the evaluation. The reporting would be tailored to the needs of the different target groups.

The actual analysis of data and reporting of results from the different evaluations is presented in detail in the following section.

3.3 Evaluation of the process for developing the mental health policy and plan and their contents

Even before accepting and implementing the new mental health policy and plan, the Government sought to ensure that best practice processes were followed in their development, and that their contents were in accordance with the needs and resources of the country. As the new policy would entail major shifts in mental health care, the Government wanted to be certain that the policy and plan had been developed through an inclusive process involving the key stakeholders. It was recognized that without proper consultation there may be resistance from health workers, consumers or families, and that this would undermine the implementation of the plan. The Government was also aware of the need for sufficient "groundwork" to inform the policy and that the policy should be up to date and fully in line with available evidence and international best practices. Finally, it was keen to ensure, before implementation, that the drafters of the policy and plan had taken into account its feasibility and appropriateness to the country's particular context. The Government therefore contracted a team of expert independent evaluators with a good knowledge of mental health policy issues and of the culture and resources available in the country to evaluate the mental health policy and plan.

The evaluators used the *WHO Checklists for Evaluating a Mental Health Policy and Plan* (see annexes 1 and 2) to conduct their evaluation. To complete this accurately, they examined records made available to them on the process, minutes of the meetings of the drafting committee and other meetings, and interviewed each of the six members of the drafting committee.

Their assessment is shown in the form below.

Checklist for evaluating a Mental Health Policy

Process issues	Rating
1a. Was there a high level mandate to develop the policy (e.g. from Minister of Health)? **1b.** At what level has the policy been officially approved and adopted? (e.g., the department of mental health, Ministry of Health, Cabinet, Minister of Health).	1
2. Is the policy based on relevant data: • from a situation assessment?	2
• from a needs assessment?	2
3. Have policies relating to mental health that have been utilized within the country and in other countries with similar cultural and demographic patterns been examined and integrated where relevant?	1
4. Has a thorough consultation process taken place with the following groups:	2
• Representatives from the health sector, including planning, pharmaceutical , human resource development, child health, HIV/AIDs, epidemiology and surveillance, epidemic and disaster preparedness divisions?	2
• Representatives from the Finance Ministry?	1
• Representatives from the Social Welfare and Housing Departments?	2

Comments on rating	Action required (if any)
The Minister of Health had given full backing to the development of the policy. The Mental health policy was endorsed at the level of the Ministry of Health.	
While no specific situation analysis was carried out for this policy, it was thought that sufficient information on the prevailing mental health situation was available. No specific needs assessment was carried out. However, estimates of need have been done based on previous studies.	
The team that drew up the policy had examined mental health policies from a number of developed and developing countries before drafting began. In addition, it took into account people's cultural needs and available human resource capacity within the country when assessing the usefulness of other countries' policies.	
A team of six people was responsible for drafting the policy. Once the policy was in final draft a feedback meeting was held with mental health staff. Twenty people attended. As the meeting took place at the psychiatric hospital in the capital, all but two of the people attending were hospital staff.	There has been a major gap in the process of policy development. Interested and relevant individuals, organizations and community groups were not consulted, and mental health and general health staff were not involved in the process. While a feedback meeting was called, this was to inform people rather than to seek their input and ownership of the policy. Also, the meeting did not include staff from outlying areas. More consultation is needed before implementing the policy.
Representatives from the health department (other than mental health) assisted with the process of policy development. However the policy was not widely canvassed and discussed with the staff who would be implementing it nor all relevant staff from other key departments who could contribute. Consultations were held with the Ministry of Finance, which committed to providing funds for the policy. It also agreed to further discussions following the presentation of a plan with costing.	Additional consultations are needed.
Both Departments had been consulted regarding the process of deinstitutionalization. While both expressed a willingness to assist, no firm commitments were obtained.	Further consultations needed.

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If "yes" or "to some extent" please state how.

If not, please state reason(s).

Checklist for evaluating a Mental Health Policy

Process issues	Rating
• Representatives from the criminal justice system?	2
• Consumers or representatives of such groups?	3
• Family members or representatives of such groups?	3
• Other NGOs?	3
• Private sector?	3
• Any other key stakeholder groups? Please name them.	3
5. Has an exchange taken place with other countries concerning their mental health policies and experiences?	1
6. Has relevant research been undertaken to inform policy development (e.g. pilot studies)?	2
Content issues	
1. Is there a realistic vision statement?	1
2. Are values and associated principles which inform the policy included?	1
3. Do these values and associated principles emphasize and/or promote:	
• Human rights?	1
• Social inclusion?	2
• Community care?	1
• Integration?	1
• Evidence-based practice?	2
• Intersectoral collaboration?	1
• Equity with physical health care?	1
4. Have clear objectives been defined?	1
5. Are objectives consistent:	
• with the vision?	1
• with the values and principles?	1
6. Are the areas for action clearly described, indicate the main policy directions and what will be achieved?	1

Comments on rating	Action required (if any)
Discussions were held with respect to transferring mentally ill people from prisons to psychiatric facilities and sending no more people requiring mental health care to prisons.	Further consultations needed.
No reasons for this could be found.	Consultations needed.
No reasons for this could be found.	Consultations needed.
No reasons for this could be found.	Consultations needed.
No reasons for this could be found.	Consultations needed.
No reasons for this could be found.	
Two neighbouring countries had recently passed new mental health policies. They were consulted with respect to the content of their policies. The Government had also requested WHO to send mental health policies from other countries on their continent and these had been closely examined.	
No specific research was undertaken to inform the policy. However, information was collated where this existed.	
Vision statement included.	
Values and principles included.	
Human rights included in values/principles.	
This is not specifically included, but the general approach appears to include social inclusion.	Include this directly.
Community care included.	
Integration included.	
Though reference is made to evidence based interventions, this needs to be more explicit.	Include this directly.
Intersectoral collaboration included.	
Equity with physical care included.	
There is a clear section on objectives.	
Objectives and vision are consistent and coherent.	
Objectives are consistent with values and principles.	
Areas for action are clearly described.	

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If "yes" or "to some extent" please state how.

If not, please state reason(s).

Checklist for evaluating a Mental Health Policy

Content issues	Rating
7. Are the areas for action written in a way that commits the Government (e.g. do they state "will" instead of "should")?	1
8. To what extent do the areas for action comprehensively address **coordination & management**?	3
• (a) Does the policy specify a dedicated mental health position/post within the Ministry of Health to coordinate mental health functions and services?	2
• b) Does the policy establish or refer to a multisectoral coordinating body to oversee major decisions in mental health?	3
9. To what extent do the areas for action comprehensively address **financing**?	3
• (a) Does the policy indicate how funding will be utilized to promote equitable mental health services?	3
• (b) Does the policy state that equitable funding between mental health and physical health will be provided?	3
• (c) If health insurance is utilized in the country, does the policy indicate whether/how mental health would be part of it?	3
10. To what extent do the areas for action comprehensively address **legislation and/or human rights**?	2
• (a) Does the policy promote human rights?	1
• (b) Does the policy promote the development and implementation of human-rights-oriented legislation?	3
• (c) Is the setting up of a review body that monitors different aspects of human rights envisaged?	3
11. To what extent do the areas for action comprehensively address **organization of services**?	1
• (a) Does the policy promote the integration of mental health services into general health services?	1
• (b) Does the policy promote a community-oriented mental health approach?	1
• (c) Does the policy promote deinstitutionalization?	1
12. To what extent do the areas for action comprehensively address **promotion, prevention and rehabilitation**? Does the policy make provision for:	2
• (a) The prevention of mental disorders?	2
• (b) Interventions that promote mental health?	2
• (c) Interventions for the rehabilitation of people with mental disorders?	2

Comments on rating	Action required (if any)
The Government is clearly committed to the policy.	
This is a gap in the policy.	Mechanisms for coordination and management should be developed.
Though there is no specific reference in the policy, a director is acting in this capacity in the country.	
This is a gap in the policy.	This needs to be addressed.
Financing is not included as an area for action.	Clarity is needed on this prior to implementation of the plan.
Equitable health care is an expressed goal, but how finances would be used to achieve this is not explained.	Clarity is needed.
No reference is made to the financing of equitable mental health services.	This should be included in the policy.
This policy covers only State and not private health care.	Private health care should either be included in this policy or a separate policy should be drawn up.
Some areas of human rights are covered, but not legislation.	
This is a basic principle of the policy.	
There is no reference in the plan to developing legislation.	In the description of services, reference is made to legislation dating back to 1960; legislative reform is likely to be needed.
No reference is made to this.	This should be addressed.
Reorganization of services is central to this policy.	
This is a fundamental part of the policy.	
This is a fundamental part of the policy.	
This is a fundamental part of the policy.	
Prevention is included in the objectives, but not in the areas for action. This is because it is not possible to include everything that needs to be done immediately.	This needs to be considered for inclusion in the next mental health policy that is drafted.
Promotion is included in the objectives, but not in the areas for action. This is because it is not possible to include everything that needs to be done immediately.	This needs to be considered for inclusion in the next mental health policy that is drafted.
Rehabilitation is included in the objectives and is implicit in the policy.	Rehabilitation needs to be made far more explicit.

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If "yes" or "to some extent" please state how.

If not, please state reason(s).

Checklist for evaluating a Mental Health Policy

Content issues	Rating
13. To what extent do the areas for action comprehensively address **advocacy**?	3
• (a) Is the policy supportive of consumers and family organizations?	3
• (b) Is there emphasis on raising awareness of mental disorders and their effective treatment?	3
• (c) Does the policy promote advocacy on behalf of people with mental disorders?	3
14. To what extent do the areas for action comprehensively address **quality improvement**? Does the policy:	1
• (a) Make a commitment to providing high quality, evidence-based interventions?	1
• (b) Include a process to measure and improve the quality of services?	1
15. To what extent do the areas for action comprehensively address **information systems**?	3
• (a) Will mental health information systems be set up to guide decision-making for future policy, planning and service development?	3
16. To what extent do the areas for action comprehensively address **human resources and training**?	1
• (a) Does the policy commit to putting in place suitable working conditions for mental health providers?	3 (in this policy)
• (b) Have appropriate management strategies been discussed to improve recruitment and retention of mental health providers?	2
• (c) Are training in core competencies and skills seen as central to human resource development?	1
17. To what extent do the areas for action comprehensively address **research and evaluation**?	3
• (a) Does the policy emphasize the need for research and evaluation of services and of the policy and strategic plan?	3
18. To what extent do the areas for action comprehensively address **intrasectoral collaboration** within the health sector? Does the policy:	
• (a) Emphasize collaboration with planning, pharmaceutical, human resource development, child health, HIV/AIDs, epidemiology and surveillance, epidemic and disaster preparedness divisions within the health sector?	2
• (b) Contain clear statements of what role each department will play in each area for action?	3

Comments on rating	Action required (if any)
This area for action is absent from the policy. This is an omission from the policy. There is no attempt in the policy to address this. There is no attempt in the policy to address this.	This problem should be addressed This problem should be addressed. Attention is needed to this issue. Attention is needed to this issue.
A specific strategy (Strategy 6) is devoted to quality of care. This is implied in the policy. This is included in Strategy 6.	
There is no reference in the policy to improving information systems. Nonetheless, there is a general policy on information systems and mental health is included in this. This is not an explicit part of the policy.	The existing information system for mental health needs to be checked to ensure it is adequate. The existing health information system needs to be checked to ensure it is adequate.
Human resources and training is a key objective and has two specific strategies: Strategies 4 and 5. This is contained in a separate policy dealing with working conditions of all health workers. There are no specific strategies as part of the policy. However the policy makes it clear that recruitment and retention of mental health staff is critical. Strategies for training are part of the policy.	The specifics should be outlined.
No mention is made in the policy itself for research and evaluation. However, it is clear that the Government is strongly committed to this. Those developing the policy believed it was not necessary to include a section on research and evaluation, even though they recognized it as being important.	More discussions should be held to decide whether this should be included in the policy or whether it is sufficient to assume that the country is committed to conducting monitoring and evaluation.
Collaboration with planning, human resource development and epidemic and disaster preparedness divisions are emphasized but not with other relevant divisions within the health sector. Even for the health divisions above, for which collaboration is emphasized in the policy, there is no clear description of the role of each department in relation with each area for action for mental health.	The policy should put more emphasis and attention into intrasectoral collaboration. The policy should clearly define the role each health department/division should play in each area for action.

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If "yes" or "to some extent" please state how.

If not, please state reason(s).

Checklist for evaluating a Mental Health Policy

Content issues	Rating
19. To what extent do the areas for action comprehensively address **intersectoral collaboration**? Does the policy:	2
• (a) Emphasize collaboration with all other relevant government departments?	2
• (b) Emphasize collaboration with all relevant NGOs, including consumer and family groups?	2
• (c) Contain clear statements of what role each sector will play in each area for action?	3
20. Have all of the following groups been considered:	
• People with severe mental disorders?	1
• Children and adolescents?	2
• Older persons?	2
• People with intellectual disability?	3
• People with substance dependence?	3
• People with common mental disorders?	3
• People affected by trauma?	3
21. Given resources available in the country, has a reasonable balance been achieved between the above groups?	1

Comments on rating	Action required (if any)
The policy does include the need to collaborate with other departments, communities and NGOs, and no details are spelt out.	The policy should specify the need for collaboration with all stakeholders.
This is a key value/principle but is not adequately translated within the strategic plans and areas for action.	This needs to be addressed.
Mention is made of collaboration, but this is not adequately covered in the areas for action or in the strategies.	This needs to be included.
See above.	
Most of the policy concentrates on this group. Children are mentioned in the values, but this is not followed through in the strategies or plan. While important, it is not possible to work in every area at the same time. It was a conscious decision not to plan for more than would be possible, given the resource constraints.	
Older persons are mentioned in the values, but this is not addressed in detail. While important, it is not possible to work in every area at the same time. It was a conscious decision not plan for more than would be possible, given the resource constraints.	While considered important, it is not possible to work in every area at the same time. It was a conscious decision not to plan for more than would be possible, given the resource constraints.
A separate policy is being drawn up for people with mental disability. A separate policy is being drawn up for people with substance dependence. While important, it is not possible to work in every area at the same time. It was a conscious decision not to plan for more than would be possible, given the resource constraints. While important, it is not possible to work in every area at the same time. It was a conscious decision not to plan for more than would be possible, given the resource constraints.	
A decision was made to concentrate mostly on people with severe mental disability, and to expand to other priority groups in the next policy cycle.	

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If "yes" or "to some extent" please state how.

If not, please state reason(s).

Checklist for evaluating a Mental Health Policy

Content issues	Rating
22. To what degree have the key mental health policy issues been integrated with/or are consistent with the country's	
• Mental health law?	3
• General health law?	2
• Patients rights charter?	1
• Disability law?	3
• Health policy?	1
• Social welfare policy?	2
• Poverty reduction policy?	2
• Development policy?	N/A
Taking into account the financial and human resources available in the country, comment on the general	
The policy is generally adequate and comprehensive, given the available financial and human resources. More	

Comments on rating	Action required (if any)
The mental health policy will now be well in advance of the mental health legislation. This could become problematic unless rectified soon as the legislation will inhibit the progress of the policy in that it emphasizes custodial rather than integrated community mental health	The mental health legislation will need to be addressed very soon as it is not only in conflict with the new policy but because of the power of law relative to policy is likely to retard the progress of the policy
A draft of new general health legislation has been developed and is currently out for public comment. This draft is more in line with the human rights approach of this policy.	The draft health legislation should be scrutinised immediately to see whether there are any changes which need to be recommended in order to be consistent with the mental health policy
The patient rights charter specifically mentions both physical and mental health and there are no clauses that contradict any provisions of this policy.	
The disability law, like the mental health legislation, has not been changed for many years and is not consistent with this policy.	It is urgent that the disability law be redrafted. This should become consistent with this policy.
New health policy has recently been passed. Key individuals who were responsible for co-ordinating the mental health policy participated in that process and gave considerable input that was included.	
Financial grants for people with mental disability were introduced the previous year. This is very important. However, rehabilitation programmes for people with mental disability have not been fully addressed in the social welfare policy.	A policy on social rehabilitation from social welfare will go a long way towards the realisation of the community oriented mental health policy.
The policy on poverty reduction makes no reference to mental health, however poverty reduction in itself should have positive impacts on mental health.	If at all possible the poverty reduction policy should be modified to take into account the specific needs of people with mental disability.
There is no “development policy” per se in the country. Development issues are included in numerous policies of different departments.	

feasibility for implementation of the policy.

consideration should be given to establishing a coordinating body for policy implementation.

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If “yes” or “to some extent” please state how.

If not, please state reason(s).

Checklist for evaluating a Mental Health Plan

Process issues	Rating
1a. Was there a high-level mandate to develop the plan (e.g. from Minister of Health)? **1b.** At what level has the plan been officially approved and adopted? (e.g., the department of mental health, Ministry of Health, Cabinet, Minister of Health)	1
2. Does the plan include strategies and activities that are consistent with an existing and up-to-date policy?	1
3. If no policy is available, does the plan include strategies and activities that are consistent with another official document(s) stating the direction(s) for mental health? Please provide relevant document(s).	
4. Are strategies and activities written in a way that commits the government (e.g. do they state "will" instead of "should")?	2
5. Has the plan been informed by:	
• a situation analysis; and/or	2
• a needs assessment?	2
6. Have effective strategies that have been utilized within the country and in other countries with similar cultural and demographic patterns been examined and integrated where necessary?	1
7. Has a thorough consultation process taken place with the following groups?	
• Representatives from the Health Department, for example, including planning, pharmaceutical, human resource development, child health, HIV/AIDs, epidemiology and surveillance, epidemic and disaster preparedness divisions?	2
• Representatives from the Finance Ministry?	3
• Representatives from the Social Welfare and Housing Departments?	2
• Representatives from the criminal justice system?	2
• Consumers or representatives of such groups?	3
• Family members or representatives of such groups?	3
• Other NGOs?	3
• Private sector?	3
• Any other key stakeholder groups? Please list them.	

Comments on rating	Action required (if any)
The Minister of Health has given full backing to the development of the plan. The Mental health plan was endorsed by the department of mental health and did not have high level backing beyond that level.	
Strategies and activities are included based on the plan.	
N/A	
Targets are included in the plan, which suggests a serious commitment to realizing its goals.	
While some information is available, additional data may have been useful to assist with the planning. While some information is available, additional data may have been useful to assist with planning.	Additional information should be gathered. Additional information should be gathered.
The team that drew up the plan examined mental health plans from other countries. In addition, it took into account people's cultural needs, the staff available and the possibilities of training more personnel in examining these plans.	
Representatives from the Health Department (other than mental health) assisted with the plan, however their involvement was limited and token. This is a gap in the plan. Both Departments were consulted about the process of deinstitutionalization. While both expressed a willingness to assist, no firm commitments were obtained. Discussion was held with respect to transferring mentally ill people from prisons to psychiatric facilities and to stop sending any more people in need of mental health care to prisons. This is a gap in the plan. This is a gap in the plan. This is a gap in the plan. This is a gap in the plan.	Consultation process needs to be put in place and refinements made to the plan depending on the input of staff from the various departments in the health sector. Consultations are needed. The plan needs to include ways of monitoring progress in other departments. This needs to be operationalized in the plan. Consultations are needed. Consultations are needed. Consultations are needed. Consultations are needed.

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If "yes" or "to some extent" please state how.

If not, please state reason(s).

Checklist for evaluating a Mental Health Plan

Operational issues	Rating
8. Have comprehensive strategies been identified for each priority area for action?	1
Looking at strategies	
9. Time frames:	
• Are time frames provided for each strategy?	1
• If so, are these time frames reasonable and feasible?	2
10. Indicators:	
• Are there indicators for each strategy?	1
• If so, are the indicators appropriate for measuring the particular strategy?	1
11. Targets:	
• Are there targets for each strategy?	1
• If so, are the targets realistic?	2
Looking at activities	
12. Are clear activities defined for each strategy?	1
13. Is the person/group/organization responsible for each activity identified?	1
14. Is it clear when each activity will start and finish?	1
15. Are the outputs for each activity outlined?	1
16. Have potential obstacles been identified?	3
17. Costs and funding:	
• Have the costs for achieving each activity been calculated?	1
• Is the funding for each activity available and allocated?	2

Comments on rating	Action required (if any)
Seven strategies have been developed.	
Each activity has a time frame for completion. Given resource constraints, these may need to be reconsidered.	
Each strategy has an indicator. No problems have been identified with the indicators.	
Each strategy has a target. Given resource constraints, these may need to be reassessed.	Consideration should be given to reducing some of the targets.
A number of activities are outlined for each strategy.	
A person/group/organization has been identified to carry out each activity.	
Time frames for each activity are provided by year.	
Expected outputs for each activity are documented.	
No obstacles have been identified.	This should be added.
Funding has been secured for most of the activities.	Funding for the “non-funded” items must be found.

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If “yes” or “to some extent” please state how.

If not, please state reason(s).

Checklist for evaluating a Mental Health Plan

Content issues	Rating
18. Does the plan include relevant strategies and activities for **coordination & management**?	3
• (a) Are the composition and functions clearly defined for: – The MH coordinating body?	3
– The MH focal point?	2
• (b) Is an adequate infrastructure in place/planned (including computers, Internet access and administrative support)?	4
• (c) Are regular meetings of the coordinating body scheduled?	3
• (d) Has a system of reporting to a high-level MoH official been set up for the MH coordinating body?	3
• (e) Are coordination and management strategies and associated activities: – Relevant?	1
– Evidence-based?	2
– Realistic and possible to implement?	2
– Adequately funded?	3
19. Does the plan include relevant strategies and activities for **financing**?	2
• (a) Is it clear how services will be funded?	2
• (b) Is the plan clear as to whether/how user charges will be made?	3
• (c) Are financing strategies and associated activities: – Relevant?	3
– Evidence-based?	3
– Realistic and possible to implement?	3
– Adequately funded?	3

Comments on rating	Action required (if any)
The plan does not cover coordination and management.	This should be included in the plan.
No coordinating body has been included.	This should be included in the plan.
The plan has assigned a number of tasks to the Director of Mental Health Services. However, there is concern that this may not be realistic.	The various roles of the Director should be assessed to establish whether he/she has a realistic job description.
This kind of information is not included in any policies in this country.	
No reference is made to such meetings.	This should be included in the plan.
No reference is made to such system.	This should be included in the plan.
The strategies and activities planned appear to be highly relevant to the needs of the country.	
The strategy appears to be evidence-based, though no direct information on this is available in the plan.	The plan should be checked against available evidence and best practices.
Given the shortage of human resources, there is concern that too many strategies and activities have been planned.	A thorough review of the feasibility of carrying out all the strategies and activities should be conducted.
A number of areas remain unfunded.	Negotiation is needed with the Treasury to obtain additional funding for mental health.
There is ongoing funding allocated to mental health, but it is mainly for the psychiatric institutions. This needs to be changed. Funding of the strategies does take this into account, but there is still a funding gap. There is no strategy for accessing additional funding, nor for the transfer of money from a hospital to a community-based budget.	Further thinking and negotiation is needed.
The current mental health budget will be adopted and some additional funding will be made available. There will also be considerable transfer of funds from hospital to community-based services. However, there is still a funding gap.	Negotiation with the Treasury is needed to try to secure additional funding for mental health.
There is a separate policy in the country for payment of health care, including mental health. It is therefore, understandably, not discussed in this policy.	
This was not adequately considered in drafting the policy.	A more specific plan for financing is needed.
This was not adequately considered in drafting the policy.	A more specific plan for financing is needed.
This was not adequately considered in drafting the policy.	A more specific plan for financing is needed.
N/A	

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If "yes" or "to some extent" please state how.

If not, please state reason(s).

Content issues	Rating
20. Does the plan include relevant strategies and activities for **legislation and/or regulations on human rights**?	3
• (a) Where legislation and/or regulations are to be developed, have clear strategies/activities been specified for:	3
– the process of drafting the law/regulations?	3
– defining the content of the law/regulations?	3
– implementing the law/regulations?	3
• (b) Where a review body to protect human rights is to be established, are clear strategies/activities specified for its establishment?	
• (c) Are there any other strategies to protect and promote the rights of people with mental disorders?	
• (d) Are the strategies on human rights and legislation and associated activities:	2
– Relevant?	N/A
– Evidence-based?	N/A
– Realistic and possible to implement?	N/A
– Adequately funded?	N/A
21. Does the plan include relevant strategies and activities for **organization of services**?	2
• (a) Are there strategies and associated activities for the provision of services at primary, secondary and tertiary levels, with continuity between them?	2
• (b) Are there strategies and associated activities for deinstitutionalization?	1
• (c) Are there strategies and associated activities for developing community mental health services?	1
• (d) Has provision been made for psychosocial rehabilitation services at all levels of the health system?	2
• (e) Are the strategies on organization of services and associated activities:	
– Relevant?	1
– Evidence-based?	1
– Realistic and possible to implement?	1
– Adequately funded?	3

Comments on rating	Action required (if any)
No plan for legislation included. Human rights to be promoted through other strategies such as community care and quality-of-care improvement. N/A N/A N/A N/A Rights will be protected through "deinstitutional-ization" and improvement of quality of care.	
The plan covers a number of aspects of organization of services in Strategies 1, 2 and 3. However, some important aspects need more detailed attention. The plan provides some information on coordination, but this is inadequate. The plan makes provision for reducing the number of people in institutions and for the development of community services. Plans are in place for developing community facilities and integrating mental health into general health care. The plan lacks specific detail. The plan is highly relevant. Information is based on best practice principles. Given scarce resources, the plan may be somewhat ambitious. A number of activities have not been funded.	More detail is needed. More is needed with regard to the involvement of other sectors. More detail is needed. Attention is needed to ensuring funding for the activities.

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If "yes" or "to some extent" please state how.

If not, please state reason(s).

Checklist for evaluating a Mental Health Plan

Content issues	Rating
22. Does the plan include relevant strategies and activities for **promotion, prevention and rehabilitation**?	3
• (a) Are there clear strategies and related activities for the promotion of mental health?	3
• (b) Are there clear strategies and related activities for the prevention of mental disorders?	3
• (c) Are the strategies on prevention, promotion and rehabilitation, and associated activities:	
– Relevant?	N/A
– Evidence-based?	N/A
– Realistic and possible to implement?	N/A
– Adequately funded?	N/A
23. Does the plan include relevant strategies and activities for the procurement and distribution of essential medicines?	2
• (a) If psychotropic medicines currently are not included on the Essential Drugs List (EDL), is there a strategy and associated activities to include them?	Are included on EDL
• (b) Does the plan incorporate strategies and associated activities to improve reliability of the supply and distribution system at relevant levels of the health service where treatment is provided?	1
• (c) Are there strategies and relevant activities for monitoring the continuous provision and assessment of psychotropic medicines?	2
• (d) Are the strategies on procurement and distribution of medicines and associated activities:	
– Relevant?	1
– Evidence-based?	2
– Realistic and possible to implement?	1
– Adequately funded?	3
24. Does the plan include relevant strategies and activities for **advocacy**?	3
• (a) Is there a strategy and related activities to support (technically and/or in practical terms) consumer groups, family groups and NGOs?	3
• (b) Is there a strategy and associated activities to involve consumers and family representatives in policy and service planning?	3

Comments on rating	Action required (if any)
While promotion and prevention were seen as priorities, it was decided that it was not possible to include everything in this policy and plan. Some of these activities will take place during the policy period, but they are not included as part of the policy/plan itself. See above. See above.	
This is covered (to a large extent) by Strategy 7. This is covered comprehensively by Strategy 7. This is included to some extent, but could be strengthened as it is more implicit than explicit. This is covered in Strategy 7. The strategy was largely informed by the WHO module, *Improving Access and Use of Psychotropic Medicines*. Key areas are covered in the plan. Additional funds are required for this strategy.	This needs to be made more explicit.
While advocacy was seen as a priority, it was decided that it was not possible to include everything in this policy and plan. Some of the relevant activities will take place during this policy period, but advocacy is not part of the present policy/plan. See above. See above.	

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If "yes" or "to some extent" please state how.

If not, please state reason(s).

Content issues	Rating
• (c) Are the advocacy strategy and associated activities: – Relevant?	3 N/A
– Evidence based?	N/A
– Realistic and possible to implement?	N/A
– Adequately funded?	N/A
25. Does the plan include relevant strategies and activities for **quality improvement**?	1
• (a) Is there a strategy and associated activities for assessing quality?	1
• (b) Is there a strategy and associated activities for ongoing quality control of mental health facilities (e.g. standards)?	1
• (c) Is there a strategy and associated activities for accrediting facilities based on quality?	1
• (d) Are both hospital and community mental health facilities included in quality assessment?	1
• (e) Are the strategies on quality improvement and associated activities: – Relevant?	1
– Evidence-based?	1
– Realistic and possible to implement?	1
– Adequately funded?	2
26. Does the plan include relevant strategies and activities for **information systems**?	3 (in this plan)
• (a) Have a strategy and linked activities been defined for: – Reviewing the current mental health information system, and/or	
– Improving the current mental health information system?	3 (in this plan)
• (b) Does the strategy, or linked activities, include the systematic collection of mental health data from a range of sources at different levels of the health system (e.g. from general hospitals, primary health care and community levels)?	3 (in this plan)
• (c) Is it clear how the information will feed back into: – Policy development, mental health planning and service delivery?	3 (in this plan)
– Clinical practice?	3 (in this plan)

Comments on rating	Action required (if any)
This is covered comprehensively in Strategy 6. This is covered comprehensively in Strategy 6. This is covered comprehensively in Strategy 6. Yes. See Strategy 6. Yes. See Strategy 6. Strategies are highly relevant. Strategies were informed by the WHO module on *Quality Improvement*. The plan is feasible. Funding is still needed for parts of the plan.	Funding must be addressed.
There is no specific reference to information systems in this plan. However, mental health is included in a general plan on information systems. See above. Perusal of the general plan on health information systems shows that mental health has been adequately included. Not in this plan, but it is included in the general health information system. Not in this plan, but it is included in the general health information system. Not in this plan, but it is included in the general health information system.	

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If "yes" or "to some extent" please state how.

If not, please state reason(s).

Content issues	Rating
• (d) Are the strategies on information systems and associated activities: – Relevant?	N/A
– Evidence-based?	N/A
– Realistic and possible to implement?	N/A
– Adequately funded?	N/A
27. Does the plan include relevant strategies and activities for **human resources and training**?	1
• (a) Is there a well-defined strategy with associated activities for assessing available personnel and competencies at different service levels?	1
• (b) Is there a strategy to improve the number of providers for mental health?	1
• (c) Are there relevant management strategies and activities to address: – Recruitment?	1
– Retention?	1
– Deployment of staff?	1
• (d) Has provision been made for ongoing education, training and skills development?	1
• (e) Is there a strategy/relevant defined activities to introduce changes to undergraduate and graduate curricula of health and allied health workers?	1
• (f) Is there a strategy for training health providers to develop appropriate competencies at the levels of: – Informal community services?	2
– Primary health care services?	1
– General hospital care?	1
– Specialist care?	1
• (g) Are the strategies on human resources and associated activities: – Relevant?	1
– Evidence based?	1
– Realistic and possible to implement?	1
– Adequately funded?	3
28. Does the plan include relevant strategies and activities for **research and evaluation**?	3 (in this plan)

Comments on rating	Action required (if any)
Relevant in the general plan. The general plan has drawn on the WHO module on *Mental Health Information Systems*. The general plan is realistic. The general plan is funded.	
This is comprehensively covered in Strategies 4 and 5. See strategy 4. See Strategy 5. See Strategy 4. See Strategy 4. See Strategy 3. See Strategy 5. See Strategy 5. No specific activities relate to this level of worker. See Strategy 5. See Strategy 5. See Strategy 5. The needs of the country have been taken into account. The strategies draw on the WHO module *Human Resources and Training*. Goals have been set realistically. A number of activities still require funding.	This needs to be addressed.
They are not included in the plan. However, it is clear from the evaluation planned that the Government places strong emphasis on research and evaluation. In fact, mental health has been included in the county's general plan for research and evaluation rather than in the mental health plan.	

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If "yes" or "to some extent" please state how.

If not, please state reason(s).

Checklist for evaluating a Mental Health Plan

Content issues	Rating
• (a) Are there strategies for improving capacity to conduct research and evaluation?	3 (in this plan)
• (b) Will the research address practical issues for the country?	3 (in this plan)
• (c) Has provision been made to evaluate the policy and plan?	1
• (d) Are research and evaluation strategies and defined activities:	
– Relevant?	1
– Evidence-based?	1
– Realistic and possible to implement?	1
– Adequately funded?	2
29. Does the plan include relevent strategies and activities for **intrasectoral collaboration**?	
• (a) Is a structure planned/in place through which intrasectoral collaboration could take place with the following departments within the health sector?	
• (b) Is collaboration with the following departments within the health sector included in the plan?	
– Planning,	
– Pharmaceutical,	
– Human resource development,	
– Child health,	
– HIV/AIDs,	
– Epidemiology and surveillance,	
– Epidemic and disaster preparedness divisions.	
30. Does the plan include relevant strategies and activities for **intersectoral collaboration**?	3
• (a) Is there a structure planned/in place through which intersectoral collaboration could take place?	3
• (b) Is collaboration with the following government departments included in the plan?	
– Social services	2
– Justice	3
– Education	3
– Housing	3
– Corrections	3
– Police	3

Comments on rating	Action required (if any)
This is included in the general plan on health evaluation. This is addressed in the general plan on health evaluation. Though not included in the mental health plan, it is part of the general plan on research and evaluation. As per the general plan on research and evaluation. As per the general plan on research and evaluation. As per the general plan on research and evaluation. Not all the evaluation planned has been funded, but there are plans to link up with donors.	
Intrasectoral collaboration is not built into the plan in any systematic way. There is a need to examine for each strategy and activity the engagement and responsibility of other departments in the health sector.	
This is a gap in the policy. This is a gap in the policy. Only with respect to community-based facilities. This is a gap in the plan. This is a gap in the plan. This is a gap in the plan. This is a gap in the plan. This is a gap in the plan.	Intersectoral collaboration needs to be included in the plan. Intersectoral collaboration needs to be included in the plan. Intersectoral collaboration with each of these sectors needs to be included in the plan.

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If "yes" or "to some extent" please state how.

If not, please state reason(s).

Checklist for evaluating a Mental Health Plan

Content issues	Rating
• (c) Is collaboration with the following groups included in the plan? – NGOs	3
– Consumer groups	3
– Family groups	3
• (d) Have the following groups been considered? – People with severe mental disorders?	2
– Children and adolescents?	3
– Older persons?	3
– People with intellectual disabilities?	3
– People with substance dependence?	1
– People with common mental disorders?	3
– People affected by trauma?	3
• (e) Given financial and human resources available in the country, has a reasonable balance been achieved between the above groups?	3
• (f) Overall, are the strategies on intersectoral collaboration and associated activities: – Relevant?	3
– Evidence-based?	3
– Realistic and possible to implement?	N/A
– Adequately funded?	N/A
31. To what degree have the key mental health strategies been integrated into the country's existing strategic plans for: – Improving patients rights?	2
– Improving rights for people living with disabilities?	3
– Overall health?	2

Comments on rating	Action required (if any)
This is a gap in the plan.	Collaboration with each of these groups needs to be included in the plan.
This is a gap in the plan.	
This is a gap in the plan.	
But only people with schizophrenia are considered.	Collaboration with each of these groups needs to be included in the plan.
This is a gap in the plan.	
This is a gap in the plan.	
This is a gap in the plan.	
This is a gap in the plan.	Collaboration with each of these groups needs to be included in the plan.
This is a gap in the plan.	
In the country context, more attention should be given to the following groups: children and adolescents, older persons, all people with severe mental disorders and people with common mental disorders.	
Plans are needed.	Specific plans are required.
Plans are needed.	Specific plans are required.
All rights already include both physical and mental health and therefore there is no need to add anything to this strategy.	
No changes were made to existing strategies for improving the rights pf people with mental disabilities.	This requires attention.
No specific changes were made in existing strategic plans. Though the plans to integrate mental health into general health in this plan have direct implications for the provision of health care there is nothing in the general health policy that suggests that this should not occur as the policy refers to “health” and never merely “physical health”. These mental health plans can therefore be carried out without needing to change the existing overall health policy.	

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If “yes” or “to some extent” please state how.

If not, please state reason(s).

Checklist for evaluating a Mental Health Plan

Content issues	Rating
– Social welfare?	3
– Poverty reduction?	3
– Development?	3

Taking into account the financial and human resources available in the country, comment on the general

A number of items in the checklist have not been included in the plan. This is unfortunate, but clearly not everything clear that a careful process of prioritization had in fact been undertaken and certain areas of action were deliberately added to this plan, as indicated under "actions required".

The real question though, is whether the plan is too ambitious. There is also the issue of whether the planned costs strategies be reduced due to human resource constraints. It was further suggested that the implementation of the were involved in this further planning exercise and also if there was high level recognition and endorsement of the

Before making recommendations to the Government following the checklist procedure, the evaluators decided to respond to the problem identified in Question 4 (Process) and conduct a rapid assessment of whether key stakeholders did in fact: (a) know that there was a new mental health policy; and if they did, (b) what they thought of it; and c) whether they were satisfied that they had been given sufficient opportunity to provide their inputs to it.

Questionnaires were sent to the three known organizations representing users and families, the health reporters of the main newspapers, and 10 random staff members in each of the psychiatric hospitals and 20 staff members in the community mental health service.

Given their findings, that the consultation and dissemination process had been poor, the evaluators were not surprised to discover that there was low awareness of the existence of a new mental health policy. Of the questionnaires that were returned, only one of the mental health consumer organizations, one journalist, and staff in only one hospital knew that there was a new mental health policy. Moreover, the majority of those who were aware of the new policy were not happy with the contents and stated that they had not been consulted.

Comments on rating	Action required (if any)
As previously identified, social welfare policy needs to be changed to facilitate community mental health care.	Social welfare needs to integrate community mental health into their own policy and plans.
Plans are still needed.	Poverty policy still needs to integrate the needs of people with mental disabilities.
No attempts have been made to integrate mental health into existing development policies.	Development policies must be examined with regard to where and how mental health can be included.

feasibility for implementation of the policy.

can be prioritized within this 5-year plan. In discussions with the people who drafted the plan it was excluded. A number of areas for action, particularly those that require few resources, should be

to complete the proposed activities have been underestimated. It is suggested that the number of policy and the plan would be more successful if staff beyond that of the department of mental health mental health plan itself.

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If "yes" or "to some extent" please state how.

If not, please state reason(s).

The evaluators considered suggesting to the Government that the new mental health policy and plan be discarded and a process involving full consultation started. Instead, however, they recommended that, while not ideal, it was possible to engage in a process of "damage control" by now involving the key stakeholders and carefully explaining the reasons behind the policy. It was felt that while the policy itself could not be changed, the Government could still receive important input on how that policy could be implemented effectively. The Government could also provide information on how and why the particular principles and structures were chosen, including sharing information on international and continent-specific experiences. In addition, the evaluators suggested that the Government consider assuring stakeholders that if they gave their full support to implementing the policy, and if, within a specified time frame the policy did not meet the objectives, it would be changed.

The evaluators also recommended a clear dissemination process for the mental health policy involving the media, NGOs and the clinics and hospital services that provide mental health care.

3.4. Monitoring and evaluating the implementation of the plan

As discussed in section 1.2, an essential task that must be conducted on an ongoing or regular basis following the adoption of a mental health policy and plan, is to carefully monitor whether the activities have been carried out, the outputs are being delivered and the timetable is on track. A policy may be discarded or be perceived by the government and other stakeholders as inadequate or inappropriate, not because of any deficiency in the policy itself, or even because the plan for its implementation was poorly conceived, but simply because the plan was not carried out as it should have been. Nonetheless, and equally important, is understanding the **reasons** why the plan may not have been implemented. These reasons may themselves indicate whether the plan is a "good" and, particularly, a "realistic" one or not – as shown by the examples which follow.

While monitoring of a plan will assess *whether* it has been implemented or not, or perhaps the *extent* to which it has been implemented, where the plan has not been implemented, an evaluation is often required to understand *why* there has been inadequate delivery. Some of the reasons a plan may not have been implemented, and which evaluators need to keep in mind, include insufficient budget, lack of staff, staff turnover, lack of management support, loss of a policy champion and attitudes of staff.

Evaluation of the plan at year 1

In the hypothetical country of the case study, the plan was set out with annual activities and outputs, and annual monitoring was thus seen as necessary.

Example:

After the first year of the above plan, a monitoring team set up by the Ministry of Health, found that of the eight tasks identified for action, only three had been completed. The team was concerned that although the country had a mental health policy in place, it appeared either to remain largely a policy on paper only, or the time frame for implementation was turning out to be far longer than planned. The team decided to evaluate why the plan was not being implemented as envisaged.

> **WHY was the evaluation conducted?**
Following information obtained from routine monitoring, it became evident that there were problems with implementation, but the nature of those problems was unclear.

> **WHO conducted the evaluation?**
A government tender was put out for qualified people to conduct the evaluation and it was won by a local research organization.

> **HOW was the evaluation funded?**
By the Ministry of Health.

The evaluators examined the plan and noticed that of the eight tasks allocated for the first year, seven were the responsibility of the Director of Mental Health. They thought the reason for lack of implementation was either that the Director may have been given more tasks than was possible for one person to carry out – they were aware that the Director had no professional assistants in her office and that the implementation of the policy was only one of her many tasks – or that the Director may simply not have been performing her job properly due to her own deficiencies. In either case it appeared that a major initiative, the new mental health policy, may have been stalled due to the delivery capacity of one person!

They suggested that a thorough investigation of the job description be carried out (i.e. an assessment be undertaken to examine the Director's functions, duties and responsibilities independently of the incumbent). This would assist in differentiating between the problems of the job itself and the person responsible.

The results of the analysis indicated that the expectations of the job had been unrealistic. The Director had too many responsibilities for one person to undertake, in addition to being required to drive the new mental health policy and plan. The investigation found that while the Director took on the responsibilities with high expectations of achieving all the tasks assigned to her, even with the highest degree of efficiency the objectives were unachievable. The evaluators thus made two alternative recommendations to the Government. Either that it employ a full-time professional assistant in the office of the Director, particularly to take over some of her more routine responsibilities, or that the implementation of the plan be reviewed with a view to setting a more realistic agenda for what one person could be expected to achieve.

After carefully perusing the recommendations, the Ministry decided that since a lot was at stake in meeting the objectives of the mental health policy, rather than radically revising the policy and its objectives, it would budget for an assistant to the Director for the coming year. In addition, it requested that a new plan be drawn up to take into account the delays already experienced. It also instructed that realistic job descriptions for the Director and her new assistant be drawn up, and that performance targets be agreed upon between the staff members concerned and the relevant managers.

In this process it was realized that even with an assistant, the objectives in the plan were too ambitious. Reducing the strategies was considered an option, but each objective was seen as crucial to the overall policy. Therefore, rather than cutting the number of strategies, it was decided to limit the number of activities that had been agreed for each year. In doing this, the duration of the plan changed from five years to six years.

Ongoing monitoring and evaluation of the plan

It is necessary to examine each strategy annually to monitor whether the activities have been conducted and the outputs realized, and to conduct evaluations where problems are identified. It is also essential, after the period has been set for the implementation of the plan, to assess whether the targets indicated for each strategy have been met.

Strategy 1. Reduce the number of people with mental disorders treated in psychiatric institutions.

Target:
A 50% reduction in beds in psychiatric institutions by year 5.

Indicator:
Number of beds in mental hospitals per 100,000 population over the next five years.

In year 1, a pilot study in the psychiatric hospitals was planned to assess the level of disability of patients and the needs for community-based mental health care, including residential facilities. In routine monitoring to find out whether this activity had been done, it was found that no progress had been made in implementing it. Evaluators needed to find out why.

> **WHY was the evaluation conducted?**
The plan was not being implemented according to schedule.

> **WHO conducted the evaluation?**
An internal evaluation team was assembled by the Director General of Health.

> **HOW was the evaluation funded?**
By the Ministry of Health.

The evaluators began their assignment by interviewing the Director whose task it was to complete this activity. They assumed this task had not been completed because of lack of capacity of the Directorate, as there were indications at an attempted start which might have failed. During the interview, the Director became flustered and angry. She said that she had tried to set up the process for the social workers to do the evaluation three times, and each time, just before they were about to visit the hospitals, the head of the facility concerned cancelled, giving different reasons why the assessment could not proceed. The Director complained that she felt she was being prevented from doing her work effectively.

To try to understand the reason why this pilot study had not been conducted, the evaluators decided to conduct **qualitative interviews** with the heads of the psychiatric facilities and other key staff members at these institutions. In the initial stages of these interviews, it appeared to the interviewers that there were indeed real and practical reasons why the assessments for community care could not take place. However as the skilled interviewers probed further, it become apparent that the heads of these psychiatric facilities and most staff members did not in fact want the assessments to take place. It became apparent that the reasons were, firstly, that they were convinced that patients would be discharged into the streets and that adequate community facilities would not be available to them. They were also concerned that money currently used to care for the mentally ill would be transferred to other priority areas. Secondly, and perhaps more importantly, the interviewers determined that the heads of these fairly large establishments had managed to develop influential power bases from their positions as heads and were reluctant to give these up. They were also afraid of where they may be redeployed and what status the new positions would have. Hospital staff, on the other hand, were afraid that the assessments would result in their losing their jobs if the hospitals were closed down or downsized.

Following due consideration, the evaluators recommended that all staff working in the inpatient, especially long-stay, facilities be brought into a consultation process. Though they realized that this could be a long and complex process, they suggested that unless key stakeholders supported the policy, it would be doomed to failure.

Following a number of meetings between health management and the heads of the establishments on the one hand and with hospital staff and trade unions on the other, a number of agreements were reached. For the first time an organogram of a more decentralized mental health system was designed. It was decided that in each district there would be a manager responsible for coordination and overall clinical responsibility of all mental health services at the primary, secondary and tertiary levels. This position would be graded at the same level of seniority as the psychiatric hospital managers. Workers, including nurses, at the hospital were assured that while there would be some redeployment, there would not be retrenchments. In fact, many staff members who were living far from their homes, because the psychiatric hospitals were situated mainly in remote areas, could return home because patients would need services in their areas of discharge.

The evaluators also conducted a **systematic review** of research and available information on institutional versus community-based care in developing countries, and the evaluators shared this with the hospital managers and staff in a series of seminars. It was also made clear that not all patients would be discharged, and that the concern that patients needing ongoing nursing care would be discharged was unfounded. It was explained that the individual patient assessments were taking place for that very reason. After some weeks, the staff, now convinced that the policy direction was the correct one, invited the social workers to conduct the assessment of which patients may be ready and able to be discharged.

Following this initial setback in time frames and no output in the first year, it was necessary to postpone each activity to a year later. A second monitoring process (in year 2) found that the pilot study had indeed been carried out that year, and that there were a number of people who could, and should, be discharged from the psychiatric institutions. Needs in the community, including the need for residential care, were identified. However, further activities were to a great extent dependent on the achievement of Strategy 2 (Strengthen community-based mental health services) and Strategy 3 (Improve access to and utilization of mental health services throughout the country, through decentralized mental health service delivery that is integrated into general health care). Nevertheless, further monitoring found that the activities concerned with preparing people for community care and discharging people to community care wherever possible continued throughout the policy period.

Monitoring and evaluation at the end of the policy period

The target set for this strategy was a 50% reduction in beds in psychiatric institutions.

As the number of beds in psychiatric institutions at the beginning of the policy and plan was known and the numbers of beds available at the end of the review period could easily be obtained, assessing whether the target was reached required only a simple calculation. This comparison showed a 40% decrease, compared with the target of 50%. It was therefore decided to reduce bed numbers by a further 10% in the following year, based on a calculation of the required number of chronic care beds needed on an ongoing basis (using the WHO module, *Planning and Budgeting to Deliver Services for Mental Health* (WHO, 2003a).

Strategy 2. Strengthen community-based mental health services.

Target:
Subject to the evaluation of the 4 pilot community mental health facilities the establishment of 10 additional community mental health facilities.

Indicator:
Number of community mental health facilities.

No activity was planned for year 1, as a needs assessment was to be carried out as part of Strategy 1 to assess the need for discharge of patients and what their requirements would be. As this was delayed by one year, the first activity in this strategy took place in year 3.

The assigned task of negotiating with the Ministry of Local Government to collaborate in the establishment of community-based residential facilities had been done and agreement reached for the establishment of four pilot community mental health centres in two rural and two urban areas. The output achieved was that specific written plans for collaboration in setting up the four facilities had been drawn up. A year later, the annual monitoring process found that all four pilot community mental health centres had been set up. Though this was a year late, following the initial lapse, implementation had gone according to plan.

The next major activity identified was to evaluate the success of these pilot facilities, and on the basis of that, establish further facilities. After a further year of allowing the community residential facilities to run, an evaluation was planned and conducted.

- **WHY was the evaluation conducted?**
  To establish the effectiveness of the community-based mental health centres, and to make recommendations as to whether additional facilities should be established.

- **WHO conducted the evaluation?**
  An independent team was assembled, and the evaluation took place using checklists of services provided and quality-of-care indicators.

- **HOW was the evaluation funded?**
  By the Ministry of Health.

Together with the Director of mental health services, the evaluators designed a checklist based on the departmental directives, which detailed the proposed functions of the community-based mental health facilities. They found that the most important functions the facilities were required to provide were:

- Short-stay residential facilities for patients with mental disorders who had no family or whose families refused to take them in.
- Day-care programmes to assist with the psychosocial rehabilitation of patients and to assist them to achieve more independent lives.
- Psychiatric medication for both residents and other community members requiring medical treatment.
- Outreach services to patients and their families, to facilitate the integration of previously institutionalized patients into family and community life.
- Liaison with non-health sector services, for activities such as employment skills training and job-finding services.

In each broad service category a list of quality indicators was drawn up (using the module, *Quality Improvement for Mental Health* (WHO, 2003b)) to assess the quality of the services provided. Using this, the evaluators found that two of the community mental health facilities were providing excellent services. Not only were all the required service areas available, but also the services were of a high standard. One of the other facilities was also providing all the required services, but in at least three of the service categories the standard of care was extremely poor. For example, while people went to day care, there was no rehabilitation programme for them – patients would sit around all day doing almost nothing. The evaluators also noted that the number of patients attending day-care had dropped significantly over the past year. A second example was that a psychiatric nurse dispensed medications once a week, but if there was a psychiatric emergency there was no one available to treat the patient. The fourth facility was poor, both with regard to the service areas covered and the quality of care. It had in fact become primarily a residential facility, which was beginning to get overcrowded. The evaluators noted that there was more and more demand for the residential care, and bed numbers were increasing.

These findings made it difficult for the evaluators to make a recommendation on the expansion of such services. They needed to find out **why** there were such wide differences in the quality of services. They first found that all the facilities had been given the same amount of funding, so this was not the reason for the differences. Secondly, the requirements of the services had been explained to all the facility managers, so it seemed that misunderstandings in this regard were unlikely to have occurred. As a first step they decide to interview the facility managers.

They found that the manager of the facility that was providing the least effective programme previously had been a manager of a psychiatric institution. He had had no experience of community care and it was clear to the evaluators that, despite his new position and mandate, his preference was for institutional care. For example, instead of buying a car for outreach work, as the managers of the other facilities had done, he had purchased the building next door, which he had converted to become part of the facility. It also became apparent in the interviews that this manager felt that people with mental disorders had few life skills and were best protected against exploitation and abuse by being placed in residential care. It also became clear that the additional demand for beds, which the manager felt vindicated his approach, arose largely because the other community services that should have been provided were not being given. As a result, the patients were relapsing and demanding the only care available.

The manager of the "middle functioning" facility was found to be highly committed to the plan and was providing a range of community-based services; however she had inadequate managerial skills. She had trained as a nurse and had performed extremely well in that capacity. Her promotion to become a facility manager had not been accompanied by specific management training. She was finding it very stressful to deal with staff, and the finances were chaotic. She could not afford to have a psychiatric nurse at the facility full time but only once a week. She intended to start the day-care rehabilitation programme but was unsure how to do this. Perusal of the financial records by one of the evaluators with extensive financial experience showed that there was a major waste of resources.

By contrast, the two managers in the well-functioning facility, one a nurse and the other a psychologist, were both committed to the concept of community care and were well-trained and well-functioning managers.

The recommendation made to the Government was that community care facilities could be effective and should be increased, but that unmonitored and unsupervised expansion would be disastrous. The evaluators suggested that a prerequisite of any new facility is that its manager should be well trained in the requirements of managing such a facility and that she or he should be committed to the objectives of community-based care. Extensive training should be given before any new facility was opened. They also recommended that all staff in a community-based facility be given training in community-based care. And since the shift from institutional to community-based care was difficult for most staff, initial training should be followed by ongoing discussions, supervision and assistance.

The Government accepted these recommendations and decide that deinstitutionalization would occur in a phased process with adequate training provided to all staff. Results of the evaluation were fed back to the different facilities and staff.

This example shows how monitoring needs to be complemented by evaluation, and how, in combination, service and policy decisions can be made.

In each of the subsequent two years, one additional facility was started. This involved extensive training of staff and support from the national office.

Monitoring and evaluation at the end of the policy period

The recommendation from evaluation of the pilot facilities had been that deinstitutionalization should occur as a phased process with adequate training of all staff. It was stated that "community care facilities can be effective and should be increased, but unmonitored and unsupervised expansion would be disastrous". Given this recommendation, the fact that two rather than ten additional facilities had become operational was considered satisfactory. It was decided that plans for further expansion should be included in the next phased plan.

Strategy 3. Improve access to and utilization of mental health services throughout the country, through decentralized mental health service delivery that is integrated into general health care.

Targets:
(a) Double the number of people seen with epilepsy and psychosis in regional hospitals and health care centres by year 5.
(b) Increase by 20% the number of beds available at this level by year 5.

Indicators:
(a) Number of people treated through regional hospitals and health care centres per 100,000 general population.
(b) Number of beds in community-based psychiatric inpatient units per 100,000 population and at least one facility per district.

Due to the pressures of other strategies in year 1, no activities were planned for this strategy for this year. However in year 2, two activities were planned. First, the regional health management team would be oriented and trained towards integrating mental health into general health care, and second, referral systems would be reviewed and developed between primary, secondary and tertiary levels.

The monitoring showed that in 8 of the 10 regions managers had been trained and oriented towards mental health integration. Of these, 6 believed that mental health could reasonably be integrated into general health care and were prepared to send staff for training and expand facilities, whereas the other 2 were reluctant to assume another function that would require considerable time and attention, since they were dealing with too many other problems.

In the six regions where the managers were amenable to integrated mental health care, systems for referral between levels of care were worked out and services set up to provide mental health care. This included introducing mental health care in primary health care services through the health centres and in the regional hospitals. The activities planned for the three subsequent years involved the provision of regular support and supervision to staff providing mental health within general health care. Records of supervision and support were available for monitoring, which indicated that these activities had been done (see also Strategy 5).

Monitoring and evaluation at the end of the policy period

An evaluation of whether the targets had been reached was undertaken.

> **WHY was the evaluation conducted?**
The Government wished to know whether the change in policy had led to achieving the targets for the number of people with epilepsy and psychosis treated in health centres.

> **WHO conducted the evaluation?**
An independent research organization was contracted.

> **HOW was the evaluation funded?**
By the Ministry of Health.

The evaluators

(a) Used the existing information system to collect and collate data on the number of people treated with psychosis and epilepsy in health centres.
(b) Conducted an evaluation in 10 random health centres in each of four districts to obtain information not available through the health information system.
(c) Assessed the qualifications of the primary care personnel at the health centres described in (b) as well as their training in mental health.

Their findings were as follows :

(a) Epilepsy was included in the routine statistical information system, but not psychosis. Based on available information collected and collated from the past five years the evaluators found a 10% overall increase in the number of people receiving medication for epilepsy at the health centres over the review period.
(b) Patient records from the four previous years were not available in the health centres to enable an assessment of whether there had been an increase in the number of people treated for psychosis. However, from some rudimentary records of the previous two years it was estimated that there had been a 15% increase in the number of people treated for psychosis during the period.

The evaluators also found there was considerable variation in mental health training between clinics. In two of the health centres, all of the personnel had been trained in mental health, with the majority having been trained over the past five years. However, in four of the clinics, no staff had been trained in mental health. In the remainder, some staff had been trained – all in the past five years.

The target had been to double the number of patients with epilepsy and psychosis seen in the health centres countrywide (both off very low basis). However, this had not been met in the six years since the implementation of the plan. The evaluators realized that the 10% increase in patients seen for epilepsy (derived from the mental health information system) and the 15% increase in the number of patients seen for psychosis in the two years in the random health centres needed to be disaggregated. While the averages gave important information concerning overall increases and progress towards meeting targets, equally important were the results from different clinics, and particularly the reasons why some clinics were doing far better than others.

The evaluators then did an analysis comparing the number of people seen in the different health centres with the numbers of staff trained in mental health at the clinics. They found that there was a direct correlation between the number of staff trained in mental health and the number of people seen for mental disorders. The findings clearly indicated that staff training was particularly important for increasing the number of people identified and treated in mental health. In the health centres where all staff had been trained, the number of patients seen had more than doubled, but no increases were evident in the other health centres.

It was concluded, that the policy clearly was being implemented and more people were being seen at a decentralized level, but this was sporadic and not being conducted in all regions. The evaluators informed the Government that, as anticipated in the plans, unless staff at the health centres were trained in providing mental health services, and unless there was total management commitment to this model at a regional level, full implementation of the policy was unlikely to be achieved.

Plans for further training of primary mental health workers in mental health and further meetings with the regional health managers would therefore need to be incorporated into the next 5-year policy and strategic plan.

Strategy 4. Recruit mental health staff, particularly in areas where there are existing staff shortages.

Targets:
A 30% increase in the number of dedicated mental health staff in each major mental health profession by year 5.

Indicators:
Number of full-time equivalent staff working in or for mental health facilities per 100,000 population by each major mental health profession.

Monitoring and evaluation at year 1

Activities in year 1 were: (i) review the existing staff establishment; and (ii) if any staff had left in the previous two years, review the reasons for their departure.

The outputs of this activity showed that the number of staff needed for working in mental health had been estimated and all vacant posts identified. However, a number of the staff who had been randomly selected to undergo an interview were not currently working in the system. It appeared that many had in fact left the country. The evaluators then decided that they should systematically establish how many people had left the service to work abroad. Results showed that 60% of the people who had left had gone to work in other, mainly more developed, countries. Of those that remained in the country but had left the service, the majority were from rural areas. When interviewed on their reasons for leaving, ex-staff complained of poor support and supervision of their work and not enough pay to keep them in these areas.

Ongoing monitoring

In accordance with the activities planned for subsequent years, active recruitment programmes were implemented and staff retention strategies devised – especially in rural areas. This included a rural allowance for doctors and greater support and back- up, such as the introduction of “telemedicine” whereby staff in rural areas could regularly contact experts in other parts of the country.

Moreover, in terms of the activities planned, recruitment strategies were devised to fill key target posts. District mental health coordinators (mental health nurses) were appointed in each district and included in the district health management team.

Monitoring and evaluation at the end of the policy period

> **WHY was the evaluation conducted?**
The Government wished to know whether the human resources for delivery of mental health had increased.

> **WHO conducted the evaluation?**
An independent organization specializing in human resources in health was contracted.

> **HOW was the evaluation funded?**
An international NGO agreed to fund the project.

The evaluators conducted the evaluation by first reviewing the number of graduates and people who had received diplomas and passed through each of the health training institutions in the country over the past four years. (Since year 1 of the policy was utilized for reviewing curricula, training started a year later.) They also documented the number of registered practitioners (i.e. currently practicing in the country) in each of the main mental health professions. They decided it would be necessary to collect information on both the number trained in the different professions and the number currently practicing as they were aware that for various reasons, such as emigration, training additional personnel did not necessarily mean that this would lead to the requisite additional human resources.

Their findings were as follows:

Health category	Total no.	No. trained in past five years	No. registered and currently practicing mental health care in the country
General nurses trained in mental health as part of initial training	350	350	350
General nurses trained in mental health – in-service training	200	200	It is unclear how many of the nurses who have undergone in-service training are practicing mental health, as there is no system of registration for them.
Interns rotating through psychiatry	50	50	All medical interns now rotate through psychiatry.
Psychiatrists	23	13	15
Psychologists	35	15	23
Psychiatric nurses	85	45	80
Social worker	240	80	55

- It was clear from these figures that a significant number of health personnel had been trained over the five years since the adoption of the policy. The evaluators noted that 550 general nurses had been trained in identifying and treating basic mental health problems: 350 as part of their initial training and 200 through ongoing in-service training. Prior to implementation of the policy, only psychiatric nurses treated psychiatric patients. As there were previously only 40 psychiatric nurses, the training had substantially increased the possibilities of integrating mental health care in primary health care in line with the new mental health policy.
- The number of psychiatric nurses had doubled in five years. At the start of the policy there were 0.2 psychiatric nurses per 100,000 population (i.e. 40 psychiatric nurses in total). There were now 80 psychiatric nurses practicing in the country. As 45 of them had been trained and there were previously 40 practicing, it was evident that 5 had left the services.
- A substantial number of social workers had been trained in accordance with the policy objectives.
- The objective of having medical interns rotate through psychiatry had been achieved. All trained doctors now had experience and training in psychiatry.
- The training and number of psychiatrists and psychologists was both encouraging and distressing. Over the five years since the adoption of the policy, 13 psychiatrists and 15 psychologists had been trained. However, given the numbers of psychiatrists and psychologists in the country at the start of the policy (i.e. 10 psychiatrists – 0.05 psychiatrists per 100,000 population – and 20 psychologists, or 0.1 psychologists per 100,000 population), there should have been 23 psychiatrists and 35 psychologists instead of 15 and 23 respectively. As there had been no retirements during the five-year period, this meant that **more than one third of psychiatrists and psychologists** had left the country to practice elsewhere.

Given the results of this evaluation, the Government was particularly concerned at the loss of mental health professionals from the country. It checked up on the professionals who had left over the past five years and found that 80% of them were practicing in developed countries where there were far better ratios of professionals to population. They also had better working conditions and opportunities for professional growth and development. Consequently, it was decided to join with other countries in the region to develop a policy to retain mental health professionals, together with other health professionals who leave the country after training. In addition, the evaluators noted that some of the strategies developed to retain staff, such as a rural allowance for doctors and greater support and back-up, including the introduction of “telemedicine” whereby staff in rural areas could regularly contact experts in other parts of the country, needed to be evaluated. The Government acknowledged that still more had to be done to realize its goals and, accordingly, set up a task force to evaluate the strategies.

For the sake of simplicity, increases in the population of the country were not taken into account in this example.

Strategy 5. Undertake extensive mental health training programmes for all health staff, including general health workers and mental health specialists.

Targets:

(a) Training in mental health provided to 50% of generalist staff in regional hospitals and health care centres by year 5.
(b) All mental health staff to undergo at least two days of in-service training every year.
(c) All nurses and doctors to have six months in psychiatry as part of their general training by year 5.

Indicators:

(a) Proportion of generalist health staff in primary care clinics trained in mental health.
(b) Proportion of mental health staff working in or for a mental health facility with at least two days of refresher training in an area relevant to the new mental health organizational structure.
(c) Proportion of undergraduate (1st degree) training hours devoted to psychiatry and mental-health-related subjects in medical schools (doctor training) and in nursing schools.

Four activities had been planned for year 1 of this strategy. Monitoring of these activities at the end of year 1 showed that a review of the mental health component used in undergraduate training and the review of the specialist post-graduate mental health programme had been done. Both had been found to require revision. However, the plan to undertake this revision in year 1 had not been achieved; neither had the in-service training modules for health workers been developed according to the plan. While negotiations had started for inclusion of psychiatry in the rotation of medical interns, no agreements had been signed so far. The monitors suggested that additional efforts would be necessary in years 2 and 3 to compensate for the limited success of year 1.

Ongoing monitoring found that the tasks remaining from year 1 were completed in year 2. Further monitoring found that progress had been made in that a programme for training generalist staff in mental health in primary care clinics had been set up; post-graduate training had been revised and upgraded; a recruitment programme to encourage students to study psychiatry (including psychiatric nursing) had been introduced, and in year four psychiatry had been included as part of the rotation of medical interns (see also results of evaluation of Strategy 4).

Monitoring and evaluation at the end of the policy period

To assess the extent to which generalist as well as specialist mental health staff had been trained in mental health, a survey was sent to each district mental health manager, who had been appointed under the terms of Strategy 4, to provide details of training in their district.

As found in Strategy 4, in 6 of the 10 districts there had been a substantial increase in the number of generalist staff trained in mental health, but in 4 of the districts no training had taken place at all. Given the total number of generalist staff working in primary clinics, an increase of 30% had been achieved. This fell short of the target by 20%. The evaluators suggested that more attention be given to the four districts in which no training had taken place.

On the other hand, in-service training for mental health practitioners was highest in the areas where no generalists had been trained. While this training was seen by the evaluators to be laudable, this finding appeared to reflect an emphasis in these districts to improve the "vertical" services provided rather than integrate the services. In all, 65% of mental health workers had received at least two days training in the two years prior to the monitoring. While this clearly fell short of the target, it was explained to the evaluators that in the areas where generalist staff had been trained, due to resource difficulties it was not possible to send all the mental health staff for training.

The evaluators visited all the educational facilities in the country where health workers were trained. They found that in year 5 all doctors were rotated through psychiatry as part of their internship. In addition, they attended a six-month course in psychiatry in their undergraduate training. With regard to nurses, it was established that there were four training colleges. Of these, two had included six-month training in psychiatry as part of the comprehensive training. The other two colleges were still examining how this change might be accommodated into their curriculum and were closely monitoring the impacts at the colleges where the training had been included.

Strategy 6. **Establish quality improvement mechanisms for mental health care.**

Targets:
(a) Full quality standards for different levels of mental health services set and three monitoring boards appointed and trained by year 3.
(b) Quality assessments conducted annually in 50% of community and general hospital services and in all psychiatric hospitals.

Indicators:
Proportion of mental hospitals and community-based mental health facilities with at least one annual external review/inspection of human rights of patients and quality of care.

The development of national standards for mental health was to take place in years 2 and 3 of the plan, while the establishment of monitoring boards which would examine and accredit facilities, was planned for years 3 to 5.

Standards for Mental Health Services were developed according to schedule. This document set formal, measurable criteria for the way in which care should be delivered. The standards, established with the agreement of the providers of services, were challenging but not to the extent that they could not be attained. The rights and legal protection of people with mental disability were safeguarded, but taking into account the resource constraints of the country. The standards set were based on the WHO quality assurance checklists (WHO, 1994; 1997) and on the *WHO Module on Quality Improvement for mental health* (WHO, 2003b).

In year 4, clinical practice guidelines for mental health interventions were developed by the consultant psychiatrist. In year 5, these guidelines were incorporated into the orientation and training wherever mental health training was being offered.

Monitoring and evaluation at the end of the policy period

> **WHY was the evaluation conducted?**
To ensure quality care standards were set, maintained and improved.

> **WHO conducted the evaluation?**
An evaluation team within the Ministry of health.

> **HOW was the evaluation funded?**
The Ministry of Health.

The evaluation had two facets: (i) to establish how many facilities were using the standards document; and (ii) to assess the quality of care provided.

The evaluation team found that, in accordance with the targets set, three monitoring boards had been set up in different parts of the country. These monitoring boards consist of service users/family members, representatives of NGOs and mental health professionals. Quality assessments had been conducted annually in a total of 10 community facilities (including primary health clinics), 6 general hospitals and all the psychiatric hospitals. This was far lower then the 50% community facility target, but in line with the number of hospitals planned for quality assessment.

The evaluation team carefully examined the results of the boards' assessments relative to the quality standards set. It also took careful note of the recommendations of the monitoring boards. It concluded that the quality standards set were being reached with respect to the inpatient services, but that the quality of care in community clinics and at the outpatient level was inadequate.

It noted particularly that there had been substantial improvements in almost all of the inpatient facilities since the introduction of the quality standards, and that regular assessments had been taking place. It attributed the improvements in part to the quality standards that had been developed. Facility management and staff had come to know what was expected from the facility and were able to adapt accordingly. For example, standards for seclusion and mechanical restraint of patients had significantly improved, both in terms of reducing the number of people who were secluded and restrained and the regularity with which they were checked. The team also attributed the quality improvements to less overcrowding resulting from the policy of deinstitutionalization.

The community facilities had not reached the quality standards in a number of respects. The evaluators suggested that some of the findings of previous, more specific evaluations undertaken and the recommendations arising from them would need to be implemented with greater urgency in order to meet the quality criteria. For example, patients at community level were not receiving their medication regularly; community facilities set up when patients had been discharged from long-stay hospital care were inadequate, and additional, qualified mental health human practitioners needed to be trained with ways found to keep them in the country to support integrated primary mental health care. Other recommendations related to the accessibility of community services and inadequate follow-up of patients who did not come for treatment on their appointment day. Recommendations were made to the service providers and managers of community-based facilities on how quality improvements could be made to meet the agreed standards for community mental health services.

The main broad conclusion emerging from the quality evaluation was that far more effort would be needed to improve the quality of care at outpatient level. While inpatient quality should not be neglected, major developmental initiatives were required for the newer clinic and outpatient services.

Strategy 7. Improve the supply and utilization of essential psychotropic medications.

Targets:
Psychotropic drugs on the revised Essential Drugs List to be available at the appropriate primary and secondary level health facilities 100% of the time by year 3.

Indicators:
Proportion of mental hospitals, community-based inpatient and outpatient/clinic facilities with the psychotropic drugs listed on the appropriate EDL available in the facility or in a nearby pharmacy throughout the year.

According to the activities of the plan, during the first year the Essential Drugs List (EDL) was to be reviewed. This was done. In years 2 and 3, staff were to be oriented and trained in the use of the new EDL and the procedures for ordering drugs revised. The evaluators established that this had been included in the training in mental health as part of Strategy 5. In years 4 and 5, processes were put in place to ensure the availability of psychotropic drugs at all relevant facilities.

Distribution of Psychotropic medication

As part of the monitoring process, during year 4 it was decided to conduct an investigation to establish whether the drugs were reaching the patients that required them. Routine data from the health information system had indicated more relapses than desirable, and there was some speculation that this may be due to drugs not being routinely available to patients.

> **WHY was the evaluation conducted?**
It was unclear whether the drugs available on the EDL were reaching patients.

> **WHO conducted the evaluation?**
An independent evaluation company was contracted.

> **HOW was the evaluation funded?**
Funding was obtained from the local embassy of a developed country.

Evaluators decide on a three-pronged **process evaluation** approach. They:

(i) Randomly chose 10 facilities at primary, 3 at secondary and 2 at tertiary level, and made unannounced visits to see whether all the drugs required at each of those levels were available, whether there were adequate stocks of the drugs and whether they were being properly stored.
(ii) Checked through records of drug supplies over the past year to assess whether any had run out.
(iii) Interviewed staff on whether they had experienced drug shortages and, if so, the reasons for this.

The combination of these evaluation processes revealed that only some of the drugs on the EDL were regularly available to patients. To understand where the problems arose and to help rectify the problem of shortages, it was decided to conduct an evaluation. The evaluators consulted the WHO module, *Improving Access and Use of Psychotropic Medicines* (WHO, 2005d), for guidance on what might have gone wrong, applying it to the information they had collected from their site visits, record reviews and interviews.

They concluded that the reasons for the irregular availability of the psychotropic medicines appeared to be a combination of *poor procurement practices, inadequate distribution strategies and various practical difficulties*. It was found that certain medicines were not always available at the central stores, but also that drugs on the shelves of the stores in certain clinics had passed their expiry date, while patients in more remote areas went without medication as they were not available at the clinics they visited.

The evaluators then interviewed the store's manager who informed them that certain drugs were available only periodically due to their high costs. At certain points in the year there was just not enough money left to buy the psychiatric drugs, which meant that these could not be supplied. The evaluators recommended a series of alternatives, derived from the module *Improving Access and Use of Psychotropic Medicines*, to make medications more affordable and accessible.

In addition, using this module, the evaluators made a number of recommendations for the efficient storage and distribution of medicines. They found, particularly, that staff required training in operational planning and logistics. Moreover, the investigation found that the shortage of medicines in some clinics was due to the lack of regular transport and poor roads, as well as some pilfering of medication. Steps to improve this situation were suggested.

As a result of the evaluation, the Government was able to secure cheaper drugs and make them more readily available to the clinics through improved supply management.

Monitoring and evaluation at the end of the policy period

In year 4, an evaluation found that there were problems with both the supply and distribution of psychiatric drugs. Various recommendations were made to improve the situation. Two years after this study was conducted, it became necessary to find out whether there were any service improvements.

> **WHY was the evaluation conducted?**
To assess whether psychotropic medication was available at primary and secondary level health services.

> **WHO conducted the evaluation?**
The Ministry of Health, through an internal assessment.

> **HOW was the evaluation funded?**
By the Ministry of Health.

As funds were in short supply, it was decided to conduct phone interviews with each of the facilities that had been involved in the initial evaluation. An additional three facilities at each level were also interviewed by telephone to ensure that there were no biases in the previously studied facilities. While the target of 100% availability of medication still had not been met, drugs were now available over 90% of the time. This was regarded as a very significant improvement. Nonetheless, mechanisms to reach the 100% target were planned.

3.5 Additional evaluations

(i) Responding to public opinion

Sometimes it is necessary to conduct an evaluation for reasons other than those prompted by the Ministry for its own planning purposes. For example, the Government may respond to a swell of public pressure, or opposition political parties may ask questions that require evaluation. Nonetheless, the results of the evaluation are usually of significant benefit to the mental health policy-makers and planners as well. In addition, if an evaluation is conducted in response to pressure, it is possible to use the opportunity to also answer some questions the government may have raised which could not previously be answered.

Example:

Human rights abuses

Within the two years of the adoption of the policy there had been numerous articles in newspapers about the lack of human rights for people with mental disability, particularly regarding the conditions in psychiatric institutions. The Ministry of Health was concerned that even though it had recently developed a new human-rights-oriented policy, public dissatisfaction with mental health services appeared to be increasing. It was also concerned about alleged human rights abuses. It therefore decided to appoint a three-person team comprising a mental health professional, a person with legal qualifications and human rights experience and a community member to conduct an assessment of conditions in psychiatric facilities and to report its findings directly to the Minister.

> **WHY was the evaluation conducted?**
To respond to complaints about human rights abuses.

> **WHO conducted the evaluation?**
A three-person team comprising a mental health professional, a person with legal qualifications and human rights experience and a community member, and this team visited various institutions.

> **HOW was the evaluation funded?**
An international human rights organization agreed to fund it.

Using a series of documents employed in other countries for evaluating conditions in psychiatric institutions, the evaluation team drew up a set of standards in a number of areas against which to measure whether the services were indeed abusing patients' rights. These included areas such as the use of seclusion and restraints, rights to informed consent and confidentiality, the physical conditions of the institutions and the availability of rehabilitation programmes. They then made unannounced visits to each of the institutions.

The findings revealed a mixed picture. While the investigation did find prevalence of the kinds of abuses reported in the press, it noted that these were the exception rather than the rule, contrary to press reports which generalized the situation as applying to all inpatient mental health care. It also found a generally highly committed staff who were working in difficult conditions. Nonetheless, the team was concerned that a number of people were being unnecessarily kept in the institutions without their consent and that they should be discharged into community-based programmes.

The main findings of the team were that the mental health policy that had recently been adopted addressed most of the major problems, but that policy implementation required more support from the Ministry. They also made some specific recommendations to improve physical conditions in certain facilities and to train staff (particularly those in certain facilities) with regard to patients' rights.

After considering the report, the Minister announced that the human rights abuses found by the evaluation team, both in terms of behavioural practices and physical conditions, should be addressed with immediate effect. She also reiterated her commitment to ensuring implementation of the policy according to plan. The initiative was also linked with Strategy 5 in the Action plan, which was to get ongoing monitoring boards in place to undertake regular inspections of quality of care.

(ii) Economic evaluation

Mental health services need to be allocated adequate budgets to promote effective outcomes for people with mental disorders. However an increase in the allocated budget does not necessarily lead to improved mental health of the population. It is the translation of the resources into effective interventions that brings benefits (see the WHO module, *Planning and Budgeting to Deliver Services for Mental Health*, WHO, 2003a).

If the same outcomes can be achieved by different modes of intervention, the one that achieves the objective at the least cost is usually preferable (i.e. cost-effective). Of course this does not mean that the end can justify any means because they are cheaper; for example, human rights and ethics must always be respected. Studies that can show cost-effectiveness are thus important. Sometimes, however, the cost is not immediately obvious. This can be because the cost is less direct, is spread over a longer time period or the benefit is an "opportunity" cost (i.e. benefits are accrued elsewhere, such as to the family rather than the health service).

Example:

In the hypothetical country of the case study, certain psychiatrists were unhappy because they believed that new, far more effective medication was available internationally for the treatment of psychosis, but because the drugs were substantially more expensive they were not included in the Essential Drugs List and hence could not be used. The psychiatrists believed that there would be major benefits if these medications were permitted, and that there would be no or only minimal additional overall costs to the health service. They argued that it was "poor economy" to disallow use of the new medicines. The Ministry of Health agreed to evaluate this issue.

> **WHY was the evaluation conducted?**
To assess whether costs to the health services as a whole would be higher if patients received more expensive antipsychotics.

> **WHO conducted the evaluation?**
The study was put out to tender and won by a health economics research organization.

> **HOW was the evaluation funded?**
An international research organization agreed to fund this research.

Psychiatrists identified 300 patients suffering from schizophrenia in outpatient treatment. These patients were then randomly assigned to one group which continued to receive the current medication (control group) and another which received the new treatment (experimental group). Besides the medication, patients in both groups received the same level and quality of care. Important costs accrued to the health service (days spent in hospital and grants given by the State to patients) were noted for all 300 patients. In addition, all patients were assessed in terms of a composite disability measure at the beginning and at the end of the two-year period. At the end of the two years it was found that, based on health service costs (i.e. the amounts spent on the different medications, number of hospital days for each group and disability pensions paid), more money had been spent on the experimental than on the control group – i.e. it had been more expensive to the health service as a whole to treat patients with the new generation medication than with the old. It was also found that there were no better outcomes on the composite disability measure among the experimental group.

On the basis of the health service costing evaluation and the fact that there were no benefits in terms of the disability measure, the Ministry of Health decided not to introduce the "atypical" anti-psychotic medication onto the Essential Drugs List.

However, in analysing the details of individual patients recruited to the study, the evaluators found that certain patients, who over the years had not responded to the available treatments at all well, had done well on the newer medication. At an individual level, in a small subgroup of patients there were also cost savings. A decision was therefore taken that the few patients who repeatedly failed to respond to the drugs available on the Essential Drugs List could be given the newer and more expensive medications following an assessment by a psychiatrist. However this would need annual review.

Results of the research with the recommendations were fed back to the patients who had participated and to the psychiatrists who had initially requested the research.

3.6 Evaluating the extent to which policy objectives have been achieved

At the completion of the planning cycle it is necessary to evaluate whether the objectives defined in the policy, and which the plan was drawn up to achieve, have in fact been achieved. As previously mentioned, evaluating the success of the policy is difficult, and though the results of the monitoring and evaluation of the implementation of the plan provide good markers of how well the objectives have been reached, further research, judgements and interpretations may be required.

Objective 1. Reduce the emphasis on institutional care for people with mental disorders

Evaluation of the targets indicated that there had been a 40% reduction in the number of institutional beds, and that six community-based facilities were operational. Though this was less than the target aimed at, given that the recommendations of the research into the community facilities had suggested that the expansion should be done cautiously and with extensive training, the move away from institutional care was regarded as substantial. However, the Government was also concerned to know at this point whether the quality of life of the patients had improved, whether they were receiving other community-based services, and whether patients and their family members were satisfied with the changes. The policy could not be regarded as "successful" until these facts had also been established.

Example:

Fortunately the designers of the policy realized soon after it was passed that it would be important, not just for the country but possibly also for the sake of other developing countries wishing to introduce such a policy, to evaluate the **outcomes** of the deinstitutionalization policy. For this reason they approached a major international research agency and paired local researchers with the agency to conduct research on the outcomes of the policy and plan. Funding for the evaluation was obtained from a bilateral donor.

> **WHY was the evaluation conducted?**
Government wished to know whether community-based services were being provided to patients and whether the outcomes of this programme were favourable to the patients and family members.

> **WHO conducted the evaluation?**
A major international research agency paired with local researchers.

> **HOW was the evaluation funded?**
By an international research agency.

The evaluators traced a randomly chosen 20% of all patients discharged within the first three years of the deinstitutionalization policy and plan. If a patient could not be traced the next person on the list was taken until the 20% was reached. Of these, 10% had relapsed and had returned to institutional care, while others had experienced short relapses and had been hospitalized for periods but then returned to the community. In all, 70% were receiving medication from the health care centres and 50% were involved in psychosocial rehabilitation programmes of various kinds run by the Department of Social Welfare. Ten percent were accommodated in the community-based facilities built as part of the deinstitutionalization plan, while the remainder were staying with family or friends.

Only 5% of patients that remained in the community said that they preferred the institution and would want to return. Though for many, life was difficult, with high unemployment and dependence on family and friends for survival, they nevertheless considered life outside the institution as preferable to the hardships experienced while in the institution. In particular, in expressing their preference to be with family and friends, patients noted that they received better food and were able to see and speak to the opposite gender and interact with children. A pre-and post-discharge quality of life survey showed similar results – only 4% experienced a better quality of life in the institution.

Family members were somewhat less enthusiastic about having the patients at home with them: 40% of those interviewed said they would prefer the family member to be back in hospital. The main reasons for this were that the patients disrupted family life, that at least one family member was prevented from seeking work because the mentally ill member needed to be looked after and that having an extra person to feed and clothe put tremendous additional stress on the family. However 80% of people who wanted the patient back in the hospital said that they would change this position if they were given financial assistance, while 50% said they would change this position if they were given some emotional help themselves to assist them in coping with the patient.

On the basis of these results, and after examining mental health expenditure, the evaluators recommended that more be spent on community-care programmes and grants to people with severe mental illness, as the principle agreed upon at the time of the adoption of the plan, that "the money spent on each person for institutional care would follow them into the community", was not being adequately applied. Savings made from reducing bed numbers in the institutions had been used for health services other than mental health and this was undermining the success of the policy.

The Government admitted that it had failed to honour its commitment not to divert money spent on mental health to other programmes. However, since the plan had been introduced, there has been a large-scale outbreak of an unanticipated infectious disease that had required substantial funding. The Government indicated that it was seeking new resources to combat this disease and expected to be able to assign more resources into community mental health care within a short while.

Objective 2. Expand community-based mental health services so that they become accessible to all people in need

The monitoring and evaluation already conducted for the hypothetical country with regard to accessibility through community-based mental health services revealed an increase in community care facilities (6 were operational); an increase in the number of patients seen in general health care (targets had been met in 6 of the 10 regions); an increase in mental health staff (e.g. the number of psychiatric nurses had doubled) and greater availability of psychotropic medications (90% of users received drugs in health centres when needed). Even though not all the targets had been reached, significant improvements had been made in each of these areas, suggesting far greater accessibility to services. However, the Government also wished to know how well other departments such as Labour, Housing and Social Services had been progressing with respect to improving the lives of people with mental disability. As there was no funding available to conduct primary research to assess the number of people with mental disorders who were in employment, the number of people with mental disorders who had been provided with housing or those on disability grants since the new policy was implemented, it was decided to collaborate with these departments to obtain whatever information was already available.

> **WHY was the evaluation conducted?**
The Government wished to know how the other departments were progressing in meeting the needs of people with mental disorders.

> **WHO conducted the evaluation?**
Officials in the Ministry of Health collaborated with officials in other departments to extract and collate the relevant information.

> **HOW was the evaluation funded?**
No additional funding was needed; officials in each of the other departments had to devote some of their time to help with this evaluation.

From information available in the national database of employment, it was found that 0.3% of formally employed people had mental disabilities, up from 0.1% five years previously. The policy of employing people with mental disabilities therefore appeared to be bearing some fruit, but more effort was considered necessary. Though the Department of Housing had given a commitment to allocate housing to people with mental disability at the beginning of the policy period, no records could be found to indicate that this had been followed through. While there was some anecdotal information that houses had indeed been allocated, no systematic record had been kept. The Departments of Health and Housing agreed that this was a priority and that in future joint monitoring would be conducted on an annual basis.

Disability grants for people with mental disorders had only been agreed by parliament the previous year. Substantial problems had been experienced in terms of how disability should be assessed and by whom. However, this had since been resolved, and it was found that 400 people had already been given grants. It was agreed between the Ministries of Health and Social Services that this would also be monitored on an annual basis.

Objective 3. Integrate mental health into general health care

This policy objective had to some extent been assessed when examining the targets for Strategy 3. Here, it was concluded that although the policy was being implemented, and significant progress had been made in integrating mental health at primary care level, particularly in health centres, the results fell short of the targets. The Government was also concerned that although there had been significant increases in the number of staff trained (see Strategy 4), it was possible they were not being deployed in a way that increased accessibility. It was therefore decided to conduct an evaluation on the deployment of human resources.

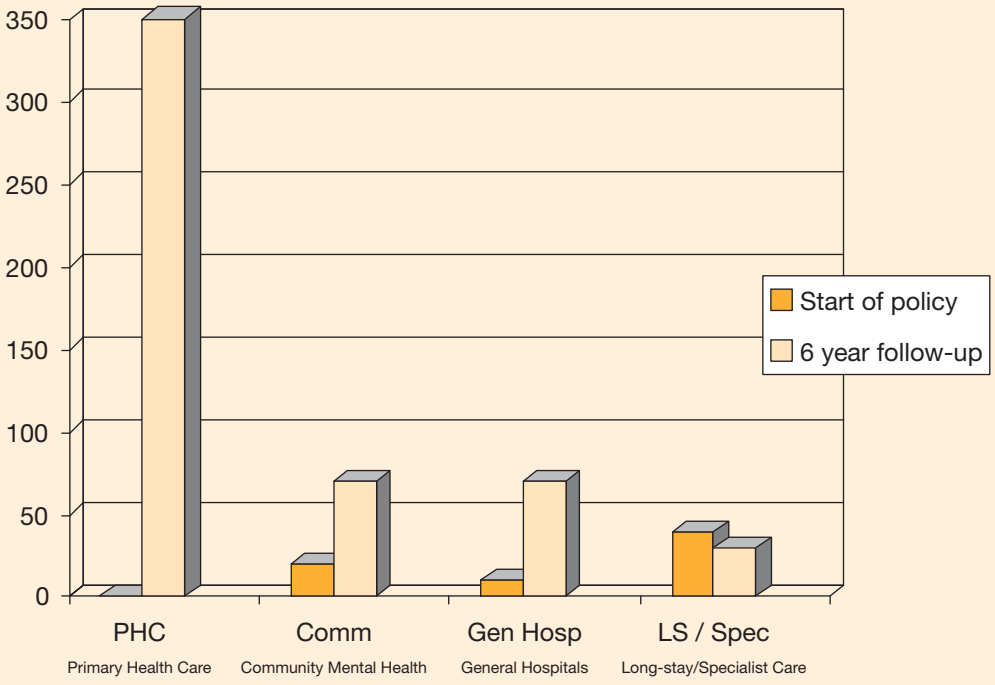
> **WHY was the evaluation conducted?**
The Government wished to know who was working in mental health, at what levels and whether this conformed with the human resources plan that had been designed. It also wished to know the skills of the staff performing different functions.

> **WHO conducted the evaluation?**
Tenders were invited and won by a local university.

> **HOW was the evaluation funded?**
By the Ministry of Health.

The aim of the human resource objectives was to treat the largest number of people in primary health care services and the least within long-stay and specialist services. Even more people were likely to be seen in informal community care and self-care but these were not part of the Government-provided mental health service.

The evaluators collected information on the deployment of personnel providing mental health care both at the start of the policy and at present. The following graph clearly shows major shifts in the placement of mental health personnel (excluding general nurses and nurse aids in hospitals) and in the provision of services since the introduction of the policy.



Three striking changes are evident from this graph. First, the total number of personnel providing mental health services had risen dramatically. This was primarily due to the larger number of general health workers providing mental health care. Prior to the new policy, mental health had been provided as a vertical service and thus no staff had been providing mental health care at this level. These additions then were not supplementary to the existing staff establishment, but were added skills and functions. However, in addition, and as was evident from the previous example, this graph illustrates that the total number of personnel providing dedicated mental health care had increased significantly since the start of the policy. Second, the increases in dedicated mental health personnel had occurred at community mental health and general hospital levels rather than at the long-stay/specialist facilities. Third, the graph shows a reversal of the pyramid of staff providing mental health care: at the start of the policy the largest number of staff worked at the long-stay/specialist level and the smallest number in primary care, but this had been spectacularly reversed by year 6.

The evaluators also examined the types of mental health workers at the different levels. They found the following:

Health category	Professional category	Number
Mental health services through primary health care	General nurses	350
Community mental health services	Psychiatrists (mainly supervisory and seeing patients who are difficult to treat)	2
	Psychiatric nurses	30
	Psychologists	10
	Social workers	31
Psychiatric services in general hospitals	Psychiatrists	4
	Psychiatric nurses	40
	Psychologists	7
	Social workers	19
Long-stay facilities and specialist services	Psychiatrists	9
	Psychiatric nurses	10
	Psychologists	6
	Social workers	5

The evaluators concluded that there was a relatively good distribution of scarce mental health skills across the four main mental health service areas. However, they felt that there were far fewer social workers working in mental health than may have been evident from the evaluation that had sought to gauge the extent of trained human resources. This information showed that there were 300 social workers trained in the five years, but not all of them had competencies to deal with mental health and not all were working in mental health. Although 80 social workers had received specific training in mental health over the previous five years, only 55 were working in mental health.

Due to the necessity of sustaining the strategy of integrated mental health and the need for health care staff to be committed to providing mental health services, the Government decided to assess the attitudes of generalist health staff to providing mental health care.

> **Why was the evaluation conducted?**
The Government wished to know the attitudes of the general health staff to providing mental health care.

> **Who conducted the evaluation?**
A post-graduate student conducted the evaluation, with supervision from her professor. This would count towards her degree.

> **Who funded the evaluation?**
The student concerned raised funds for it through a post-graduate bursary programme.

The evaluator decided to assess attitudes towards providing mental health care among three different groups: nurses trained to provide mental health care and providing such services, nurses trained but not providing mental health care, and nurses who had not (yet) been trained in mental health. In all other respects the nurses were similar (e.g. in education levels, years since initial training and place of work). A questionnaire was sent to randomly selected nurses in each category. The results showed that those who had not been trained in mental health stigmatized mental illness and were the least likely of the three groups to want to have mental health in their scope of service provision. On the other hand, nurses who were trained and already providing mental health care stigmatized such illness the least, and were the most willing to provide mental health care. Results therefore indicated that training reduces the stigma surrounding mental illness and increases the willingness to provide mental health care to some extent, but it is the actual working with people with mental illness following training that most significantly changes attitudes and willingness to conduct mental health interventions as part of general health care.

It thus became clear to the Government from this research that initial resistance to working with people with mental illness and stigmatization could be combated by training people and by their working in mental health.

Objective 4. Promote and protect the human rights of people with mental disorders

The promotion and protection of the human rights of people with mental disability can be measured in various ways. For example, greater accessibility to services, living in a community rather than an institution, availability of medication when needed, not being sent to a prison due to behaviour caused by mental illness, being able to vote and having decent quality of care are all as much human rights as not being physically abused, unnecessarily secluded, mechanically restrained or held for political reasons. Given this and the results of the above monitoring and evaluations, significant progress had been made in promoting the human rights of people with mental disorders in the six years since the adoption of the policy. However, given that the media had uncovered human rights abuses after two years of implementation of the plan and that various recommendations and instructions for change had been issued at the time, the Government decided to convene the same team that had conducted the investigation four years earlier to repeat its evaluation.

Example:

The evaluators used the same methods and instruments as they had for their first assessment. Through this they were not only able to investigate human rights abuses, but were also able to compare their results with their previous assessment. The findings showed a marked improvement. The incidence of abuse within facilities had decreased and the number of people unnecessarily institutionalized had declined significantly. The team still found most of the staff to be highly committed, displaying interest and caring about the welfare of patients. Almost all the specific recommendations regarding improvement of physical conditions in particular facilities had been acted upon, but the staff had not been given training about human rights.

In terms of the objective of protecting and promoting human rights of people with mental disorders, it was therefore found that the health service was on the right track and making steady and significant progress, although more needed to be done.

Objective 5. Ensure the delivery of high quality, evidence-based interventions for mental health promotion, prevention, treatment and rehabilitation

When the policy was drawn up, a process had been undertaken to examine the evidence for optimal mental health systems and services for treatment and rehabilitation. An independent team had also assessed the policy and plan to make sure that it took into account the latest evidence. Delivery of services according to this plan was largely measured by the extent to which the targets of the six strategies had been reached. However it was decided to conduct a survey of key stakeholders to obtain their views concerning the success of the policy.

> **Why was the evaluation conducted?**
The Government wished to hear the views of a range of stakeholders as to whether or not the policy had been a success.

> **Who conducted the evaluation?**
A local research organization specializing in running focus groups was commissioned.

> **Who funded the evaluation?**
The Ministry of Health.

Qualitative evaluation

To assess the views of various stakeholders regarding the success of the mental health policy in improving the quality of treatment and care provided, eight focus groups were set up: two consisting of consumers, two of family members, one of senior mental health managers, one of mental health middle managers and two of mental health staff (one hospital, one community). An appropriate set of questions was designed to determine whether participants thought the objectives had been achieved during the six years of implementation, as well as their views on the policy itself.

The results showed that participants believed that while not all the aims in developing the new policy had been achieved, mental health services in the country had been fundamentally transformed during the six years. With few exceptions, the focus group participants stated that the changes brought about by the policy had been for the better and that the mental health services were much more accessible and equitable. Staff, service users and family members all felt that the rights of people with mental disability were far more respected than before. A number of problems experienced at the beginning of policy implementation, such as poor drug supplies and lack of staff at primary care level that knew anything about mental health, had substantially improved. However areas noted for their absence, despite being identified as essential aspects of the policy, were the creation of links with traditional healing systems and better cultural understanding of mental health and illness by health workers.

Despite the relatively bumpy start of the new policy, all members of the focus groups felt they had been included in decision-making and that if they had complaints about services or plans, these were noted and acted upon.

All agreed that it was time for a new policy, although almost all also agreed that the new policy should not be substantially different from the existing one.

The objective of the policy had been not only to improve treatment and rehabilitation but also to give more attention to prevention and promotion. When drawing up the plan, however, it had been decided to concentrate resources on treatment and rehabilitation. Given that services were now reoriented to a more primary health care approach, additional resources were available for mental health and substantial progress had been made. It was therefore recognized that it would be necessary in the future to give significant attention to prevention and promotion activities.

Report to the Minister on six years of implementation and evaluation of the Mental Health Policy

Taking the results of all the evaluations conducted in the six years, the results of implementation of the seven strategies, evaluations of the objectives, additional evaluations conducted and the results of the focus group interviews, the relevant section in the Ministry prepared a report for the Minister which showed that the policy had resulted in substantial changes. Notable achievements were a far more community-based approach to care, substantial integration of mental health into primary health care, far greater respect for the human rights and dignity of people with mental disorders, improved quality of care and more people trained in mental health.

As indicated by the focus groups, it was recommended to the Minister that the new mental health policy should not be significantly different from the existing one, that the principles and values did not need changing, but that plans were needed for better implementation in certain areas such as prevention and promotion. It was also suggested to the Minister that before embarking on a process of consultation and negotiation for a new policy, it would be important to conduct a new, systematic review of the international literature to see whether there had been any new policy developments in mental health (especially mental health in developing countries) that might provide guidance in moving in new and different directions.

4. Recommendations and conclusions

Monitoring and Evaluation are key elements of policy development and restructuring processes.

- Monitoring and evaluation are key elements of policy development and restructuring processes.
- A policy document and the plans derived from it must be evaluated with respect to the process of developing the policy and plan and the contents. Thorough consultation must precede the formulation of the policy and plan and they should be based on local needs and resources, follow up-to-date international best practices and be feasible and appropriate for the country.
- Monitoring the plan is extremely important to ensure that the implementation proceeds according to a defined set of activities, timetables and budgets, and to assess whether the outputs are being realized. Where difficulties are identified, they can then be rectified. Moreover, monitoring the plan and knowing what has and has not been achieved ensures that the policy is not evaluated "as if" it had been implemented, but on actual implementation.
- Where the plan is not being implemented as intended, an evaluation may be needed to understand the reasons for this.
- There are many ways of conducting evaluations. Depending on the human and financial resources available, the questions that need to be answered and the time frame available, different methods are appropriate. Quantitative and qualitative research is important for evaluation of a policy and plan – and in certain circumstances both may be needed. In some situations a rapid appraisal may be appropriate, whereas in others, in-depth research involving, for example, an experimental design (such as a randomized controlled trial or in-depth interviews) may be more appropriate.
- At the end of a policy period it is important to assess whether the objectives set have been reached.
- Good evaluation depends to a large extent on a clear and focused policy and plan. However, even if this is not the case, evaluation is still possible.
- While evaluation may be perceived as an unnecessary expense and a time-consuming activity, good evaluation, on the contrary, can often save money and time.
- Evaluations can often assist in overcoming obstacles to progress – sometimes even when the stakeholders themselves are not aware of any hindrances.
- While most policy and planning evaluations are likely to originate with the Ministry of Health, which would be interested in determining or understanding progress made in its mental health services, problems may be identified in related sectors, by concerned individuals or organizations.
- By asking the questions: "How well have we done? How well are we doing?" and "How can we do better?", it is possible to make much more progress than if these questions were never asked or answered.

Annex 1 - Checklist for evaluating a mental health policy

Introduction

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

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

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

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

This checklist has been developed by Dr Michelle Funk, Ms Natalie Drew and Dr Edwige Faydi, Mental Health Policy and Service Development, Department of Mental Health and Substance Abuse, World Health Organization, Prof Melvyn Freeman, Human Sciences Research Council, Pretoria, South Africa and Dr Sheila Ndyanabangi, Ministry of Health Uganda.

Checklist for evaluating a Mental Health Policy

Process issues	Rating
1a. Was there a high-level mandate to develop the policy (e.g. from the Minister of Health)? **1b.** At what level has the policy been officially approved and adopted? (e.g., the department of mental health, Ministry of Health, Cabinet, Minister of Health).	
2. Is the policy based on relevant data: • From a situation assessment? • From a needs assessment?	
3. Have policies relating to mental health that have been utilized within the country and in other countries with similar cultural and demographic patterns been examined and integrated where relevant?	
4. Has a thorough consultation process taken place with the following groups: • Representatives from the Health Sector, including planning, pharmaceutical , human resource development, child health, HIV/AIDs, epidemiology and surveillance, epidemic and disaster preparedness divisions. • Representatives from the Finance Ministry? • Representatives from Social Welfare and Housing Ministries? • Representatives from the criminal justice system? • Consumers, or representatives of consumer groups? • Family members or their representatives? • Other NGOs? • Private sector? • Any other key stakeholder groups? If so, please list them.	
5. Has an exchange taken place with other countries concerning their mental health policies and experiences?	
6. Has relevant research been undertaken to inform policy development, (e.g. pilot studies)?	

Comments on rating	Action required (if any)

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If “yes” or “to some extent” please state how.

If not, please state reason(s).

Checklist for evaluating a Mental Health Policy

Content issues	Rating
1. Is there a realistic vision statement?	
2. Are values and associated principles which inform the policy included?	
3. Do these values and associated principles emphasize and/or promote: • Human rights? • Social inclusion? • Community care? • Integration? • Evidence-based practice? • Intersectoral collaboration? • Equity with physical health care?	
4. Have clear objectives been defined?	
5. Are objectives consistent: • With the vision? • With the values and principles?	
6. Are the areas for action clearly described to indicate the main policy directions and what will be achieved?	
7. Are the areas for action written in a way that commits the Government (e.g. do they state "will" instead of "should")?	

Comments on rating	Action required (if any)

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If “yes” or “to some extent” please state how.

If not, please state reason(s).

Checklist for evaluating a Mental Health Policy

Content issues	Rating
8. To what extent do the areas for action comprehensively address **coordination & management**? • (a) Does the policy specify a dedicated mental health position/post within the Ministry of Health to coordinate mental health functions and services? • (b) Does the policy establish or refer to a multisectoral coordinating body to oversee major decisions in mental health?	
9. To what extent do the areas for action comprehensively address **financing**? • (a) Does the policy indicate how funding will be utilized to promote equitable mental health services? • (b) Does the policy state that equitable funding between mental health and physical health will be provided? • (c) If health insurance is utilized in the country, does the policy indicate whether/how mental health would be part of it?	
10. To what degree do the areas for action comprehensively address **legislation and/or human rights**? • (a) Does the policy promote human rights? • (b) Does the policy promote the development and implementation of human-rights-oriented legislation? • (c) Is the setting up of a review body envisaged to monitor different aspects of human rights?	
11. To what extent do the areas for action comprehensively address **organization of services**? • (a) Does the policy promote the integration of mental health services into general health services? • (b) Does the policy promote a community-oriented mental health approach? • (c) Does the policy promote deinstitutionalization?	
12. To what extent do the areas for action comprehensively address **promotion, prevention and rehabilitation**? Does the policy make provision for: • (a) The prevention of mental disorders? • (b) Interventions that promote mental health? • (c) Interventions for the rehabilitation of people with mental disorders?	
13. To what extent do the areas for action comprehensively address **advocacy**? • (a) Is the policy supportive of consumers and family organizations? • (b) Is there emphasis on raising awareness of mental disorders and their effective treatment? • (c) Does the policy promote advocacy on behalf of people with mental disorders?	

Comments on rating	Action required (if any)

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If "yes" or "to some extent" please state how.

If not, please state reason(s).

Checklist for evaluating a Mental Health Policy

Content issues	Rating
14. To what extent do the areas for action comprehensively address **quality improvement**? Does the policy • (a) Make a commitment to providing high quality, evidence- based interventions? • (b) Include a process to measure and improve the quality of services?	
15. To what extent do the areas for action comprehensively address **information systems**? • (a) Will mental health information systems be set up to guide decision-making for future policy, planning and service development?	
16. To what extent do the areas for action comprehensively address **human resources and training**? • (a) Does the policy commit to putting in place suitable working conditions for mental health providers? • (b) Have appropriate management strategies been discussed to improve recruitment and retention of mental health providers? • (c) Are training in core competencies and skills seen as central to human resources development?	
17. To what extent do the areas for action comprehensively address **research and evaluation**? • (a) Does the policy emphasize the need for research and evaluation of services and of the policy and strategic plan?	
18. To what extent do the areas for action comprehensively address **intrasectoral collaboration** within the health sector? Does the policy: • (a) Emphasize collaboration with planning, pharmaceutical, human resource development, child health, HIV/AIDs, epidemiology and surveillance, epidemic and disaster preparedness divisions within the health sector? • (b) Contain clear statements of what role each department will play in each area for action?	
19. To what extent do the areas for action comprehensively address **intersectoral collaboration**? Does the policy: • (a) Emphasize collaboration with all other relevant government departments? • (b) Emphasize collaboration with all relevant NGOs, including consumer and family groups? • (c) Contain clear statements of what role each sector will play in each area for action?	

Comments on rating	Action required (if any)

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If “yes” or “to some extent” please state how.

If not, please state reason(s).

Checklist for evaluating a Mental Health Policy

Content issues	Rating
20. Have all of the following groups been considered: • People with severe mental disorders? • Children and adolescents? • Older persons? • People with intellectual disability? • People with substance dependence? • People with common mental disorders? • People affected by trauma?	
21. Given resources available in the country, has a reasonable balance been achieved between the above groups?	
22. To what degree have the key mental health policy issues been integrated with/or are consistent with the country's: • Mental health law? • General health law? • Patients rights charter? • Disability law? • Health policy? • Social welfare policy? • Poverty reduction policy? • Development policy?	
Taking into account the financial and human resources available in the country, comment on the general	

Comments on rating	Action required (if any)

feasibility for implementation of the policy.

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If “yes” or “to some extent” please state how.

If not, please state reason(s).

Annex 2 - Checklist for evaluating a mental health plan

Introduction

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

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

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

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

This checklist has been developed by Dr Michelle Funk, Ms Natalie Drew and Dr Edwige Faydi, Mental Health Policy and Service Development, Department of Mental Health and Substance Abuse, World Health Organization, Prof Melvyn Freeman, Human Sciences Research Council, Pretoria, South Africa and Dr Sheila Ndyanabangi, Ministry of Health Uganda.

Checklist for evaluating a Mental Health Plan

Process issues	Rating
1a. Was there a high-level mandate to develop the plan (e.g. from the Minister of Health)? **1a.** At what level has the plan been officially approved and adopted? (e.g., the department of mental health, Ministry of Health, Cabinet, Minister of Health)	
2. Does the plan include strategies and activities that are consistent with an existing and up-to-date policy?	
3. If no policy is available, does the plan include strategies and activities that are consistent with another official document(s) stating the direction(s) for mental health? Please provide relevant document(s).	
4. Are strategies and activities written in a way that commits the governments (e.g. do they state "will" instead of "should")?	
5. Has the plan been informed by: • a situation analysis? and/or • a needs assessment?	
6. Have effective strategies that have been utilized within the country and in other countries with similar cultural and demographic patterns been examined and integrated where necessary?	
7. Has a thorough consultation process taken place with the following groups? • Representatives from the health sector, for example, including planning, pharmaceutical, human resource development, child health, HIV/AIDs, epidemiology and surveillance, epidemic and disaster preparedness divisions? • Representatives from the Finance Ministry? • Representatives from the Social Welfare and Housing Ministry? • Representatives from the criminal justice system? • Consumers or their representatives? • Family members or their representatives? • Other NGOs? • Private sector? • Any other key stakeholder groups? If so, please list them.	

Comments on rating	Action required (if any)

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If “yes” or “to some extent” please state how.

If not, please state reason(s).

Operational issues	Rating
8. Have comprehensive strategies been identified for each priority area for action?	
Strategies	
9. Time frames: • Are time frames provided for each strategy? • If so, are these time frames reasonable and feasible?	
10. Indicators: • Are there indicators for each strategy? • If so, are the indicators appropriate for measuring the particular strategy?	
11. Targets: • Are there targets for each strategy? • If so, are the targets realistic?	
Activities	
12. Are clear activities defined for each strategy?	
13. Is the person/group/organization responsible for each activity identified?	
14. Is it clear when each activity will start and finish?	
15. Are the outputs for each activity outlined?	
16. Have potential obstacles been identified?	
17. Costs and funding: • Have the costs for achieving each activity been calculated? • Is the funding for each activity available and allocated?	

Comments on rating	Action required (if any)

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If "yes" or "to some extent" please state how.

If not, please state reason(s).

Checklist for evaluating a Mental Health Plan

Content issues	Rating
18. Does the plan include relevant strategies and activities for **coordination & management**? • (a) Are the composition and functions clearly defined for: – The mental health coordinating body? – The mental health focal point? • (b) Is an adequate infrastructure in place/planned (including computers, Internet access and administrative support)? • (c) Are regular meetings of the coordinating body scheduled? • (d) Has a system of reporting to a high-level MoH official been set up for the mental health coordinating body? • (e) Are coordination and management strategies and associated activities: – Relevant? – Evidence-based? – Realistic and possible to implement? – Adequately funded?	
19. Does the plan include relevant strategies and activities for **financing**? • (a) Is it clear how services will be funded? • (b) Is the plan clear as to whether/how user charges will be made? • (c) Are financing strategies and associated activities: – Relevant? – Evidence-based? – Realistic and possible to implement? – Adequately funded?	
20. Does the plan include relevant strategies and activities for **legislation and/or regulations on human rights**? • (a) Where legislation and/or regulations are to be developed, have clear strategies/activities been specified for: – the process of drafting the law/regulations? – defining the content of the law/regulations? – implementing the law/regulations? • (b) Where a review body to protect human rights is to be established, are clear strategies/activities specified for its establishment? • (c) Are there any other strategies to protect and promote the rights of people with mental disorders?	

Comments on rating	Action required (if any)

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If “yes” or “to some extent” please state how.

If not, please state reason(s).

Checklist for evaluating a Mental Health Plan

Content issues	Rating
• (d) Are the strategies on human rights and legislation and associated activities: – Relevant? – Evidence-based? – Realistic and possible to implement? – Adequately funded?	
21. Does the plan include relevant strategies and activities for **organization of services**? • (a) Are there strategies and associated activities for the provision of services at primary, secondary and tertiary levels, with continuity between them? • (b) Are there strategies and associated activities for deinstitutionalization? • (c) Are there strategies and associated activities for developing community mental health services? • (d) Has provision been made for psychosocial rehabilitation services at all levels of the health system? • (e) Are the strategies on organization of services and associated activities: – Relevant? – Evidence-based? – Realistic and possible to implement? – Adequately funded?	
22. Does the plan include relevant strategies and activities for **promotion, prevention and rehabilitation**? • (a) Are there clear strategies and related activities for the promotion of mental health? • (b) Are there clear strategies and related activities for the prevention of mental disorders? • (c) Are the strategies on prevention, promotion and rehabilitation, and associated activities: – Relevant? – Evidence-based? – Realistic and possible to implement? – Adequately funded?	
23. Does the plan include relevant strategies and activities for the **procurement and distribution of essential medicines**? • (a) If psychotropic medicines currently are not included on the Essential Drugs List (EDL), is there a strategy and associated activities to include them? • (b) Does the plan incorporate strategies and associated activities to improve reliability of the supply and distribution system at relevant levels of the health service where treatment is provided? • (c) Are there strategies and relevant activities for monitoring the continuous provision and assessment of psychotropic medicines?	

Comments on rating	Action required (if any)

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If "yes" or "to some extent" please state how.

If not, please state reason(s).

Content issues	Rating
• (d) Are the strategies on procurement and distribution of medicines and associated activities: – Relevant? – Evidence-based? – Realistic and possible to implement? – Adequately funded?	
24. Does the plan include relevant strategies and activities for **advocacy**? • (a) Is there a strategy and related activities to support (technically and/or in practical terms) consumer groups, family groups and NGOs? • (b) Is there a strategy and associated activities to involve consumers and family representatives in policy and service planning? • (c) Are the advocacy strategy and associated activities: – Relevant? – Evidence based? – Realistic and possible to implement? – Adequately funded?	
25. Does the plan include relevant strategies and activities for **quality improvement**? • (a) Is there a strategy and associated activities for assessing quality? • (b) Is there a strategy and associated activities for ongoing quality control of mental health facilities (e.g. standards)? • (c) Is there a strategy and associated activities for accrediting facilities based on quality? • (d) Are both hospital and community mental health facilities included in quality assessment? • (e) Are the strategies on quality improvement and associated activities: – Relevant? – Evidence-based? – Realistic and possible to implement? – Adequately funded?	
26. Does the plan include relevant strategies and activities for **information systems**? • (a) Have a strategy and linked activities been defined for: – Reviewing the current mental health information system, and/or – Improving the current mental health information system? • (b) Does the strategy, or linked activities, include the systematic collection of mental health data from a range of sources at different levels of the health system (e.g. from general hospitals, primary health care and community levels)?	

Comments on rating	Action required (if any)

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If “yes” or “to some extent” please state how.

If not, please state reason(s).

Content issues	Rating
• (c) Is it clear how the information will feed back into: – Policy development, mental health planning and service delivery? – Clinical practice? • (d) Are the strategies on information systems and associated activities: – Relevant? – Evidence-based? – Realistic and possible to implement? – Adequately funded?	
27. Does the plan include relevant strategies and activities for **human resources and training**? • (a) Is there a well-defined strategy with associated activities for assessing available personnel and competencies at different service levels? • (b) Is there a strategy to improve the number of providers for mental health? • (c) Are there relevant management strategies and activities to address: – Recruitment? – Retention? – Deployment of staff? • (d) Has provision been made for ongoing education, training and skills development? • (e) Is there a strategy/relevant defined activities to introduce changes to undergraduate and graduate curricula of health and allied health workers? • (f) Is there a strategy for training health providers to develop appropriate competencies at the levels of: – Informal community services? – Primary health care services? – General hospital care? – Specialist care? • (g) Are the strategies on human resources and associated activities: – Relevant? – Evidence based? – Realistic and possible to implement? – Adequately funded?	
28. Does the plan include relevant strategies and activities for **research and evaluation**? • (a) Are there strategies for improving capacity to conduct research and evaluation? • (b) Will the research address practical issues for the country?	

Comments on rating	Action required (if any)

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If “yes” or “to some extent” please state how.

If not, please state reason(s).

Content issues	Rating
• (c) Has provision been made to evaluate the policy and plan? • (d) Are research and evaluation strategies and defined activities: – Relevant? – Evidence-based? – Realistic and possible to implement? – Adequately funded?	
29. Does the plan include relevent strategies and activities for **intrasectoral collaboration**? • (a) Is a structure planned/in place through which intrasectoral collaboration could take place with the following departments within the health sector? • (b) Is collaboration with the following departments within the health sector included in the plan? – Planning, – Pharmaceutical, – Human resource development, – Child health, – HIV/AIDs, – Epidemiology and surveillance, – Epidemic and disaster preparedness divisions.	
30. Does the plan include relevant strategies and activities for **intersectoral collaboration**? • (a) Is there a structure planned/in place through which intersectoral collaboration could take place? • (b) Is collaboration with the following government departments included in the plan? – Social services – Justice – Education – Housing – Corrections – Police • (c) Is collaboration with the following groups included in the plan? – NGOs – Consumer groups – Family groups	

Comments on rating	Action required (if any)

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If “yes” or “to some extent” please state how.

If not, please state reason(s).

Checklist for evaluating a Mental Health Plan

Content issues	Rating
• (d) Have the following groups been considered? – People with severe mental disorders? – Children and adolescents? – Older persons? – People with intellectual disabilities? – People with substance dependence? – People with common mental disorders? – People affected by trauma? • (e) Given financial and human resources available in the country, has a reasonable balance been achieved between the above groups? • (f) Overall, are the strategies on intersectoral collaboration and associated activities: – Relevant? – Evidence-based? – Realistic and possible to implement? – Adequately funded?	
31. To what degree have the key mental health strategies been integrated into the country's existing strategic plans for: – Improving patients rights? – Improving rights for people living with disabilities? – Overall health? – Social welfare? – Poverty reduction? – Development?	
Taking into account the financial and human resources available in the country, comment on the general	

Comments on rating	Action required (if any)

feasibility for implementation of the policy.

Please use the following rating scale to rate each item:

1 = *yes/to a great degree*
2 = *to some extent*
3 = *no/not at all*
4 = *unknown*

If "yes" or "to some extent" please state how.

If not, please state reason(s).

Annex 3 - World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS)

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) is a new tool for collecting essential information on the mental health system of a country or subregion of a country. The aim of collecting this information is to improve mental health systems.

The WHO Atlas Study *Mental Health Atlas* (WHO, 2005c) reports that in 2005 more than 24% of countries did not have any system for collecting and reporting mental health information. Many other countries have information systems that are of limited scope and quality. This lack of good information impedes the development of mental health policies, plans and services.

WHO-AIMS was developed to assess key components of a mental health system and thereby provide essential information to strengthen such systems. It is based on the WHO strategy to provide information-based mental health assistance to countries within the *WHO Mental Health Global Action Plan (mhGAP)*, as endorsed by WHO's governing bodies. Through WHO-AIMS it is possible to identify major weaknesses in mental health systems and obtain essential information for relevant public action for mental health.

The 10 recommendations of the *World Health Report 2001* serve as the foundation for WHO-AIMS:

1. Provide treatment for mental disorders in primary care
2. Ensure wider accessibility to the essential psychotropic drugs
3. Increase the treatment of individuals with severe mental illnesses within community psychiatric services
4. Provide public education on mental health
5. Involve communities, families and consumers in mental health care
6. Establish national policies
7. Establish programmes and legislation on mental health
8. Develop appropriate human resources
9. Link the mental health system to the other health and non-health sectors
10. Develop information and monitoring mechanisms and support relevant research.

These recommendations address essential aspects of mental health system development in resource-poor settings. For each recommendation (domain of interest), items were generated and grouped together in a number of facets (subdomains). Experts and key focal point people from resource-poor countries provided inputs to ensure the clarity, validity and feasibility of the items.

WHO-AIMS 2.2 consists of six domains covering the 10 recommendations noted above through 28 facets and 154 items. The six domains are interdependent and conceptually interlinked, and all of them need to be assessed to form a relatively complete picture of a mental health system.

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