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QUALITY ASSURANCE IN MENTAL HEALTH CARE

CHECK-LISTS & GLOSSARIES

VOLUME 1

DIVISION OF MENTAL HEALTH

WORLD HEALTH ORGANIZATION

GENEVA

QUALITY ASSURANCE IN MENTAL HEALTH CARE

CHECK-LISTS & GLOSSARIES

VOLUME 1

This document includes check-lists with respective glossaries designed to assist in the development of programmes of quality assurance in mental health care. They are based on recommendations of a group of experts in this field and are being issued after field testing in 10 countries in all WHO Regions.

This volume contains instruments for the assessment of mental health policies, mental health programmes, primary health care facilities, outpatient mental health facilities, inpatient mental health facilities and residential facilities for the elderly. A future volume will contain instruments on day centres and hospitals, forensic psychiatric facilities, community-based services, protected housing, and psychosocial rehabilitation facilities.

Key-words: quality assurance, standards of care, mental health care, mental health services, service indicators.

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(Editor)

DIVISION OF MENTAL HEALTH
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FOREWORD

A group of experts in mental health care meeting in September 1991, recommended to WHO that instruments and methodologies for comprehensively assessing the quality of mental health care and services should be developed and tested[1]; in addition, it was also recommended that these be based on a public health perspective.

Following those recommendations a set of draft instruments were produced[2-8]. Those drafts included a list of criteria of high quality mental health care, glossaries and recording forms. A study protocol was also designed for the multisite field testing of those draft instruments.

The present document includes the final version of instruments for the assessment of mental health policies, mental health programmes, primary health care facilities, outpatient mental health facilities, inpatient mental health facilities and residential facilities for the elderly mentally ill , incorporating modifications indicated by the study. A future volume will include instruments for the assessment of forensic psychiatric facilities, community-based services, protected housing and psychosocial rehabilitation programmes.

In choosing sites to participate in the study a major concern was the inclusion of countries with a variety of social, economic and political organizations, in addition to having different health care systems and mental health care traditions. Out of the initial 13 countries considered for participation only three could not accept the invitation or could not complete the study. At any rate, we are confident that we have included such a variety of countries as to satisfy the requirements of a wide coverage of different systems.

Another major concern was with the obtention of instruments for self-assessment. Accordingly, the study protocol tested the performance of the drafts completed by independent research assistants with the self-reporting done by the director of the facilities included in the study. Only those criteria for which there was an acceptable rate of agreement (80% or more) between these two groups of raters were retained. This guarantees that the instruments are useful for managers willing to examine their own services, in view of improving them. At the same time, the instruments can also be very useful for external evaluation e.g. accreditation purposes.

Although the formulation of the criteria and the glossaries are straightforward, it is useful to insist on a few points in order to decrease misunderstandings.

Criteria included here, notwithstanding the fact that they do represent standards of quality, **are not WHO official norms**. They should be looked at rather as WHO guidelines for the formulation of norms, at country level. At country (or regional, or local) level, these criteria should be re-examined. In most places the set of criteria for a given facility will be retained as presented here; in other places, a few criteria could be dropped without irreparable damage to the integrity of the instrument, whereas in others, additional criteria will have to be formulated. Still in other countries quantitative criteria (such as those related to staffing) could be readjusted (e.g. according to local availability of human resources) in order to

improve their appropriateness. **In any case, an instrument specific for a given facility only acquires its full meaning when analyzed together with the corresponding modules on mental health policy and on the mental health programmes, which frame them.**

Also, when assessing a given facility it is important to have an idea of its general outlay and services production. To this end, examples of simple background information forms on each facility are provided, together with operational definitions of its main items, immediately after the glossary.

As for the rating of each criteria, an effort was made to provide indications on a three point scale, indicated between [ ] (0 = absent; 1 = partially present; and 2 = fully present). However, this was not always possible and for some criteria only the two extreme points are indicated (0 = absent; and 2 = present). In these cases those wishing to do so could define an intermediate point.

These instruments are the result of a collective work. In Acknowledgements a complete list of participants in the study, to whom we express our thanks, is shown. In addition to those people, at least three other names must be mentioned in this connection: those of Dr N. Sartorius, former Director of WHO Division of Mental Health (MNH) who provided the initial stimulus to this endeavour; of Dr J. Orley, Senior Medical Officer in MNH, who actually started the work presented here[9-10]; and of Dr G. Goldemberg, Consultant, MNH, who conducted data processing and analysis. Also, contributions from the Mario Negri Institute, WHO Collaborating Centre for Research and Training in Mental Health, in Milan, and from the International Psychogeriatric Association were received. These people and institutions not only contributed their knowledge and expertise but also made the management of the project a pleasant and enriching experience; to them all our profound gratitude.

At the end of the document, there are also indications of cut-off points for different levels of quality of services. Generally speaking, good quality was considered when a score of at least 80% of the maximum possible score was reached; fair quality, between 60% and 79%; barely acceptable, between 40% and 59%; and unacceptable, below 40 %.

The publication of this set of instruments (together with the following ones previously mentioned) covers what has been called the first two levels of quality assurance (QA), i.e. policy and organization, and services[11]. Other WHO documents already available[12-14] cover the third level (specific interventions), e.g. the series on Essential Treatments and on indicators in mental health care. This third level, however, being closer to where care is effectively provided, greatly benefits from inputs provided by people working locally. Among nationally developed tools for quality assurance (at the third level) those produced in Australia and New Zealand[15], and in Sweden[16] could be mentioned.

The next step relates to the development of mechanisms for the implementation and assessment of QA. Previous WHO documents have already indicated the nature and the composition of bodies to monitor QA[17-20]. Although there is much room for development and improvement in this area - particularly in relation to mental health and mental health care indicators - there is already a robust base on which to launch quality assurance programmes in mental health care .

As a consequence of the multisite study, these instruments are now available in Chinese, English, French, Italian, Portuguese, Russian and Spanish. Experience has shown that the efficacy of similar instruments improve when they are available in local languages. Therefore, they can be freely reproduced or translated into any other language, but are not for sale or for use in conjunction with commercial purposes. Comments on these instruments, as well as copies of possible translations, are welcome and should be sent to:

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CHECK-LISTS

A - MENTAL HEALTH POLICY CHECK-LIST

1. There is a written Mental Health Policy.

2. The Mental Health Policy is integrated into the Primary Health Care Strategy.

3. There is an operational programme to give effect to the policy.

DECENTRALIZATION

4. There is a formal effort to increase planning and management capabilities at district/local level.

5. Funds are allocated to district/local level authorities with flexibility for using at least a substantial part of these funds according to locally perceived needs.

INTERSECTORAL ACTION

6. Specific role and functions in mental health actions and programmes attributed to each sector in the government have been identified.

7. Specific role and functions in mental health actions and programmes attributed to non-governmental and religious organizations have been identified.

COMPREHENSIVENESS

8. Specific promotive, preventive, treatment and rehabilitative activities and actions have been indicated.

9. Specific actions/programmes addressed to vulnerable age groups have been indicated.

10. Specific actions/programmes addressed to psychosocial needs and alcohol and drug abuse have been indicated.

11. Orientation for training and research has been given.

EQUITY

12. Equal access to same types of care to every segment of the population is assured.

13. Health resources are equitably distributed.

CONTINUITY

14. The coordinated integration of mental health care with general health care is indicated and specified.

15. The linkage among services is indicated and specified.

COMMUNITY PARTICIPATION

16. The role and functions of consumers in the planning of mental health actions/programmes is specified.

17. The role and functions of consumers in the implementation of mental health actions/programmes is specified.

18. The role and functions of consumers in the evaluation of mental health actions/programmes is specified.

PERIODICAL REVIEWS

19. The composition of the group to undertake periodical reviews of the mental health policy is indicated.

20. The frequency of the reviews of the mental health policy is indicated.

21. Eventual changes indicated by periodical reviews are duly and timely implemented.

B - MENTAL HEALTH PROGRAMME CHECK-LIST

1. There is a written National Mental Health Programme.

2. There are written Regional Mental Health Programmes.

3. There are written Local Mental Health Programmes.

4. Technicians, politicians and consumers participated in the preparation of Mental Health Programmes.

RANGE OF ACTIONS

5. Actions for the promotion of mental health are clearly indicated.

6. Actions for the prevention of mental disorders are clearly indicated.

7. Actions for the treatment of people with mental disorders are clearly indicated.

8. Actions for psychosocial rehabilitation are clearly indicated.

9. Actions for improving the linkage between mental health, social, and general health services are clearly indicated.

10. Actions for enhancing the quality of life are clearly indicated.

11. Actions for improving education related to health are clearly indicated.

12. Actions for improving research are clearly indicated.

13. Actions for improving information dissemination are clearly indicated.

PLAN OF WORK

14. The general objectives of the Mental Health Programme are clearly stated.

15. The specific objectives of the Mental Health Programme are clearly stated.

16. Targets have been defined.

17. Strategies and approaches are specified.

18. Priorities have been identified.

19. The division/unit/post responsible for the programme is specified.

20. Catchment areas have been defined.

21. The linkage among health services is indicated and specified.

22. The linkage with the social services sector is specified.

23. Mechanisms for coordination and information exchange across national, regional, and local levels are indicated.

24. Mechanisms for decision making are indicated.

25. Mechanisms for resource allocation are indicated.

26. Cost estimates and other budgetary implications are specified.

27. The Mental Health Programme is based on reasonable information on general, psychiatric and psychosocial morbidity/mortality data.

28. The Mental Health Programme is based on existing facilities.

29. The Mental Health Programme is based on existing human resources.

MONITORING AND EVALUATION

30. Monitoring and evaluation systems are specified.

31. The monitoring system of programme implementation includes client characteristics and services utilization pattern.

32. The monitoring system of programme implementation includes cost assessments.

COMMUNITY PARTICIPATION

33. The role and functions of consumers in the planning of mental health actions/programmes is specified.

34. The role and functions of consumers in the implementation of mental health actions/programmes is specified.

35. The role and functions of consumers in the evaluation of mental health actions/programmes is specified.

C - THE PRIMARY HEALTH CARE FACILITY CHECK-LIST

PHYSICAL ENVIRONMENT

1. The facility has been officially inspected and meets local standards for the protection of the health and safety of patients and staff.

2. The space is sufficient for the number of patients seen.

3. There is reasonable space for specific treatment procedures.

4. The facility has an adequate supply of basic medical drugs.

5. The facility has an adequate supply of basic psychiatric drugs.

6. A first-aid kit is available in the facility.

ADMINISTRATIVE ARRANGEMENTS

7. A written policy on philosophy and model of care is available.

8. Priorities have been defined.

9. Written policies on conditions of service for staff are available.

10. Job descriptions are specified for all staff.

11. Staff have a full medical examination annually.

12. Written procedures for the protection of confidentiality of patients' and staff records are available.

13. Written records are appropriately maintained on all patients.

14. Written records are appropriately maintained on all staff.

15. Written procedures to be followed if a violent episode breaks out are available.

16. Written procedures for dealing with complaints from patients and families are available.

17. Written policies on disciplinary procedures are available.

18. All caregiving staff are required to participate in in-service training programmes.

19. All staff have been trained in first aid.

20. All caregiving staff have received training in basic nursing skills.

21. Staff have been trained for the identification and treatment of patients with mental disorders.

22. Staff have been trained for the management of psychiatric emergencies.

23. Staff have access to mental health specialist help.

24. At least 10% of each staff's working time is dedicated to training, supervision and administrative activities.

25. At least 20% of each staff's working time is dedicated to work in the community.

26. Opportunities are provided for staff to discuss with their superiors difficulties they may have in working with people with mental disorders.

27. Annually, staff conduct an internal study to identify strengths and weaknesses in the facility's policies and programmes.

CARE PROCESS

28. There is a manual for the identification and treatment of patients with mental disorders.

29. Every patient is evaluated in terms of biological, psychological and social functioning.

30. An informed consent is obtained prior to starting a planned treatment programme.

31. Treatment plans are written down for each patient and followed by all staff.

32. There are clear written guidelines on the indications and use of drug therapies.

33. Meetings are held regularly for staff to discuss individual patient care plans.

34. Patients are kept informed about their own progress.

35. Help and support are quickly available if violence breaks out.

INTERACTION WITH FAMILIES

36. Upon request, family members have a chance to discuss the patient's care with a responsible member of staff.

37. Family members are encouraged to be involved in the patient's treatment programme.

38. When needed help and support are made available by staff to family members.

39. Home visits are caried out for improving caring and coping skills of families of some selected patients.

40. Families and patients are thoroughly oriented in relation to other health and social services available in their community.

41. Patients and family members are instructed about measures to take in case of relapse or reappearance of symptoms.

OUTREACH

42. Regular contact is maintained with other health facilities.

43. Contact is regularly made with schools in the facility's area.

44. Regular contact is maintained with other social agencies in the facility's area.

45. Regular contact is maintained with patients' employers.

46. A standard information form is always sent to another facility whenever a patient is referred to it.

47. A standard information form is always given to the patient whenever referred to another facility.

D - THE OUTPATIENT MENTAL HEALTH FACILITY CHECK-LIST

PHYSICAL ENVIRONMENT

1. The facility has been officially inspected and meets local standards for the protection of the health and safety of patients and staff.

2. The space is sufficient for the number of patients seen.

3. There is reasonable space for specific treatment procedures.

4. The facility has an adequate supply of basic medical drugs.

5. The facility has an adequate supply of basic psychiatric drugs.

6. A first-aid kit is available in the facility.

ADMINISTRATIVE ARRANGEMENTS

7. A written policy on philosophy and model of care is available.

8. Priorities have been defined.

9. Written policies on conditions of service for staff are available.

10. Job descriptions are specified for all staff.

11. Staff is multidisciplinary.

12. Staff have a full medical examination annually.

13. Written procedures for the protection of confidentiality of patients' and staff records are available.

14. Written records are appropriately maintained on all patients.

15. Written records are appropriately maintained on all staff.

16. Written procedures to be followed if a violent episode breaks out are available.

17. Written procedures for dealing with complaints from patients and families are available.

18. Written policies on disciplinary procedures are available.

19. All caregiving staff are required to participate in in-service training programmes.

20. All staff have been trained in first aid.

21. All caregiving staff have received training in basic nursing skills.

22. Staff have been trained for dealing with and treating patients with mental disorders.

23. Staff have been trained specifically for the management of psychiatric emergencies.

24. At least 10% of each staff's working time is dedicated to training, supervision and administrative activities.

25. At least 20% of each staff's working time is dedicated to work in the community.

26. Opportunities are provided for staff to discuss with their superiors, difficulties they may have in working with people with mental disorders.

27. Annually, staff conduct an internal study to identify strengths and weaknesses in the facility's policies and programmes.

CARE PROCESS

28. Every patient is evaluated in terms of biological, psychological and social functioning.

29. Staff always speak to patients in a friendly, positive and courteous manner.

30. At least 45 minutes are allocated for a staff member to see each new patient.

31. At least 20 minutes are allocated for a staff member to see each patient from the second visit on.

32. At least 60 minutes are allocated for each group activity with patients.

33. An informed consent is obtained prior to starting a planned treatment.

34. There are clear written guidelines on the indications and use of drug therapies.

35. There are clear written guidelines on the indications and use of occupational therapy and rehabilitation activities.

36. Treatment plans are written down for each patient and followed by all staff.

37. Meetings are held regularly for staff to discuss individual patient care plans.

38. Patients are kept informed about their own progress.

39. Help and support are quickly available if violence breaks out.

40. Staff have access to specialist medical help in case of an emergency.

INTERACTION WITH FAMILIES

41. Upon request family members have a chance to discuss the patient's care with a responsible member of staff.

42. Family members are encouraged to be involved in the patient's treatment programme.

43. When needed help and support are made available by staff to family members.

44. Home visits for improving caring and coping skills of families of some selected patients are carried out.

45. Discharge plans are discussed by all staff and with both the patient concerned and family members.

46. Patients are thoroughly oriented in terms of other health and social services available in their community.

47. Family members are instructed about measures to take in case of relapse or reappearance of symptoms.

OUTREACH

48. Regular contact is maintained with other health facilities.

49. Contact is regularly made with schools in the facility's area.

50. Regular contact is maintained with other social agencies in the facility's area.

51. Regular contact is maintained with patients' employers.

52. A standard information form is always sent to another facility whenever a patient is referred to it.

53. A standard information form is always given to the patient whenever referred to another facility.

E - THE INPATIENT MENTAL HEALTH FACILITY CHECK-LIST

PHYSICAL ENVIRONMENT

1. The facility has been officially inspected and meets local standards for the protection of the health and safety of the inpatients and staff.

2. The ward space is sufficient for the number of patients admitted.

3. There is reasonable space for specific treatment procedures.

4. There is reasonable space for recreational activities.

5. There is reasonable space for receiving visitors.

6. Adequate space is provided for patients to store their personal belongings.

7. The ward is arranged in such a way that each patient has a small piece of territory which is seen as his/hers.

8. Toilets are in good working order for all patients.

9. A reasonable daily supply of water is available for patients.

10. There is reasonable privacy for relevant bodily functions.

11. The ward has adequate lighting.

12. The ward is cleaned daily.

13. Sufficient and appropriate bedding equipment is available for use by the patients.

14. Sufficient and appropriate seating equipment is available for use by the patients.

15. Sufficient and appropriate eating utensils are available for use by the patients.

16. The facility has an adequate supply of basic medical drugs.

17. The facility has an adequate supply of basic psychiatric drugs.

18. A first-aid kit is available in each ward.

19. All potentially dangerous products are stored out of reach of patients.

20. The facility kitchen complies with recommended local standards for hygiene and food service.

ADMINISTRATIVE ARRANGEMENTS

21. A written policy on philosophy and model of care is available.

22. Written policies on conditions of service for staff are available.

23. Job descriptions are specified for all staff.

24. At least two-thirds of the caregivers on the facility's staff are employed full-time.

25. Staff have a full medical examination annually.

26. Staff are provided with space to be away from patients at appropriate periods during the day.

27. Staff are provided with time to be away from patients at appropriate periods during the day.

28. Written procedures for the protection of the confidentiality of patients' and staff records are available.

29. Written records are appropriately maintained for all patients.

30. Written records are appropriately maintained for all staff.

31. Written procedures to be followed if a violent episode breaks out are available.

32. Written procedures for dealing with complaints from patients and families are available.

33. Written policies on disciplinary procedures are available.

34. All caregiving staff are required to participate in in-service training programmes.

35. All caregiving staff have been trained in first aid.

36. All caregiving staff have received training in basic nursing skills.

37. Staff have been trained for dealing with and treating patients with mental disorders.

38. Staff have been trained specifically for the management of psychiatric emergencies.

39. Opportunities are provided for staff to discuss with their superiors, difficulties they may have in working with people with mental disorders.

40. Annually, staff conduct an internal study to identify strengths and weaknesses in the facility's policies and programmes.

STAFFING

41. The facility has the equivalent of at least one full-time psychiatrist per 20 acute patients.

42. The facility has the equivalent of at least one full-time psychiatrist per 60 chronic patients.

43. The facility has the equivalent of at least one full-time registered nurse per 40 patients.

44. The facility has the equivalent of at least one full-time qualified occupational therapist per 40 patients.

45. The facility has the equivalent of at least one full-time qualified clinical psychologist per 40 patients.

46. The facility has the equivalent of at least one full-time qualified social worker per 40 patients.

47. The facility has at least one dedicated internist per 60 patients.

48. The facility has at least one half-time dentist per 200 patients.

49. The facility has at least one full-time caregiving staff member per 5 patients, during day shifts.

50. The facility has at least one full time caregiving staff member per 15 patients, during night shifts.

51. At least one professional staff member is on duty in the ward at all times.

CARE PROCESS

52. Newly arrived patients are made to feel welcome on admission.

53. Staff speak frequently to patients and always in a friendly, positive and courteous manner.

54. There is adequate attention to personal appearance for those unable to care for themselves.

55. Meals served to patients meet recommended minimum nutritional requirements.

56. Suitable food is provided for those with special nutritional needs.

57. Every newly admitted patient has a full medical evaluation within the first 24 hours after admission.

58. Acute patients have a medical evaluation at least every day.

59. Chronic patients have a medical evaluation at least every month.

60. An informed consent is obtained prior to starting a planned treatment.

61. There are clear written guidelines on the indications and use of drug therapies.

62. There are clear written guidelines on the indications and use of electroconvulsive therapy.

63. There are clear written guidelines on the role and on the goals of occupational therapy/rehabilitation activities.

64. Treatment plans are written down for each patient and followed by all staff.

65. Meetings are held regularly for staff to discuss care plans for individual patients.

66. Patients are kept informed about their own progress.

67. Help and support are quickly available if violence breaks out.

68. Staff have access to specialist medical help in case of an emergency.

69. Patients who are able are encouraged to take up work of a suitable kind.

70. No patient is kept locked in an individual room.

INTERACTION WITH FAMILIES

71. Upon request, family members have a chance to discuss the patient's care with a responsible member of staff.

72. Family members are encouraged to be involved in the patient's treatment programme.

73. When needed, help and support are made available by staff to family members.

74. Home visits are carried out for improving caring and coping skills of families of some selected patients.

DISCHARGE AND FOLLOW-UP

75. Discharge plans are discussed by all staff and with the patient concerned.

76. When discharged, patients are thoroughly oriented in terms of follow-up and social services available in their community.

77. When a patient is discharged, family members are instructed about measures to take in case of relapse or reappearance of acute symptoms.

78. Upon discharge, a standard information form is sent to the health facility responsible for follow-up.

79. When discharged the patient is given a standard information form.

F - THE RESIDENTIAL FACILITY FOR THE ELDERLY MENTALLY ILL CHECK-LIST

PHYSICAL ENVIRONMENT

1. The facility has been officially inspected and meets local standards for the protection of the health and safety of the residents and staff.

2. There are no more than 30 residents living in the facility.

3. The space is sufficient for the number of residents.

4. There is reasonable space for specific treatment procedures.

5. There is reasonable space for recreational activities.

6. There is reasonable space for receiving visitors.

7. Adequate space is provided for residents to store their personal belongings.

8. Space is arranged in such a way that each resident has a small piece of territory which is seen as his/hers.

9. The layout, decor and furnishing of the facility have been designed to minimize confusion.

10. Floors in residents' rooms are covered in non-slip materials.

11. Toilets are in good working order for all residents.

12. The location and fittings of bathrooms and toilets are planned to minimize the effects of disability of residents.

13. A reasonable daily supply of water is available for residents.

14. There is reasonable privacy for relevant bodily functions.

15. The facility has adequate lighting and temperature control.

16. The facility is cleaned daily.

17. Sufficient and appropriate bedding equipment is available for use by the residents.

18. Sufficient and appropriate seating equipment is available for use by the residents.

19. Sufficient and appropriate eating utensils are available for use by the residents.

20. A first-aid kit is available in the facility.

21. All potentially dangerous products are stored out of reach of residents.

22. The facility kitchen complies with recommended local standards for hygiene and food service.

ADMINISTRATIVE ARRANGEMENTS

23. A written policy on philosophy and model of care is available.

24. Written policies on conditions of service for staff are available.

25. Job descriptions are specified for all staff.

26. At least two-thirds of the caregivers on the facility's staff are employed full-time.

27. Staff have a full medical examination annually.

28. Written procedures for the protection of the confidentiality of residents' and staff records are available.

29. Written records are appropriately maintained on all residents.

30. Written records are appropriately maintained on all staff.

31. Written procedures to be followed if a violent episode breaks out are available.

32. Written procedures for dealing with complaints from residents and families are available.

33. Written policies on disciplinary procedures are available.

34. Domestic routines aim to meet the needs and preferences of residents rather than being set for convenience of the administration.

35. All caregiving staff are required to participate in in-service training programmes.

36. All caregiving staff have been trained in first aid.

37. All caregiving staff have received training in basic nursing skills.

38. Staff have been trained to understand the needs of and to deal with the elderly with mental disorders.

39. Opportunities are provided for staff to discuss with their superiors, difficulties they may have in working with the residents.

40. Annually, staff conduct an internal study to identify strengths and weaknesses in the facility's policies and programmes.

41. The facility has at least one full-time caregiving staff per 3 residents during day shifts.

42. The facility has at least one full-time caregiving staff per 10 residents during night shifts.

CARE PROCESS

43. Intending residents are able to visit the facility prior to admission.

44. Residents are encouraged to bring personal possessions into the facility.

45. A full assessment of physical, emotional and social needs is available on admission.

46. Residents have at least a full medical examination annually.

47. The special needs of residents showing signs of institutionalization are met.

48. Newly arrived residents are made to feel welcome on admission.

49. Staff speak frequently to residents and always in a friendly, positive and courteous manner.

50. Rules relating to residents are kept to a minimum.

51. There is adequate attention to personal appearance for those unable to care for themselves.

52. Meals served to residents meet recommended minimum nutritional requirements.

53. Suitable food is provided for those with special nutritional needs.

54. An informed consent is obtained prior to starting a planned treatment programme

55. Care plans are written down for each resident and followed by all staff.

56. Meetings are held regularly for staff to discuss individual resident care plans.

57. Help and support are quickly available if violence breaks out.

58. Staff have prompt access to specialist medical help in case of an emergency.

59. All residents have the right of access to health and remedial services provided in the community.

60. Residents are encouraged to maintain their independence within the facility.

61. Positive day-time activity is provided.

62. Physical restraint and control by sedation are not used.

63. No resident is kept locked in an individual room.

64. When a resident is dying, the need for support to relatives, staff, and other residents is recognized and met.

65. Local, cultural and religious customs surrounding the death of a resident are observed.

INTERACTION WITH FAMILIES AND COMMUNITY

66. Upon request, family members have a chance to discuss the resident's care with a responsible member of staff.

67. Family members are encouraged to be involved in the resident's care programme.

68. When needed help and support are made available by staff to family members.

69. Regular contacts are maintained with support and treatment services existing in the community.

GLOSSARIES

A - MENTAL HEALTH POLICY GLOSSARY

1. **There is a written Mental Health Policy.**

A national (or regional, or local) health policy is usually couched in general terms and is the basis of a national strategy, which lays down the broad lines of action required in all the sectors concerned to give effect to the national (or regional, or local) health policy and indicates the problems and ways of dealing with them. The strategy usually includes specific programmes for delivery by the health system infrastructure. In these cases rate 2. If it has only been orally expressed in the form of a declaration of commitment by the Head of State or Minister of Health rate 1. [0 - 1 - 2]

2. **The Mental Health Policy is integrated into the Primary Health Care Strategy.**

The primary health care (PHC) approach simply means the establishment of a health system as described in the Alma-Ata report, with primary health care as the central function and main focus supported by the rest of the health system. PHC is essential health care made accessible at a cost the country and community can afford, with methods that are practical, scientifically sound and socially acceptable. Everyone in the community should have access to and be involved in PHC. Related sectors should also be involved in addition to the health sector. [0 - 2]

3. **There is an operational programme to give effect to the policy.**

A programme is an organized aggregate of activities directed towards the attainment of defined objectives and targets, which are progressively more specific than the goals to which they contribute. Each health programme should have its specific objectives and targets, whenever possible quantified, that are consistent with those of the national (or regional, or local) health strategy. The programme should set out clearly the requirements for health workers, physical facilities, technology, equipment and supplies, information and intercommunication, the methods of monitoring and evaluation, the timetable of activities, and the ways of ensuring correlation between its various elements and related programmes. [0 - 2]

4. **There is a formal effort to increase planning and management capabilities at district/local level.**

Wherever feasible it is desirable that the managerial process for national health development be decentralized through delegation of authority and resources to intermediate and local administrative levels. A national plan of action is established for the whole country but also, for example, provincial plans for the provinces and local plans for the local communities. The advantage of such decentralization is that intermediate levels are near enough to the community to respond to its needs and to the central level to put government policies into practice, thus giving them greater opportunities for direct involvement. [0 - 2]

5. **Funds are allocated to district/local level authorities with flexibility for using at least a substantial part of these funds according to locally perceived needs.**

These needs should be related to community social and health care and the like, and for training, excluding hospital care. [0 - 2]

INTERSECTORAL ACTION

6. **Specific role and functions in mental health actions and programmes attributed to each sector in the government have been identified.**

Government sectors most relevant to mental health actions include, in addition to the health sector, education and youth, housing, welfare, labour, justice and interior.

Rate 1 if these sectors have been only mentioned without specification of their roles and functions. Rate 2 if these are specified. [0 -1 -2]

7. **Specific role and functions in mental health actions and programmes attributed to non-governmental and religious organizations have been identified.**

Non-governmental organizations (NGOs) most relevant to mental health actions include political parties and community-organized groups, such as trade unions, women's organizations, farmers or other occupational groups (particularly organizations of health or mental health workers), churches or other religious groups and consumer groups (users, ex-users and family groups).

Rate 1 if these groups have been only mentioned without specification of their roles and functions. Rate 2 if these are specified. [0 - 1 - 2]

COMPREHENSIVENESS

8. **Specific promotive, preventive, treatment and rehabilitative activities and actions have been indicated.**

Promotion of mental health means raising the value attached to mental life and mental health in individuals, communities and societies. *Preventive activities* seek to prevent the initial occurrence of a disease or other health problems. *Treatment activities* seek to arrest or retard existing diseases or to reduce the occurrence of relapses and the establishment of chronicity. *Rehabilitative activities* seek to restore the individual's social value and, more particularly, his/her working capacity, to the fullest extent possible; this implies responsibility for reorganizing a patient's whole life and re-establishing satisfactory relationships between patients, on the one hand, and their families and the occupational as well as the entire social environment, on the other hand.

Rate 2 only if the four levels are indicated, 1 if only any three, and 0 if two or less of these levels are indicated. [0 - 1- 2]

9. **Specific actions/programmes addressed to vulnerable age groups have been indicated.**

The approach consisting of identifying and devoting more care to individual groups who, for biological, environmental or socioeconomic reasons, are at specific risk of having their health impaired, of contracting a specific disease, or of having inadequate attention paid to their health problems, is known as the *risk approach.*

Rate 2 only if specific actions/programmes addressed to children, to pregnant women and the elderly are indicated; 1 if only any two of these age groups are indicated and 0 if only one or less is indicated. [0 - 1 - 2]

10. **Specific actions/programmes addressed to psychosocial needs and alcohol and drug abuse have been indicated.**

Rate 2 only if activities indicated in item 8 above also cover alcohol and drug abuse, and psychosocial needs - e.g. education and day care for children, housing for the homeless - and not only mental disorders. Rate 1 if only one of the above are indicated. [0 - 1 - 2]

11. **Orientation for training and research activities has been given.**

Rate 2 only if the policy clearly indicates both mechanisms for revising or reforming curricula in schools (particularly health profession schools) adapting them to PHC and research priorities related to PHC, and in-service (or continuing education) training. Rate 1 if only one of the above are indicated. [0 - 1 - 2]

EQUITY

12. **Equal access to same types of care to every segment of the population is assured.**

This includes:

a) availability of at least four essential psychiatric drugs (for instance, chlorpromazine, imipramine, phenobarbitone and diazepam) within one hours' walk or travel, and
b) no more than two hours' travel time (usually vehicle transport) from either a peripheral health facility or a village settlement to a referral facility.

Rate 2 if a) and b) above are present; 1 if only a) or b) is present. [0 - 1 - 2]

13. **Health resources are equitably distributed.**

This means the ratios of per capita expenditure, hospital beds and other health services, and of doctors and other health workers to population are similar for various

population groups or geographical areas, such as urban and rural areas.

Rate 2 only if the differences across groups or regions between these means are smaller than 2; 1 if they are between 2 and 3; and 0 if they are greater than 3. [0 - 1 - 2]

CONTINUITY

14. **The coordinated integration of mental health care with general health care is indicated and specified.**

These essential resources include services, facilities, institutions or establishments, organizations and those operating them for the delivery of a variety of health programmes.

Rate 1 if it is only indicated, and 2 if specified. [0 - 1 - 2]

15. **The linkage among services is indicated and specified.**

This implies organized collaboration as necessary among those providing services at the same and different levels of the health system in order to make the most efficient use of resources, as well as among the various categories of health workers following agreement on the division of labour.

Rate 1 if it is only indicated, and 2 if specified. [0 - 1 - 2]

COMMUNITY PARTICIPATION

16. **The role and functions of consumers in the planning of mental health actions/programmes is specified.**

Consumers of mental health services are those who suffer mental health problems ("primary consumers", who can be further subdivided into current users and ex-users), or their family members, who are also frequently involved in the service system. Planning includes:

a) defining a strategy with clearly stated objectives and targets;
b) programme budgeting to ensure the preferential allocation of resources for the implementation of the strategy;
c) preparing plans of action, indicating the main lines of action to be taken in the health and other sectors to implement the strategy;
d) working out detailed activities for each of the programmes in the plan of action;
e) indicating monitoring and evaluating programme mechanisms with a view to ensuring that they are proceeding as planned; and
f) ensuring the information support required for all the above.

Rate 2 if consumer's role in most of the above activities is clearly specified. Rate 1 if their role is only mentioned without specification. Rate 0 if not even mentioned.
[0 - 1 - 2]

17. **The role and functions of consumers in the implementation of mental health actions/programmes is specified.**

Programme implementation is its delivery by the health infrastructure, applying sound day-to-day managerial procedures. See criterion 16 above for other definitions and rating. [0 - 1 -2]

18. **The role and functions of consumers in the evaluation of mental health actions/programmes is specified.**

Evaluation is the essential part of the managerial process which systematically assesses the relevance, adequacy, progress, efficiency, effectiveness, and impact of a health programme. A programme is *relevant* if it answers the needs and social and health policies and priorities it has been designed to meet. It is *adequate* if it is proportionate to requirements. It is making good *progress* if its component activities are being carried out in accordance with the planned schedule. It is *efficient* if the effort expended on it is as good as possible in relation to the resources devoted to it. It is *effective* if the results obtained are in accordance with the objectives and targets for reducing the dimensions of a problem or improving an unsatisfactory situation. The *impact* of a programme is its overall effect on health status and socioeconomic development. See criterion 16 above for other definitions and rating. [0 - 1 -2]

PERIODICAL REVIEWS

19. **The composition of the group to undertake periodical reviews of the mental health policy is indicated.**

This group should include representatives of at least some of the sectors mentioned in criteria 6 and 7 above, in addition to experts in assessment and evaluation of health programmes.

Rate 1 if these sectors have been only mentioned without specification of their roles and functions. Rate 2 if these are specified. [0 - 1 - 2]

20. **The frequency of the reviews of the mental health policy is indicated.**

Rate 2 if reviews are done at least every two years; rate 1 if review intervals are greater than two years. [0 - 1 - 2]

21. **Eventual changes indicated by periodical reviews are duly and timely implemented.**

This criterion is to be assessed only if the policy has been in effect for at least two years and in accordance with its periodicity (see criterion 20 above). Implementation of changes is to be verified through independent informants; in these cases rate 2. Rate 1 if there is only internal audit. [0 - 1 - 2]

B - MENTAL HEALTH PROGRAMME GLOSSARY

1. **There is a written National Mental Health Programme.**

A national mental health programme is an organized aggregate of activities directed towards the attainment of specified objectives and targets, at national level, consistent with those of the national health policy and strategy. It should set out clearly the requirements in terms of health workers, physical facilities, technology, equipment and supplies, information and intercommunication, the methods of monitoring and evaluation, the timetable of activities, and the ways of ensuring correlation between its various elements and related programmes.

Rate 2 only if all these requirement are indicated and 1 if some but not all are indicated. [0 - 1 - 2]

2. **There are written Regional Mental Health Programmes.**

A regional mental health programme is a version of the national mental health programme adapted to certain defined regions. A region is the political and administrative unit immediately below the national level; in many federate countries it is called state, land or province, whereas in others it is called district.

Rate 2 only if all these requirements are indicated and 1 if some but not all are indicated. [0 - 1 - 2]

3. **There are written Local Mental Health Programmes.**

A local mental health programme is a version of the national (or regional) mental health programme adapted to certain and defined local levels. A local level is the smallest political and administrative unit in a region; in many countries it is designated by county, municipality, borough, burg, city or town.

Rate 2 only if all these requirement are indicated and 1 if some but not all are indicated. [0 - 1 - 2]

4. **Technicians, politicians and consumers participated in the preparation of Mental Health Programmes.**

Planning includes:

a) defining a strategy with clearly stated objectives and targets;
b) programme budgeting to ensure the preferential allocation of resources for the implementation of the strategy;
c) preparing plans of action, indicating the main lines of action to be taken in the health and other sectors to implement the strategy;
d) working out in detail each of the programmes in the plan of action;

e) indicating monitoring and evaluating programme mechanisms with a view to ensuring that they are proceeding as planned; and
f) ensuring the information support required for all the above.

Any given mental health programme should be an action programme agreed upon by all interested parties which includes:

a) parliamentarians, politicians and political administrators, who have the final decision on policy promulgation and budgetary allocations;
b) health and social workers, who are most closely involved in programme implementation; and
c) consumers, for whom the programme has been established and who will determine the utilization or not of the programme. *Consumers* of mental health services are those who suffer mental health problems ("primary consumers", who can be further subdivided into current users and ex-users), or their family members, who are also frequently involved in the service system.

Community participation in the preparation of health programmes is usually done through political parties and community-organized groups such as trade unions, women's organizations, farmers or other occupational groups (including organizations of health workers), churches and other religious groups.

Rate 2 if technicians, politicians and consumer's role in most of the above activities is clearly specified. Rate 1 if their role is only mentioned without specification. Rate 0 if not even mentioned. [0 - 1 - 2]

RANGE OF ACTIONS

5. **Actions for the promotion of mental health are clearly indicated.**

Promotion of mental health means raising the value attached to mental life and mental health in individuals, communities and societies. It is an evolving concept that encompasses fostering life-styles and other social, economic, environmental and personal factors conducive to health. These include:

a) raising people's awareness about health and mental health matters and enabling them to cope with health problems by increasing their knowledge and providing them with valid information;
b) encouraging adequate and appropriate diet and exercise and enough sleep;
c) ensuring education and work in conformity with physical and mental capacity;
d) making available suitable housing and safe water and sanitary facilities;
e) improving the physical, economic, cultural, psychological, and social environment; and
f) social support, for example by local women's groups.

Rate 2 only if all of a) - f) are indicated and 1 if some but not all of them are indicated. Rate 0 if no one is indicated. [0 - 1 - 2]

6. **Actions for the prevention of mental disorders are clearly indicated.**

Primary prevention covers measures seeking to prevent the initial occurrence of a disease or other health problems such as low birth weight or mental retardation, through such measures as health education, immunization, improved nutrition, improvement of the environment and appropriate care of women during pregnancy.

Rate 2 if clearly indicated and 1 if only mentioned. [0 - 1 - 2]

7. **Actions for the treatment of people with mental disorders are clearly indicated.**

Treatment - or secondary prevention - of mental disorders seeks to arrest or retard existing mental disorders through early detection and appropriate care or to reduce the occurrence of relapses and the establishment of chronicity.

Rate 2 if at least 3 disorders are included and 1 if only 1 or 2. [0 - 1 -2]

8. **Actions for psychosocial rehabilitation are clearly indicated.**

Psychosocial rehabilitation - or tertiary prevention - is a process whose aim is to restore the individual's social value and, more particularly, his/her working capacity to the fullest extent possible. It implies responsibility for reorganizing a patient's whole life and re-establishing satisfactory relationships between patients, on the one hand, and their families and the occupational as well as the entire social environment, on the other hand. Its actions, therefore, are not limited to the patient as an isolated individual, but covers also families, neighbours and colleagues at the workplace.

Rate 2 only with this wide coverage; rate 1 if only actions targeted at isolated individuals are indicated. [0 - 1 - 2]

9. **Actions for improving the linkage between mental health, social, and general health services are clearly indicated.**

The delivery of mental health services should be "horizontally" integrated into general health care services; it should not constitute an isolated "vertical" programme. Therefore, any mental health programme should indicate how the linkage among these sectors is to be put into operation.

Rate 2 only if mental, general health and social sectors are included; rate 1 if only social or general health care; rate 0 if there is no mention to this linkage. [0 - 1 - 2]

10. **Actions for enhancing the quality of life are clearly indicated.**

The perception and value of quality of life varies very much across cultures. Generally speaking the quality of life is a result of an interaction among physical status and mental status, social interactions, perceived environment and economic functioning. The health care system, however, usually deals with physical and - more rarely - mental aspects only.

Rate 2 only if actions including all the abovementioned factors are indicated; rate 1 if any other than physical and mental factors are mentioned, and rate 0 if only physical or mental aspects are mentioned. [0 - 1 - 2]

11. **Actions for improving education related to health are clearly indicated.**

Service quality depends basically on the people who provide services. These people must be given support via improved training and research. Training programmes - undergraduate, graduate and in-service - should be made available and be in line with the general principles of the mental health programme, favouring multidisciplinary practices, a movement beyond the traditional practice context into the living environment and participation of all partners.

Rate 2 only if indications of actions concerning all three abovementioned levels of education are given; rate 1 if at least one is included. [0 - 1 -2]

12. **Actions for improving research are clearly indicated.**

Research should be practically oriented and aim at the integration of biological, psychological and social factors. Research priority areas should be identified, such as those dealing with determinants of mental health and of mental disorders, needs of populations, consumer involvement, and service-oriented research.

Rate 2 only if priorities have been identified and are in line with the abovementioned aims; rate 1 if only the orientation or priorities are indicated. [0 - 1 -2]

13. **Actions for improving information dissemination are clearly indicated.**

Information programmes should be designed to improve the people's understanding of mental health problems, to promote access to services, and to offer information to persons with problems, their families and health workers on existing legislation respecting the right to health and social services.

Rate 2 if at least two of these aspects are indicated, and 1 if only one is indicated. [0 - 1- 2]

PLAN OF WORK

14. **The general objective of the Mental Health Programme is clearly stated.**

A general objective is the goal or general aim towards which to strive, for example to have an environment that is conducive to health or to have primary health care available to everybody or to have the population educated in relation to health and mental health. [0 - 1 - 2]

15. **The specific objectives of the Mental Health Programme are clearly stated.**

Specific objectives are the end results a programme seeks to achieve; for example, the objective of health education (see criterion 11 above) can be further specified as ensuring that people will want to be healthy, know how to stay healthy, do what they can individually and collectively to maintain health, and know how to seek help when required.

Rate 2 only if at least 3 specific objectives are clearly stated and 1 if 1 or 2 only. [0 - 1 - 2]

16. **Targets have been defined.**

A target is an intermediate result towards the objective that a programme seeks to achieve. It is more specific than an objective and the period within which it is to be attained is usually specified. It also lends itself more readily to being expressed in quantitative terms. Examples are the provision of essential psychiatric drugs to 80% of the population by 1995, or the reduction of psychiatric hospitals with more than 300 beds to less than 20% of the total number of psychiatric hospitals by 1996 or to 0 by 2000.

Rate 2 only if numerical results within a given timeframe are indicated; rate 1 if only one of these, and rate 0 if none. [0 - 1 - 2]

17. **Strategies and approaches are specified.**

An approach is a means or method of attaining an objective or target as, for example, the enactment of suitable legislation or the provision of appropriate training. [0 - 2]

18. **Priorities have been identified.**

Priorities are usually defined on the basis of the *dimension* and the *severity* of the problem, on the degree of *concern to societies and communities*, on the availability of *effective means of facing the problem* and on *cost/benefit* evaluations.

Rate 2 only if at least 3 specific priorities are clearly stated and 1 if 1 or 2 only. [0 - 1 - 2]

19. **The division/unit/post responsible for the programme is specified.**

Both the name of the person currently responsible for the overall management of the programme and his/her functional position in the government are indicated. [0 - 2]

20. **Catchment areas have been defined.**

Catchment area is a geographic area for which each facility is responsible. Although it certainly varies for facilities at different levels of complexity, there should be no overlapping of catchment areas for facilities of the same level of complexity. Moreover, all catchment areas put together should include all of the territory, leaving no uncovered areas;

in this case rate 2. If catchment areas have been defined without full coverage of the territory, rate 1. [0 - 1 - 2]

21. **The linkage among health services is indicated and specified.**

This implies organized collaboration as necessary among those providing services at the same and different levels of the health system - including both mental and general health services - in order to make the most efficient use of resources, as well as among the various categories of health workers, following agreement on the division of labour. [0 -1 - 2]

22. **The operational linkage with the social services sector is specified.**

These essential resources includes services, facilities, institutions or establishments, organizations and those operating them for the delivery of a variety of programmes useful for supporting mental health programme users. [0 - 2]

23. **Mechanisms for coordination and information exchange across national, regional, and local levels are indicated.**

Information support is essential for the managerial process. If there is no information the magnitude of the problem can be conveniently obscured and no decision or action need be taken; at the other extreme, however, there is the danger of over-collection of information that is irrelevant and never analyzed or presented in a meaningful way. Also, there is a trade-off between what is relatively simple and cheap to collect and the degree of precision of the information or its validity. A balance has to be struck between the allocation of resources to information collection for making priority decisions about alternative strategies and action, and the allocation of resources to the programmes themselves. It is important that the collection of information should not be undertaken as an alternative to decision-making. Difficulties in quantification, however, whether for planning or evaluation, should not impede action.

Rate 2 only if both precise indication on the content and format of the information to be collected, and the system of information exchange are given. Rate 1 if only either one is indicated. [0 - 1 - 2]

24. **Mechanisms for decision-making are indicated.**

A distinction should be made between the performance of a programme and the performance within a programme. The decision-maker is usually more interested in the performance of the system, whereas providers are more concerned with the performance of the health workers within the system and consumers with the quantity and quality of attention and services they receive. In order to avoid undue manipulation of the programme by legislative, administrative, educational or other means, clear principles, indicators and direction of results on which decisions are to be taken should be defined from the very beginning of the programme implementation. Also the levels in the administration responsible for different types of decision-making should also be indicated.

Rate 2 only if both principles and indicators, and persons responsible for the decisions are indicated; rate 1 if only either one is indicated. [0 - 1 - 2]

25. **Mechanisms for resource allocation are indicated.**

If the money is not there to pay for the programme, it will fail. Possible sources of funds include public sources, such as the government through the ministry of health or its equivalent and other ministries, regional and local governments, and state governments in countries with a federal system, as well as compulsory health insurance. They could also include private sources such as voluntary health insurance, voluntary organizations, community contributions, private employers, and individual payment. Moreover, they could derive from external sources such as international organizations, bilateral agencies and philanthropic bodies.

Rate 2 only if both the sources and the destination of the budget are indicated and rate 1 if only sources or destination is indicated. [0 - 1 - 2]

26. **Cost estimates and other budgetary implications are specified.**

There is a distinction between *capital expenditure* - i.e. the expenditure on land, buildings, and initial equipment and supplies to establish or extend health facilities such as health centres and hospitals - and *recurrent expenditure*, or current operating expenditure, which covers items that recur year after year, such as the remuneration of health workers and other staff; the cost of food and other goods and services; the cost of medicines, appliances and other supplies; the replacement of equipment; and the maintenance of buildings and equipment.

Rate 2 only if there is a detailed estimate of at least recurrent expenditure and rate 1 if only an overall estimate of the total cost of programme is made. [0 - 1 - 2]

27. **The Mental Health Programme is based on reasonable information on general, psychiatric and psychosocial morbidity/mortality data.**

These data are most reliable when obtained through a variety of sources, such as vital events registers, population and housing censuses, routine health service records, epidemiological surveillance data, sample surveys and diseases registers. In certain cases in which these sources are not available, or are too difficult to be obtained, reliable key-informants have proved to be reasonably good substitutes. The important point is that not only data related to treated mental disorders be used for planning, but that data on general health and on psychosocial factors be also included.

Rate 2 only if these latter two are used, in addition to psychiatric morbidity; rate 1 if either one is used. [0 - 1 - 2]

28. **The Mental Health Programme is based on existing facilities.**

To be feasible, the mental health programme has to be based on reality and not on dreams. Planned facilities should not be counted on for services delivery, except in future development plans. [0 - 2]

29. **The Mental Health Programme is based on existing human resources.**

The actual number and qualification of personnel should be considered when defining the programme actions. See criterion 25 above for other details and rating. [0 - 1 - 2]

MONITORING AND EVALUATION

30. **Monitoring and evaluation systems are specified.**

Monitoring is the term used for the continuous follow-up of activities to ensure that they are proceeding according to plan and that services and institutions concerned are delivering them *efficiently* and *effectively*. It keeps track of achievements, staff movements and utilization, supplies and equipment, and the money spent in relation to the resources available, so that if anything goes wrong immediate corrective measures can be taken. *Evaluation*, another essential part of the managerial process, systematically assesses the relevance, adequacy, progress, efficiency, effectiveness, and impact of a health programme. A programme is *relevant* if it answers the needs and social and health policies and priorities it has been designed to meet. It is *adequate* if it is proportionate to requirements. It is making good *progress* if its component activities are being carried out in accordance with the planned schedule. It is *efficient* if the effort expended on it is as good as possible in relation to the resources devoted to it. It is *effective* if the results obtained are in accordance with the objectives and targets for reducing the dimensions of a problem or improving an unsatisfactory situation. The *impact* of a programme is its overall effect on health status and socioeconomic development.

Rate 2 if both monitoring and evaluation are specified; rate 1 if only either one. [0 - 1 - 2]

31. **The monitoring system of programme implementation includes client characteristic and services utilization pattern.**

Programme implementation is its delivery by the health infrastructure applying sound day-to-day managerial procedures. A programme can only be useful and successful when services are compatible with population needs. Therefore, clients' characteristics and the pattern of utilization of services are useful indicators for an on-going monitoring of the programme and for rapidly indicating eventual corrections to be introduced.

Rate 2 only if both variables are included and 1 if only one of them. [0 - 1 - 2]

32. **The monitoring system of programme implementation includes cost assessments.**

See criteria 26 and 31 above for definitions. Rate 2 if actual costs are included and 1 if cost estimates are included. [0 - 1 - 2]

COMMUNITY PARTICIPATION

33. **The role and functions of consumers in the planning of mental health actions/programmes is specified.**

See item 4 above for other definitions. Rate 2 if consumer's role in most of the activities mentioned in item 4 is clearly specified. Rate 1 if their role is only mentioned without specification. Rate 0 if not even mentioned. [0 - 1 - 2]

34. **The role and functions of consumers in the implementation of mental health actions/programmes is specified.**

See criteria 4, 27 and 33 above for definitions and rating. [0 - 1 - 2]

35. **The role and functions of consumers in the evaluation of mental health actions/programmes is specified.**

See criteria 4, 30 and 33 above for other definitions and rating. [0 - 1 - 2]

C - THE PRIMARY HEALTH CARE FACILITY GLOSSARY

PHYSICAL ENVIRONMENT

1. **The facility has been officially inspected and meets local standards for the protection of the health and safety of patients and staff.**

Inspection must have taken place within the last 18 months. It is important to check to make certain that the facility has an adequate number of fire exits from the building. Other important safety factors, apart from emergency exits should also be checked, such as staircases (banisters), windows (large panes of glass or screens), etc.

Rate 2 only if the facility passed the inspection; otherwise, rate 0. [0 - 2]

2. **The space is sufficient for the number of patients seen.**

Space here refers to waiting rooms, toilets and space for administrative functions; it should be assessed by reference to local residential standards. [0 - 2]

3. **There is reasonable space for specific treatment procedures.**

This criterion refers to the types of treatment provided by the facility, for instance, medical examinations, family interviews, group therapy, occupational therapy, etc. Conditions which ensure privacy and confidentiality are essential to rate this criterion. The same space can be used for different therapeutic purposes, but *not* at the same time. Consider also the adequacy of the space, in terms of size, lighting and whether sound-proof. [0 - 2]

4. **The facility has an adequate supply of basic medical drugs.**

The supply should include at least essential drugs for the most frequent clinical conditions, (e.g. diarrhea, hypertension, diabetes, fever, cough, pain). Quantity should be sufficient to treat the number of patients with diseases for which these drugs are indicated.

Rate 2 if only supply is enough both in qualitative and quantitative terms; rate 1 if only in one of those; otherwise, rate 0. [0 - 1 - 2]

5. **The facility has an adequate supply of basic psychiatric drugs.**

The supply should include at least the psychoactive essential drugs listed by WHO (amitriptyline and/or imipramine, tablet; lithium carbonate, capsule or tablet; chlorpromazine and haloperidol, tablet and injectable; fluphenazine (decanoate or enantate) injectable; diazepam, tablet and injectable; phenobarbital, tablet; carbamazapine, tablet; biperiden, tablet and injectable). Quantity should be sufficient to treat the number of patients with diseases for which these drugs are indicated.

Rate 2 only if supply is enough both in qualitative and quantitative terms; rate 1 if only in one of these; otherwise, rate 0. [0 - 1 - 2]

6. **A first-aid kit is available in the facility.**

This includes anti-septic (e.g. chlorhexidine solution and gentian violet solution), absorbent cotton wool, adhesive tape, elastic bandage, gauze bandage and adhesive compresses. [0 - 2]

ADMINISTRATIVE ARRANGEMENTS

7. **A written policy on philosophy and model of care is available.**

This statement does not have to be lengthy or fancy. However, it should inform about programme philosophy specifying its objectives (e.g. to provide "crisis intervention" during acute situations, to provide social and vocational rehabilitation support to chronic patients, etc.). It should also provide enough information on the degree of expected family involvement in the care of the patient and on the working schedule of the facility. Information on fees and payments, if any, should also be provided. For patients and family members who do not read well, someone should read the statement to them on more than one occasion, if necessary and/or requested. [0 - 2]

8. **Priorities have been defined.**

Since it is usually impossible to deal with and treat every kind of mental disorder and problem situation appearing in the community, the facility should define and list some programme priorities (e.g. depression, alcoholism, mental retardation, functional psychoses, marital discord, family breakdown, dementia, etc) on which staff's efforts should concentrate. Priorities are best defined when based on the *dimension and severity* (both clinical and social) of the problem, on the *degree of concern to the community* and on the *availability of effective and affordable means of treatment* of (or for effectively dealing with) the problem. [0 - 2]

9. **Written policies on conditions of service for staff are available.**

These should cover at least salary, sick leave, hospitalization and holidays. Over and above the written contract of labour, the existence of positive benefits for each employee (depending on the conditions in force in each country) should also be considered important. In some cases even though written contracts do exist they do not ensure positive benefits for the employee, while in others, there are no written statements, yet labour relations are positive. [0 - 2]

10. **Job descriptions are specified for all staff.**

Ideally job descriptions should be made in terms of the expected outcomes of functioning of the facility - or of each of its units. Job descriptions could be specified either by professional category or by function. What is important is that each staff member knows exactly what is expected from him/her and the limits of his/her responsibilities and duties, and also that staff's skills are matched to tasks needed to reach the facility's objectives and goals. [0 - 2]

11. **Staff have a full medical examination annually.**

Benefits are expected to both staff and patients. Reports should be kept on file. Again, local patterns should be respected: in most developed countries, a bare minimum would include a chest X-ray, however this may not be feasible in some regions. [0 - 2]

12. **Written procedures for the protection of confidentiality of patients' and staff records are available.**

Confidentiality of patients' records is the responsibility of every staff member with access to them, including not only caregivers but also clerks in charge of records. Only the patient - or his/her legal or personal representative - may authorize the disclosure of any of this information to any person, even to family members, unless local law determines otherwise.

[0 - 2]

13. **Written records are appropriately maintained on all patients.**

Patients' records should include all information pertaining to the clinical situation and to all procedures and actions taken by any caregiver in relation to the patient as well as his/her responses and reactions. Information should be recorded in a legible format yet ensure full confidentiality; patients, nevertheless, should have access to their files upon request.

Rate 2 only if the information is recorded and patients have access to their own files; rate 1 if the information is recorded but patients do not have access to own files; otherwise rate 0. [0 - 1 - 2]

14. **Written records are appropriately maintained on all staff.**

Records on staff should include indication of function and its changes; salary; health status; absences, holidays and sick-leaves; promotions and disciplinary sanctions. They should also be confidential and each staff should have access to his/her own file upon request.

Rate 2 only if the information is recorded and staff have access to their own files; rate 1 if the information is recorded but staff do not have access to their own files; otherwise rate 0. [0 - 1 - 2]

15. **Written procedures to be followed if a violent episode breaks out are available.**

These written procedures should cover at least the situations described in criterion 35 (see) clearly indicating specific responsibilities during the episode and in its follow-up.

[0 - 2]

16. **Written procedures for dealing with complaints from patients and families are available.**

A specific book should exist to this end and a specific staff member should be

designated to take up this function. Procedures should also clearly indicate the level of authority expected to deal with complaints. [0 - 2]

17. **Written policies on disciplinary procedures are available.**

Beyond the purely labour contract rules, disciplinary sanctions should be clearly specified in case of abuse of patients and of infringements of patients' rights. The use of *undue* physical force and restraint to control a patient during episodes of violence or retaliatory measures taken afterwards are particular examples of abuse to which specific disciplinary procedures should be indicated. [0 - 2]

18. **All caregiving staff are required to participate in in-service training programmes.**

Such training programmes (also known as staff development) should be made available to develop the skills required for working with people with mental disorders. Training programmes should be made available according to indications of need. Participation in these training programmes should be recorded in staff files. [0 - 2]

19. **All staff have been trained in first aid.**

Training in first aid such as that given by the Red Cross, meets this requirement. [0 -.2]

20. **All caregiving staff have received training in basic nursing skills.**

This includes at least the ability to take care of personal hygiene and to feed patients when their physical or mental conditions do not allow them to do so for themselves. [0 - 2]

21. **Staff have been trained for the identification and treatment of patients with mental disorders.**

Many caregivers - even at the professional level - come to work with the mentally ill without any previous specific training. Therefore, at least one in-service training programme should be regularly provided to those arriving to work in this situation, during which they should be prepared for identifying and treating patients with mental disorders who come to the health facility *irrespective of the reasons for consulting*. Training for the management of violent patients and of episodes of violence is another specific training programme that must be made available.

Rate 2 if staff have been trained both for the identification and treatment of people with mental disorders *and* on management of violence; rate 1 if in only one of these programmes; otherwise rate 0. [0 - 1 - 2]

22. **Staff have been trained for the management of psychiatric emergencies.**

These emergencies should include at least suicide ideation or attempts, psychomotor excitement and consciousness disturbances (such as in toxic states and in delirium). Staff

should know how to handle patients and families, how to medicate and how and where to refer these patients.

Rate 2 if training covers the three conditions mentioned above; rate 1 if only one or two and 0 if none. [0 - 1 - 2]

23. **Staff have access to mental health specialist help in case of difficulty in the management of some patients.**

This includes both contact at distance (e.g. by telephone or radio) and the referral system that should be already agreed upon by the facility and the mental health specialist; in these instances, rate 2. Rate 1 if this possibility exists but depends on arrangements of the moment. [0 - 1 - 2]

24. **At least 10% of each staff's working time is dedicated to training, supervision and administrative activities.**

This time could be spent in either in-service training (see criterion 18) or training outside the facility (e.g. those mentioned in criteria 19-21), and in activities such as those mentioned in criteria 23, 26 and 27.

Rate 2 if this percentage is 10% or more; rate 1 if between 1% and 9%; otherwise rate 0. [0 - 1 - 2]

25. **At least 20% of each staff's working time is dedicated to work in the community.**

This time should be spent mostly in promotive and preventive activities, such as those mentioned in criteria 42-45, but part of it could also be used for home visits (see criterion 39).

Rate 2 if this percentage is 20% or more; rate 1 if between 1% and 19%; otherwise rate 0. [0 - 1 - 2]

26. **Opportunities are provided for staff to discuss with their superiors difficulties they may have in working with people with mental disorders.**

The daily work with people with mental disorders poses a burden on any person, even on those with adequate background training. Having the opportunity to discuss with a qualified person his/her own difficulties (a process also known as supervision) and possible alternatives to deal with them can greatly reduce the impact of this burden. These opportunities should be available on a regular basis but should also be made available when special situations arise.

Rate 2 if supervision is available in both circunstances; rate 1 when in only one; rate 0 when in none. [0 - 1 - 2]

27. **Annually, staff conduct an internal study to identify strengths and weaknesses in facility's policies and programmes.**

This type of study should lead to the specification of 3 or 4 programme goals for the year. These goals should be written down and anchored to specific objectives so that, at the end of the year, some sort of judgement can be made as to whether they have been achieved (*effectiveness*). All staff should participate in the selection of these goals, and should be involved in the decision as to whether they have been achieved. [0 - 2]

CARE PROCESS

28. **There is a manual for the identification and treatment of patients with mental disorders .**

This manual should include at least the facility's identified priorities (see criterion 8 above). One of the simplest models of such a manual can be found in WHO's "The Community Health Worker". [0 - 2]

29. **Every patient is evaluated in terms of biological, psychological and social functioning.**

The important point here is that not only physical aspects are evaluated; there should be a minimum understanding of the patient's current psycho-social situation and how these relate to the patient's visit to the facility. In these cases rate 2. Rate 1 if only brief and eventual mention is made to some of the patient's psychological or social conditions. [0 - 1 - 2]

30. **An informed consent is obtained prior to starting a planned treatment programme.**

Information on the goals and duration of the treatment, as well as risks involved and side-effects anticipated, should be clearly explained to and discussed with each patient in a language he/she can understand. All this information should exist in writing so that each patient can sign a consent-giving form. When the patient is not in a condition to understand the information or to give informed consent, this should be obtained from his/her personal representative. No treatment procedure, except for emergencies, should be started before these steps have been taken. [0 - 2]

31. **Treatment plans are written down for each patient and followed by all staff.**

Treatment plans should be appropriate for the patient's clinical condition and age. All the staff should comply with and enforce the plan written down in the patient's file. [0 - 2]

32. **There are clear written guidelines on the indications and use of drug therapies.**

These guidelines should include as a minimum:

a) indication of drug class by clinical diagnosis;
b) contraindications;
c) dosage (including range and specification of maximum dose authorized);
d) schedules for the introduction and for the withdrawal of medication;
e) measures in case of adverse effects;
f) persons authorized to prescribe and persons authorized to minister medication.

Rate 2 only if all a) - f) are written; rate 1 if at least some are written. [0 - 1 - 2]

33. **Meetings are held regularly for staff to discuss individual patient care plans.**

Ideally, meetings should be held more often than weekly; this is a bare minimum. All caregiving staff should attend these meetings (except for those who are supervising or are in other meetings with patients, and this duty should be rotated) and they should feel free to speak and participate in the discussions.

Rate 1 for meetings held at least once a week and 2 for more frequent meetings. [0 - 1 - 2]

34. **Patients are kept informed about their own progress.**

Patients should be informed on the reasons and the goals of the treatment and on what is expected from them. They should also be regularly and periodically - e.g. at every medical evaluation - informed on their progress in relation to those goals.

Rate 2 if both initial and periodical information are provided; rate 1 if only one of them; rate 0 if none. [0 - 1 - 2]

35. **Help and support are quickly available if violence breaks out.**

All staff (not only caregiving staff) have to be trained on the management of a violent patient or of collective violence without endangering their own security and without necessarily involving other patients. They should be instructed on how to react in case of, for instance, being grabbed around the neck or by the hair or tie, attacked with a sharp weapon, or threatened with a fire arm. Training in therapeutic physical control should be available on a regular and periodic basis to all staff to be used when:

i) a patient makes an attack on another person;
ii) a patient becomes disturbed to the extent that he/she is considered a danger to him/herself and/or others; and
iii) the use of force as an emergency measure is needed to give essential treatment.

Rate 2 if both initial and periodical training are provided; rate 1 if only one of them; rate 0 if none. [0 - 1 - 2]

INTERACTION WITH FAMILIES

36. **Upon request, family members have a chance to discuss the patient's care with a responsible member of staff.**

Ideally there should be regular meetings to which families are invited to discuss a patient's progress and to obtain orientation from the staff. As a bare minimum, visiting family members should have access to a responsible member of the staff (e.g. charge nurse, doctor) able to inform them on the patient's progress and to answer their doubts in relation to the patient and the disease. [0 - 2]

37. **Family members are encouraged to be involved in the patient's treatment programme.**

A maximum score for this criterion means not only that family members are encouraged to do these things but also that they actually do them, i.e. accompany the patient in some of the internal activities, participate in organized social activities, volunteer their services for help with special activities and attend family meetings. [0 - 2]

38. **Help and support are made available by staff to family members who need them.**

Caring for a person with a mental disorder can be a highly burdensome activity. In addition, having someone mentally ill in the family can create a great deal of anxiety and uncertainty. Staff should make themselves available to discuss family members' doubts and anxieties about the treatment and about the implications of mental illness. [0 - 2]

39. **Home visits are carried out for improving caring and coping skills of families of some selected patients.**

Some patients pose specific difficulties which can be best managed when families are instructed on how to act and react, and how to deal with them. Home visits for families with these specific difficulties represent a good opportunity not only for transmitting these instructions but also for strengthening the collaboration between staff, patient and family. [0 - 2]

40. **Patients are thoroughly oriented in relation to other health and social services available in their community.**

Patients and families should obtain clear information on other helpful facilities available and adequate for their needs both verbally and in writing. [0 - 2]

41. **Patients and family members are instructed about measures to take in case of relapse or reappearance of symptoms.**

Information on the immediate measures to be taken in case of relapse and on where to obtain quick help in case of need, particularly in hours when the facility is not open to the public, should also be given in writing to the patient and family. They should also be specifically informed on how to continue the treatment. [0 - 2]

OUTREACH

42. **Regular contact is maintained with other health facilities.**

Particularly with mental health outpatient and inpatient facilities, and with local or regional general hospitals. The aim is not only to follow-up patients being currently seen by both facilities but also to facilitate future referrals and back-referrals. [0 - 2]

43. **Regular contact is maintained with schools in the facility's area.**

The main goal is to develop promotive and primary prevention programmes but could also be effective for following-up some children under treatment. [0 - 2]

44. **Regular contact is maintained with other social agencies in the facility's area.**

Patients have many needs that cannot be satisfied by a single agency, therefore calling for a good coordination of efforts. The number and range of these social service agencies will vary from place to place but usually include housing, labour, welfare, education, justice, youth, family etc. Regular contacts should serve both for being updated on the availability of services and for adequate support of actual patients who need them. [0 - 2]

45. **Regular contact is maintained with patients' employers.**

Keeping or returning to a regular job is a sensible goal for many patients. Regular contact with employers (or with enterprises' departments of personnel) can be very useful for monitoring patients' progress and also for the development of promotive and primary prevention programmes reaching the enterprise as a whole. [0 - 2]

46. **A standard information form is always sent to another facility whenever a patient is referred to it.**

At least the reasons for referral should be indicated. If the patient does not manifest opposition, it should also contain information on maintenance medication; on social, occupational and family needs; on special areas of attention; and on specific risks. The same information should be written in duplicate: one copy to be given to the patient and the other one to be sent to the facility to which the patient is being referred. [0 - 2]

47. **A standard information form is always given to the patient whenever he/she is referred to another facility.**

The patient and/or his/her family are requested to present this form (with the same content as described in criterion 46 above) to the facility to which the patient is being referred. [0 - 2]

D - THE OUTPATIENT MENTAL HEALTH FACILITY GLOSSARY

PHYSICAL ENVIRONMENT

1. **The facility has been officially inspected and meets local standards for the protection of the health and safety of patients and staff.**

Inspection must have taken place within the last 18 months. It is important to check to make certain that the facility has an adequate number of fire exits from the building. Other important safety factors, apart from emergency exits should also be checked, such as staircases (banisters), windows (large panes of glass or screens), etc.

Rate 2 only if the facility passed the inspection; otherwise, rate 0. [0 - 2]

2. **The space is sufficient for the number of patients seen.**

Space here refers to waiting rooms, toilets and space for administrative functions; it should be assessed by reference to local residential standards. [0 - 2]

3. **There is reasonable space for specific treatment procedures.**

This criterion refers to the types of treatment provided by the facility, for instance, medical examinations, family interviews, group therapy, occupational therapy, etc. Conditions which ensure privacy and confidentiality are essential to rate this criterion . The same space can be used for different therapeutic purposes, but *not* at the same time. Consider also the adequacy of the space, in terms of size, lighting and whether sound-proof. [0 - 2]

4. **The facility has an adequate supply of basic medical drugs.**

The supply should include at least essential drugs for the most frequent clinical conditions, (e.g. diarrhea, hypertension, diabetes, fever, cough, pain). Quantity should be sufficient to treat the number of patients with diseases for which these drugs are indicated.

Rate 2 only if supply is enough both in qualitative and quantitative terms; rate 1 if only in one of those; otherwise, rate 0. [0 - 1 - 2]

5. **The facility has an adequate supply of basic psychiatric drugs.**

The supply should include at least the psychoactive essential drugs listed by WHO (amitriptyline and/or imipramine, tablet; lithium carbonate, capsule or tablet; chlorpromazine and haloperidol, tablet and injectable; fluphenazine (decanoate or enantate) injectable; diazepam, tablet and injectable; phenobarbital, tablet; carbamazapine, tablet; biperiden, tablet and injectable). Quantity should be sufficient to treat the number of patients with diseases for which these drugs are indicated.

Rate 2 only if supply is enough both in qualitative and quantitative terms; rate 1 if only in one of those, otherwise, rate 0. [0 - 1 - 2]

6. **A first-aid kit is available in the facility.**

This includes anti-septic (e.g. chlorhexidine solution and gentian violet solution), absorbent cotton wool, adhesive tape, elastic bandage, gauze bandage and adhesive compresses. [0 - 2]

ADMINISTRATIVE ARRANGEMENTS

7. **A written policy on philosophy and model of care is available.**

This statement does not have to be lengthy or fancy. However, it should inform about programme philosophy specifying its objectives (e.g. to provide "crisis intervention" during acute situations, to provide social and vocational rehabilitation support to chronic patients, etc.). It should also provide enough information on the degree of expected family involvement in the care of the patient and on the working schedule of the facility. Information on fees and payments, if any, should also be provided. For patients and family members who do not read well, someone should read the statement to them on more than one occasion, if necessary and/or requested. [0 - 2]

8. **Priorities have been defined.**

Since it is usually impossible to deal with and treat every kind of mental disorder and problem situation appearing in the community, the facility should define and list some programme priorities (e.g. depression, alcoholism, mental retardation, functional psychoses, marital discord, family breakdown, dementia, etc.) on which staff efforts should concentrate. Priorities are best defined when based on the *dimension* and *severity* (both clinical and social) of the problem, on the degree of *concern to the community* and on the *availability of effective and affordable means of treatment* of or for effectively dealing with the problem. [0 - 2]

9. **Written policies on conditions of service for staff are available.**

These should cover at least salary, sick leave, hospitalization and holidays. Over and above the written contract of labour, the existence of positive benefits for each employee (depending on the conditions in force in each country) should also be considered important. In some cases even though written contracts do exist they do not ensure positive benefits for the employee, while in others, there are no written statements, yet labour relations are positive. [0 - 2]

10. **Job descriptions are specified for all staff.**

Ideally job descriptions should be made in terms of the expected outcomes of functioning of the facility - or of each of its units. Job descriptions could be specified either by professional category or by function. What is important is that each staff member knows exactly what is expected from him/her and the limits of his/her responsibilities and duties, and

also that staff skills are matched to tasks needed to reach the facility's objectives and goals. [0 - 2]

11. **Staff is multidisciplinary.**

A complete multidisciplinary mental health team is usually composed of at least one of each professionals such as psychiatrist, clinical psychologist, nurse, occupational therapist and social worker, each of these last three with training in psychiatry or mental health. A multidisciplinary team for an outpatient mental health facility should comprise at least three of these five types of professionals. When it does not include a psychiatrist, the team should have easy and regular access to a physician for eventual drug prescription for some patients who might need it.

Rate 2 only if all types of professionals are present during working hours. Rate 1 if all are available during at least part of a working hours; otherwise rate 0. [0 - 1 - 2]

12. **Staff have a full medical examination annually.**

Benefits are expected for both staff and patients. Reports should be kept on file. Again, local patterns should be respected. In most developed countries, a bare minimum would include a chest X-ray, however this may not be feasible in some regions. [0 - 2]

13. **Written procedures for the protection of confidentiality of patients' and staff records are available.**

Confidentiality of patient records is the responsibility of every staff member with access to them, including not only caregivers but also clerks in charge of records. Only the patient - or his/her legal or personal representative - may authorize the disclosure of any of this information to any person, even to family members, unless local law determines otherwise. [0 - 2]

14. **Written records are appropriately maintained on all patients.**

A patient's records should include all information pertaining to the clinical situation and to all procedures and actions taken by any caregiver in relation to the patient as well as his/her responses and reactions. Information should be recorded in a legible format yet ensuring full confidentiality; patients, nevertheless, should have access to their files upon request.

Rate 2 only if the information is recorded and patients have access to their own files; rate 1 if the information is recorded but patients do not have access to their own files; otherwise rate 0. [0 - 1 - 2]

15. **Written records are appropriately maintained on all staff.**

Records on staff should include an indication of function and its changes; salary; health status; absences (holidays and sick-leave); promotions and disciplinary sanctions. They

should also be confidential and each staff member should have access to his/her own file upon request.

Rate 2 only if the information is recorded and staff have access to their own files; rate 1 if the information is recorded but staff do not have access to their own files; otherwise rate 0. [0 - 1 - 2]

16. **Written procedures to be followed if a violent episode breaks out, are available.**

These written procedures should cover at least the situations described in criterion 39 (see) clearly indicating specific responsibilities during the episode and in its follow-up. [0 - 2]

17. **Written procedures for dealing with complaints from patients and families are available.**

A specific book should exist to this end and a specific staff member should be designated to take up this function. Procedures should also clearly indicate the level of authority expected to deal with complaints. [0 - 2]

18. **Written policies on disciplinary procedures are available.**

Beyond the purely labour contract rules, disciplinary sanctions should be clearly specified in case of abuse of patients and infringements of patients' rights. The use of *undue* physical force and restraints to control a patient during episodes of violence or retaliatory measures taken afterwards are particular examples of abuse to which specific disciplinary procedures should be indicated. [0 - 2]

19. **All caregiving staff are required to participate in in-service training programmes.**

Such training programmes (also known as staff development) should be made available to develop the skills required for working with people with mental disorders. Training programmes should be made available according to indications of need. Participation in these training programmes should be recorded in staff files. [0 - 2]

20. **All staff have been trained in first aid.**

Training in first aid such as that given by the Red Cross, meets this requirement. [0 - 2]

21. **All caregiving staff have received training in basic nursing skills.**

This includes at least the ability to take care of personal hygiene and to feed patients when their physical or mental condition does not allow them to do so for themselves. [0 - 2]

22. **Staff have been trained for dealing with and treating patients with mental disorders.**

Many caregivers - even at the professional level - come to work with the mentally ill without any previous specific training. Therefore, at least one in-service training programme should be regularly provided to those arriving to work in this situation, during which they should be prepared for the tasks pertaining to their functions. Training for the management of violent patients and of episodes of violence is another specific training programme that must be made available.

Rate 2 if staff have been trained both for their task *and* on management of violence; rate 1 if in only one of these programmes; otherwise rate 0. [0 - 1 - 2]

23. **Staff have been trained specifically for the management of psychiatric emergencies.**

These emergencies should include at least suicide ideation or attempts, psychomotor excitement and agitation, and consciousness disturbances (such as in toxic states and in delirium). Staff should know how to handle patients and families, how to medicate, and how and where to refer these patients.

Rate 2 if training covers the three conditions mentioned above; rate 1 if only one or two, and 0 if none. [0 - 1 - 2]

24. **At least 10% of each staff member's working time is dedicated to training, supervision and administrative activities.**

This time could be spent in either in-service training (see criterion 19) or in training outside the facility (e.g. those mentioned in criteria 20-23), and in activities such as those mentioned in criteria 26 and 27.

Rate 2 if this percentage is 10% or more; rate 1 if between 1% and 9%; otherwise rate 0. [0 - 1 - 2]

25. **At least 20% of each staff member's working time is dedicated to work in the community.**

This time should be spent mostly in promotive and preventive activities, such as those mentioned in criteria 48-51, but part of it could also be used for home visits (see criterion 44).

Rate 2 if this percentage is 20% or more; rate 1 if between 1% and 19%; otherwise rate 0. [0 - 1 - 2]

26. **Opportunities are provided for staff to discuss with their superiors, difficulties they may have in working with people with mental disorders.**

The daily work with people with mental disorders poses a burden on any person, even on those with adequate background training. Having the opportunity to discuss with a qualified person his/her own difficulties (a process also known as supervision) and possible alternatives to deal with them can greatly reduce the impact of this burden. These opportunities should be available on a regular basis but also should be made available when special situations arise.

Rate 2 if supervision is available in both circunstances; rate 1 when in only one; rate 0 when in none. [0 - 1 - 2]

27. **Annually, staff conduct an internal study to identify strengths and weaknesses in the facility's policies and programmes.**

This type of study should lead to the specification of 3 or 4 programme goals for the year. These goals should be written down and anchored to specific objectives so that, at the end of the year, some sort of judgement can be made as to whether they have been achieved (*effectiveness*). All staff should participate in the selection of these goals, and should be involved in the decision as to whether they have been achieved. [0 - 2]

CARE PROCESS

28. **Every patient is evaluated in terms of biological, psychological and social functioning.**

The important point here is that not only psychological aspects are evaluated; there should be a minimum understanding of the patient's current physical and social situation as well, and how these relate to the patient's visit to the facility. In these cases rate 2. Rate 1 if only brief and eventual mention is made to some of the patient's physical or social conditions. [0 - 1 - 2]

29. **Staff speak frequently to patients and always in a friendly, positive and courteous manner.**

"Positive" refers to supportive as opposed to critical comments made to patients. The language employed should reveal respect for the patients, just as staff expect the patients to respect them. Staff should address patients politely, preferably using the titles they are given in their community or any other form patients prefer. [0 - 2]

30. **At least 45 minutes are allocated for a staff member to see each new patient.**

Depending on the patient's actual situation more time may be needed. Rate 2 for this criterion only if at least 45 minutes are allocated; rate 1 if between 15 and 44 minutes, and 0 if less than 15 minutes are allocated to see a patient for the first time. [0 - 1 - 2]

31. **At least 20 minutes are allocated for a staff member to see each patient from the second visit on.**

Again depending on the patient's actual situation more time may be needed. Rate 2 only if at least 20 minutes are allocated; rate 1 if between 10 and 19 minutes, and 0 if less than 10 minutes are allocated for each patient's visit. [0 - 1 - 2]

32. **At least 60 minutes are allocated for each group activity with patients.**

Group activities should include at least three patients and frequently include more than four. The actual size of the group will depend on the technique being employed and on the responsible for the group's preference.

Rate 2 if group activities last for at least 60 minutes; rate 1 if they last between 30 and 59 minutes, and 0 if they last for less than 30 minutes. [0 - 1 - 2]

33. **An informed consent is obtained prior to starting a planned treatment programme.**

Information on the goals and duration of the treatment, as well as risks involved and side-effects anticipated, should be clearly explained to and discussed with each patient in a language he/she can understand. All this information should exist in writing so that each patient can sign a consent-giving form. When the patient is not in a condition to understand the information or to give informed consent, this should be obtained from his/her personal representative. No treatment procedure, except for emergencies, should be started before these steps have been taken. [0 - 2]

34. **There are clear written guidelines on the indications and use of drug therapies.**

These guidelines should include as a minimum:

a) indication of drug class by clinical diagnosis;
b) contraindications;
c) dosage (including range and specification of maximum dose authorized);
d) schedules for the introduction and for the withdrawal of medication;
e) measures in case of adverse effects;
f) persons authorized to prescribe and persons authorized to minister medication.

Rate 2 only if all a) - f) are written; rate 1 if at least some are written. [0 - 1 - 2]

35. **There are clear written guidelines on the role and on the goals of occupational therapy and rehabilitation activities.**

Occupational therapy and rehabilitation activities are meant to help patients, not to exploit them, and should never be imposed upon them; they should never be "prescribed" as a means of keeping patients "busy". If any money or value is derived from these activities, they should go to the patient and not to the facility or the caregivers. The cost of basic goods

can of course be deducted from the final value of the product. Guidelines should indicate the range of activities available to patients and the system for cost-evaluating them. [0 - 2]

36. **Treatment plans are written down for each patient and followed by all staff.**

Treatment plans should be appropriate for the patient's clinical condition and age. All staff should comply with and enforce the plan written down in the patient's file. [0 - 2]

37. **Meetings are held regularly for staff to discuss individual patient care plans.**

Ideally, meetings should be held more often than weekly; this is a bare minimum. All caregiving staff should attend these meetings (except for those who are supervising or are in other meetings with patients, and this duty should be rotated) and they should feel free to speak and participate in the discussions.

Rate 1 for meetings held at least once a week and 2 for more frequent meetings. [0 - 1 - 2]

38. **Patients are kept informed about their own progress.**

Patients should be informed on the reasons and the goals of the admission and on what is expected from them. They should also be regularly and periodically - e.g. at every medical evaluation - informed on their progress in relation to those goals.

Rate 2 if both initial and periodical information are provided; rate 1 if only one of them; rate 0 if none. [0 - 1 - 2]

39. **Help and support are quickly available if violence breaks out.**

All staff (not only caregiving staff) have to be trained on the management of a violent patient or of collective violence without endangering their own security and without necessarily involving other patients. They should be instructed on how to react in case of, for instance, being grabbed around the neck or by the hair or tie, attacked with a sharp weapon, or threatened with a fire arm. Training in therapeutic physical control should be available on a regular and periodic basis to all staff to be used when:

i) a patient makes an attack on another person;
ii) a patient becomes disturbed to the extent that he/she is considered a danger to him/herself and/or others; and
iii) the use of force as an emergency measure is needed to give essential treatment.

Rate 2 if both initial and periodical training are provided; rate 1 if only one of them; rate 0 if none. [0 - 1 - 2]

40. **Staff have access to specialist medical help in case of an emergency.**

Such as when a patient is badly scalded. This medical help can exist in the same

facility or at an external service, in which case the means and the process for transferring patients have been established and made known to all relevant staff. [0 - 2]

INTERACTION WITH FAMILIES

41. **Upon request family members have a chance to discuss the patient's care with a responsible member of staff.**

Ideally there should be regular meetings to which families are invited to discuss a patient's progress and to obtain orientation from the staff. As a bare minimum, visiting family members should have access to a responsible member of the staff (e.g. charge nurse, doctor) able to inform them on the patient's progress and to answer their doubts in relation to the patient and the disease. [0 - 2]

42. **Family members are encouraged to be involved in the patient's treatment programme.**

A maximum score for this criterion means not only that family members are encouraged to do these things but also that they actually do them, i.e. accompany the patient to some of the internal activities, participate in organized social activities, volunteer their services to help with special activities and attend family meetings. [0 - 2]

43. **Help and support are made available by staff to family members who need them.**

Caring for a person with a mental disorder can be a highly burdensome activity. In addition, having someone mentally ill in the family can create a great deal of anxiety and uncertainty. Staff should make themselves available to discuss family members' doubts and anxieties about the treatment and about the implications of mental illness. [0 - 2]

44. **Home visits for improving care and coping skills of families of some selected patients are carried out.**

Some patients pose specific difficulties which can be best managed when families are instructed on how to act and react, and how to deal with them. Home visits for families with these specific difficulties represent a good opportunity not only for transmitting these instructions but also for strengthening the collaboration between staff, patient and families. [0 - 2]

DISCHARGE AND FOLLOW-UP

45. **Discharge plans are discussed by all staff and with the patient concerned.**

As soon as the situation which resulted in the treatment is resolved, discharge should take place. All caregiving staff involved in the patient's treatment should be heard in this respect and the patient be kept informed on the discharge plans. [0 - 2]

46. **Patients are thoroughly oriented in terms of other health and social services available in their community.**

Patients and families should obtain clear information on other helpful facilities available and adequate for their needs both verbally and in writing. [0 - 2]

47. **Patients and family members are instructed about measures to take in case of relapse or reappearance of symptoms.**

Information on the immediate measures to be taken in case of relapse and on where to obtain quick help in case of need, particularly in hours when the facility is not open to the public, should be given in writing to the patient and family. They should also be specifically informed on how to continue the treatment. [0 - 2]

OUTREACH

48. **Regular contact is maintained with other health facilities.**

Particularly with primary health care facilities, mental hospitals, and with local and regional general hospitals in the same catchment area of the facility. The aim is not only to follow-up patients being currently seen in both facilities but also to facilitate future referrals and back-referrals. [0 - 2]

49. **Regular contact is maintained with schools in the facility's area.**

The main goal is to develop promotive and primary prevention programmes but could also be effective for following-up some children under treatment. [0 - 2]

50. **Regular contact is maintained with other social agencies in the facility's area.**

Patients have many needs that cannot be satisfied by a single agency and therefore call for a good coordination of efforts. The number and range of these social service agencies will vary from place to place but usually include housing, labour, welfare, education, justice, youth, family etc. Regular contacts should serve both as an update on the availability of services and as adequate support of actual patients who need them. [0 - 2]

51. **Regular contact is maintained with patients' employers.**

Keeping or returning to a regular job is a sensible goal for many patients. Regular contact with employers (or with enterprises' departments of personnel) can be very useful for monitoring a patient's progress and also for the development of promotive and primary prevention programmes reaching the enterprise as a whole. [0 - 2]

52. **A standard information form is always sent to another facility whenever a patient is referred to it.**

At least the reasons for referral should be indicated. If the patient does not manifest opposition, it should also contain information on maintenance medication; on social, occupational and family needs; on special areas of attention; and on specific risks. The same information should be written in duplicate: one copy to be given to the patient and the other copy to be sent to the facility to which the patient is being referred. [0 - 2]

53. **A standard information form is always given to the patient whenever he/she is referred to another facility.**

The patient and/or his/her family are requested to present this form (with the same content as described in criterion 52 above) to the facility to which the patient is being referred. [0 - 2]

E - THE INPATIENT MENTAL HEALTH FACILITY GLOSSARY

PHYSICAL ENVIRONMENT

1. **The facility has been officially inspected and meets local standards for the protection of the health and safety of the inpatients and staff.**

This criterion should be scored even in regions which have no state or local laws or regulations pertaining to hospitals. In such cases, the observer/interviewer is expected to use standards based on the knowledge of conditions in other facilities that provide care. Last inspection must have taken place within the last 18 months. It is important to ensure that the hospital/unit has an adequate number of exits from the building. Other important safety factors, apart from emergency exits should also be checked, such as staircases (banisters), windows (large panes of glass or screens), etc.

Rate 2 only if the facility passed the inspection; otherwise, rate 0. [0 - 2]

2. **The ward space is sufficient for the number of patients admitted.**

In many regions, four to six square meters per patient is considered a reasonable amount of indoor space per patient; this amount should be adjusted for local residential standards. [0 - 2]

3. **There is reasonable space for specific treatment procedures.**

For instance, for admission, medical examinations, occupational therapy activities; conditions which ensure privacy and confidentiality are essential to rate this criterion. The same space can be used for different therapeutic purposes, but *not* at the same time. Consider also the adequacy of the space, in terms of size, lighting and whether sound-proof. [0 - 2]

4. **There is reasonable space for recreational activities.**

Rate 2 when space for both indoor and outdoor activities is available; rate 1 when only one is available; otherwise rate 0. [0 - 1 - 2]

5. **There is reasonable space for receiving visitors.**

This criterion should be rated according to local usage in terms of privacy and seating accommodations. [0 - 2]

6. **Adequate space is provided for patients to store their personal belongings.**

This does not have to be an expensive or highly formalized arrangement; there must be at least some safe space for storing a few pieces of clothing and some toiletries. [0 - 2]

7. **The ward is arranged in such a way that each patient has a small piece of territory which is seen as his/hers.**

The important aspect of this criterion is that each patient should have some little space that is identified as a "personal space" that is respected by everyone in the hospital. [0 - 2]

8. **Toilets are in good working order for all patients.**

This also includes state of cleanliness of toilet basins and floors. Assessment is to be made chiefly on the basis of observations, in addition to interviewing patient. [0 - 2]

9. **A reasonable daily supply of water is available for patients.**

Availability of both drinking and washing water is to be assessed, taking into account local climatic conditions. [0 - 2]

10. **There is reasonable privacy for relevant bodily functions.**

Both toilets and bathrooms have doors that can be locked from the inside. Staff, however, need to have means to open those doors in case of emergencies. [0 - 2]

11. **The ward has adequate lighting.**

There should be enough light in the rooms for patients to see well enough to carry out their ordinary activities. [0 - 2]

12. **The ward is cleaned daily.**

The type of cleaning process will depend on the floor material. Rate 2 only if floor is washed or brushed every day and the waste is removed accordingly. Rate 1 if cleaning is done less than daily, but at least once a week; otherwise rate 0. [0 - 1 - 2]

13. **Sufficient and appropriate bedding equipment is available for use by the patients.**

Local usage (e.g. bed, mattress, hammock) should be taken into account when assessing this criterion . Bed linen should be changed at least once every week or whenever soiled by bodily fluids or excreta. There should be at least one bed (or equivalent) per patient. [0 - 2]

14. **Sufficient and appropriate seating equipment is available for use by the patients.**

Local usage (e.g. seating or squatting) should be taken into account when assessing this criterion. When seating is the local preference there should be a seat for every patient. [0 - 2]

15. **Sufficient and appropriate eating utensils are available for use by the patients.**

Local usage (e.g. cutlery, sticks, fingers) should be taken into account when assessing this criterion. Also adequacy of eating utensils for type of food served and for clinical conditions of patients. Clean utensils should be available for every patient at every meal. [0 - 2]

16. **The facility has an adequate supply of basic medical drugs.**

The supply should include at least essential drugs for the most frequent clinical conditions, (e.g. diarrhea, hypertension, diabetes, fever, cough, pain). Quantity should be sufficient to treat the number of patients with diseases for which these drugs are indicated.

Rate 2 if only supply is enough both in qualitative and quantitative terms; rate 1 if only in one of those; otherwise, rate 0. [0 - 1 - 2]

17. **The facility has an adequate supply of basic psychiatric drugs.**

The supply should include at least the psychoactive essential drugs listed by WHO (amitriptyline and/or imipramine, tablet; lithium carbonate, capsule or tablet; chlorpromazine and haloperidol, tablet and injectable; fluphenazine (decanoate or enantate) injectable; diazepam, tablet and injectable; phenobarbital, tablet; carbamazapine, tablet; biperiden, tablet and injectable). Quantity should be sufficient to treat the number of patients with diseases for which these drugs are indicated.

Rate 2 if only supply is enough both in qualitative and quantitative terms; rate 1 if only in one of those; otherwise, rate 0. [0 - 1 - 2]

18. **A first-aid kit is available in each ward.**

This includes anti-septic (e.g. chlorhexidine solution and gentian violet solution), absorbent cotton wool, adhesive tape, elastic bandage, gauze bandage and adhesive compresses. [0 - 2]

19. **All potentially dangerous products are stored out of reach of patients.**

Dangerous products include medicines, syringes and needles, chemicals and cleaning products. There should be at least one locked cupboard for storage of medical supplies and another one for storage of cleaning products. [0 - 2]

20. **The facility kitchen complies with recommended local standards for hygiene and food service.**

Irrespective of local standards, all cooking and eating utensils should be washed with soap and hot water, after every use and stored away from insects reach. The kitchen's and eating-room's floor should be washed and waste removed on a daily basis. [0 - 2]

ADMINISTRATIVE ARRANGEMENTS

21. **A written policy on philosophy and model of care is available.**

This statement does not have to be lengthy or fancy. However, it should inform about programme philosophy specifying its objectives (e.g. to provide "crisis intervention" during acute situations, to provide social and vocational rehabilitation support to chronic patients, etc.). It should also provide enough information on the degree of expected family involvement in the care of the patient, on the working schedule of the facility and on the limits of displacements of patients within and outside the facility. Information on fees and payments, if any, should also be provided. For patients and family members who do not read well, someone should read the statement to them on more than one occasion, if necessary and/or requested. [0 - 2]

22. **Written policies on conditions of service for staff are available.**

These should cover at least salary, sick leave, hospitalization and holidays. Over and above the written contract of labour, the existence of positive benefits for each employee (depending on the conditions in force in each country) should also be considered important. In some cases even though written contracts do exist they do not ensure positive benefits for the employee, while in others, there are no written statements, yet labour relations are positive. [0 - 2]

23. **Job descriptions are specified for all staff.**

Ideally job descriptions should be made in terms of the expected outcomes of functioning of the facility - or of each of its units. Job descriptions could be specified either by professional category or by function. What is important is that each staff member knows exactly what is expected from him/her and the limits of his/her responsibilities and duties, and also that staff skills are matched to tasks needed to reach the facility's objectives and goals. [0 - 2]

24. **At least two-thirds of the caregivers in the facility's staff are employed full-time.**

Caregivers are members of the staff who actually and directly work with patients and may not include other persons present in the facility (director, cleaner, cook, secretary) who might be on the premises but who are not directly involved with the patients. *Full-time* work means approximately six to eight hours per day of work or 40 to 50 hours per week. In many parts of the world, caregiving staff are hired on a part-time basis and come to work at erratic and unpredictable hours (usually due to the accumulation of more than one part-time employment). When a significant proportion of the caregivers are hired in this way, it becomes difficult for the patients to find predictability in the personnel of the facility.

Rate 2 if at least two-thirds of caregivers are employed full-time. Rate 1 if between 40% and 60% of caregivers are employed full-time; otherwise rate 0. [0 - 1 - 2]

25. **Staff have a full medical examination annually.**

Benefits are expected for both staff and patients. Reports should be kept on file. Again, local patterns should be respected. In most developed countries, a bare minimum would include a chest X-ray, however this may not be feasible in some regions. [0 - 2]

26. **Staff are provided with space to be away from patients at appropriate periods during the day.**

The care of mental patients is very demanding and staff should be given regular breaks during the day. There should be at least a 15-minute break in the morning and again in the afternoon (for full time staff) and a 30-minute break for main meals. A maximum score on this criterion should also indicate that there is a separate bathroom for caregivers, a separate place to eat their food (when they are not on meal duty with patients) and a place where they can be physically away from the patients during their breaks. [0 - 2]

27. **Staff are provided with time to be away from patients at appropriate periods during the day.**

See criterion 26 above. [0 - 2]

28. **Written procedures for the protection of confidentiality of patients' and staff records are available.**

Confidentiality of patients' records is the responsibility of every staff member with access to them, including not only caregivers but also clerks in charge of records. Only the patient or his/her legal or personal representative may authorize the disclosure of any of these information to any person, even to family members, unless local law determines otherwise. [0 - 2]

29. **Written records are appropriately maintained for all patients.**

Patients' records should include all information pertaining to the clinical situation and to all procedures and actions taken by any caregiver in relation to the patient as well as his/her responses and reactions. Information should be recorded in a legible format yet ensuring full confidentiality; patients, nevertheless, should have access to their files upon request.

Rate 2 only if the information is recorded and patients have access to their own files; rate 1 if the information is recorded but patients do not have access to their own files; otherwise rate 0. [0 - 1 - 2]

30. **Written records are appropriately maintained on all staff.**

Records on staff should include an indication of function and its changes; salary; health status; absences (holidays and sick-leave); promotions and disciplinary sanctions. They should also be confidential and each staff member should have access to his/her own file upon request.

Rate 2 only if the information is recorded and staff have access to their own files; rate 1 if the information is recorded but staff do not have access to their own files; otherwise rate 0. [0 - 1 - 2]

31. **Written procedures to be followed if a violent episode breaks out, are available.**

These written procedures should cover at least the situations described in criterion 66 (see) clearly indicating specific responsibilities during the episode and in its follow-up. [0 - 2]

32. **Written procedures for dealing with complaints from patients and families are available.**

A specific book should exist to this end and a specific staff member should be designated to take up this function. Procedures should also clearly indicate the level of authority expected to deal with complaints. [0 - 2]

33. **Written policies on disciplinary procedures are available.**

Beyond the purely labour contract rules, disciplinary sanctions should be clearly specified in case of abuse of patients and of infringement of patients' rights. The use of *undue* physical force and restraint to control a patient during episodes of violence or retaliatory measures taken afterwards are particular examples of abuse to which specific disciplinary procedures should be indicated. [0 - 2]

34. **All caregiving staff are required to participate in in-service training programmes.**

Such training programmes (also known as staff development) should be made available to develop the skills required for working with people with mental disorders. Training programmes should be made available according to indications of need. Participation in these training programmes should be recorded in staff files. [0 - 2]

35. **All caregiving staff have been trained in first aid.**

Training in first aid such as that given by the Red Cross, meets this requirement. [0 - 2]

36. **All caregiving staff have received training in basic nursing skills.**

This includes at least the ability to take care of personal hygiene and to feed patients when their physical or mental conditions do not allow them to do it for themselves. [0 - 2]

37. **Staff have been trained for dealing with and treating patients with mental disorders.**

Many caregivers - even at the professional level - come to work with the mentally ill without any previous specific training. Therefore, at least one in-service training programme

should be regularly provided to those arriving to work in this situation, during which they should be prepared for the tasks pertaining to their functions. Training for the management of violent patients and of episodes of violence is another specific training programme that must be made available.

Rate 2 if staff have been trained both for the identification and treatment of people with mental disorders *and* on management of violence; rate 1 if in only one of these programmes; otherwise rate 0. [0 - 1 - 2]

38. **Staff have been trained specifically for the management of psychiatric emergencies.**

These emergencies should include at least suicide ideation or attempts, psychomotor excitement and agitation, and consciousness disturbances (such as in toxic states and in delirium). Staff should know how to handle patients and families, how to medicate, and how and where to refer these patients.

Rate 2 if training covers the three conditions mentioned above; rate 1 if only one or two and 0 if none. [0 - 1 - 2]

39. **Opportunities are provided for staff to discuss with their superiors, difficulties they may have in working with people with mental disorders.**

The daily work with people with mental disorders poses a burden on any person, even on those with adequate background training. Having the opportunity to discuss with a qualified person his/her own difficulties (a process also known as supervision) and possible alternatives to deal with them can greatly reduce the impact of this burden. These opportunities should be available on a regular basis but should also be made available when special situations arise.

Rate 2 if supervision is available in both circunstances; rate 1 when in only one ; rate 0 when in none. [0 - 1 - 2]

40. **Annually, staff conduct an internal study to identify strengths and weaknesses in the facility's policies and programmes.**

This type of study should lead to the specification of 3 or 4 programme goals for the year. These goals should be written down and anchored to specific objectives so that, at the end of the year, some sort of judgement can be made as to whether they have been achieved (*effectiveness*). All staff should participate in the selection of these goals, and should be involved in the decision as to whether they have been achieved. [0 - 2]

STAFFING

41. **The facility has the equivalent of at least one full-time psychiatrist per 20 acute patients.**

A *psychiatrist* is a medical doctor who has had at least two years of post-graduate training in psychiatry, in a recognized teaching institution. An *acute patient* is a patient who has been in the hospital for less than a month, whose clinical condition does not indicate a chronic and deteriorating condition requiring an indefinite stay in hospital and for whom discharge can be reasonably expected within the next three months. See criterion 24 for definition of *full-time*, in this case it could be either one psychiatrist working eight hours per day or two psychiatrists working four hours per day each or four psychiatrists working two hours per day each.

Rate 2 if the criterion is fulfilled; rate 1 if there is at least one full-time psychiatrist at the facility; otherwise rate 0. [0 - 1 - 2]

42. **The facility has the equivalent of at least one full-time psychiatrist per 60 chronic patients.**

A *chronic patient* is a patient whose current hospitalization lasts for at least six months, or who has spent at least one out of the last four years as an inpatient in a psychiatric facility; usually, but not necessarily, he/she lives in the facility on an indefinite basis. See criteria 24 and 41 above for other definitions.

Rate 2 if the criterion is fulfilled; rate 1 if there is at least one full-time psychiatrist at the facility; otherwise rate 0. [0 - 1 - 2]

43. **The facility has the equivalent of at least one full-time registered nurse per 40 patients.**

A *registered nurse* is a graduate from a recognized Nursing School at the university level, registered at the local Board (or equivalent) of Nurses. Consider patients irrespective of their status of acute or chronic. See criteria 24 and 41 above for other definitions.

Rate 2 if the criterion is fulfilled; rate 1 if there is at least one full-time registered nurse at the facility; other wise rate 0. [0 - 1 - 2]

44. **The facility has the equivalent of at least one full-time qualified occupational therapist per 40 patients.**

A *certified occupational therapist* is a graduate from a recognized School of Occupational Therapy at the university level, registered at the local Board (or equivalent) of Occupational Therapists. See criteria 24, 41and 43 above for other definitions.

Rate 2 if the criterion is fulfilled; rate 1 if there is at least one full-time certified occupational therapist at the facility; otherwise rate 0. [0 - 1 - 2]

45. **The facility has the equivalent of at least one full-time qualified clinical psychologist per 40 patients.**

A *certified clinical psychologist* is a graduate from a recognized School of Psychology at the university level, with specialization in Clinical Psychology, and registered at the local Board (or equivalent) of Psychologists. See criteria 24, 41 and 43 above for other definitions.

Rate 2 if the criterion is fulfilled; rate 1 if there is at least one full-time certified clinical psychologist at the facility; otherwise rate 0. [0 - 1 - 2]

46. **The facility has the equivalent of at least one full-time qualified social worker per 40 patients .**

A *certified social worker* is a graduate from a recognized School of Social Work at the university level, registered at the local Board (or equivalent) of Social Workers. See criteria 24, 41 and 43 above for other definitions.

Rate 2 if the criterion is fulfilled; rate 1 if there is at least one full-time certified social worker at the facility; otherwise rate 0. [0 - 1 - 2]

47. **The facility has at least one dedicated internist per 60 patients.**

An *internist* is a medical doctor who, irrespective of having any medical specialization, works in this facility as a general physician looking after the general aspects of health care of patients. No specific time allotment is indicated but the intervals between examinations for each patient are indicated in criteria 56-58.

Rate 2 if the criterion is fulfilled; rate 1 if there is at least one full-time internist at the facility; otherwise rate 0. [0 - 1 - 2]

48. **The facility has at least one half-time dentist per 200 patients.**

A *dentist* is a graduate from a recognized Dental School at the university level, registered at the local Board (or equivalent) of Dentists. The main tasks of the dentist include an oral examination of newly admitted patiens, care for oral health emergencies, general oral health care to patients who may need it, and prevention of oral disorders. Facilities with less than 200 patients should ensure that their patients' oral health is cared for by a dentist from another nearby facility. See criteria 24, 41 and 43 above for other definitions.

Rate 2 if the criterion is fulfilled; rate 1 if patients at least have access to an outside dentist; otherwise rate 0. [0 - 1 - 2]

49. **The facility has at least one full-time caregiving staff member per 5 patients during day shifts.**

See criterion 24 above for definitions. In this case they include both professionals mentioned above and non-professionals, such as nursing-aides, health assistants, etc. [0 - 2]

50. **The facility has at least one full time caregiving staff member per 15 patients during night shifts.**

See criteria 24 and 48 above for definitions. Since most therapeutic activities occur during day time, day shifts call for more caregivers than night shifts, when patients are expected to sleep and less activities are planned. [0 - 2]

51. **At least one professional staff member is on duty in the ward at all times.**

This refers to both day and night shifts. This professional staff member has to have the capacity of dealing with urgent matters, admitting patients, making necessary referrals, receiving and informing family members and authorizing leave or discharging patients, eventually on behalf of the competent authority. [0 - 2]

CARE PROCESS

52. **Newly arrived patients are made to feel welcome on admission.**

Newly arrived patients are introduced to staff and to other patients; are shown the premises - with particular indication of washrooms and of his/her bed and locker - and are informed on the main rules of the facility, e.g. meal times, awakening and silence hours, meeting hours and rooms. [0 - 2]

53. **Staff speak frequently to patients and always in a friendly, positive and courteous manner.**

"Positive" refers to supportive as opposed to critical comments made to patients. The language employed should reveal respect for the patients, just as staff expect the patients to respect them. Staff should address patients politely, preferably using the titles they are given in their community or any other form the patients prefer. [0 - 2]

54. **There is adequate attention to personal appearance for those unable to care for themselves.**

Patients are stimulated to take care of their personal hygiene and appearance (e.g. to shower, to comb their hair, to trim nails). Those unable to do so - due to their clinical conditions - should be cared for by the staff. The external aspect of patients can be an indirect indicator of the overall level of care provided by the facility. [0 - 2]

55. **Meals served to patients meet recommended minimum nutritional requirements.**

FAO/WHO joint nutritional standards indicate 2,000 kilocalories and 40 g of proteins as a minimum daily intake for an adult weighing 60 kg. Adjustments of these levels should be made according to the patient's weight, level of activity and physical efforts and to local nutritional standards. At any rate, no patient should receive less than what is reasonably

expected because of being admitted to a psychiatric facility. A nutritionist can be helpful in defining local adaptations of minimum nutritional requirements. [0 - 2]

56. **Suitable food is provided for those with special nutritional needs.**

Special nutritional needs can be posed by clinical (e.g. diabetes, hypertension, mania, dementia) or other (e.g. frail and/or the elderly) conditions or can be derived from cultural and/or religious prohibitions. Staff members need to be aware of special nutritional needs which may be present in some of the patients. Food service personnel may need to consult with nutritionists who are specialists in the compilation of menus, if these are not already part of the hospital's staff. [0 - 2]

57. **Every newly admitted patient has a full medical evaluation within the first 24 hours after admission.**

This applies to every admission, including re-admissions of a patient recently discharged. Full medical evaluation includes evaluation of physical, mental and social aspects of the patient. Data and conclusions from the evaluation must be appropriately recorded in the patient's file and necessary actions taken thereafter. [0 - 2]

58. **Acute patients have a medical evaluation at least every day.**

See criteria 41 and 57 above for definitions and instructions. [0 - 2]

59. **Chronic patients have a medical evaluation at least every month.**

See criteria 42 and 57 above for definitions and instructions. [0 - 2]

60. **An informed consent is obtained prior to starting a planned treatment programme.**

Information on the goals and duration of the treatment, as well as risks involved and side-effects anticipated, should be clearly explained to and discussed with each patient in a language he/she can understand. All this information should exist in writing so that each patient can sign a consent-giving form. When the patient is not in a condition to understand the information or to give informed consent, this should be obtained from his/her personal representative. No treatment procedure, except for emergency ones, should be started before these steps have been taken. [0 - 2]

61. **There are clear written guidelines on the indications and use of drug therapies.**

These guidelines should include as a minimum:

a) indication of drug class by clinical diagnosis;
b) contraindications;
c) dosage (including range and specification of maximum dose authorized);
d) schedules for the introduction and for the withdrawal of medication;

e) measures in case of adverse effects;
f) persons authorized to prescribe and persons authorized to minister it.

Rate 2 only if all a) - f) are written; rate 1 if at least some are written. [0 - 1 - 2]

62. **There are clear written guidelines on the indications and use of electroconvulsive therapy.**

Informed consent by the patient or by his legal or personal representative, if he/she is not in a condition to understand the situation, is mandatory before starting electroconvulsive therapy (ECT). There should also be specification of indications and contraindications, of number and frequency of sessions, technical specifications (e.g. voltage, type of electric wave, duration of electric stimulation), use of anesthesia and of curarization, persons authorized to prescribe and to minister ECT. *In no case ECT could be used without medical supervision or for punishment.* [0 - 1 - 2]

63. **There are clear written guidelines on the role and on the goals of occupational therapy/rehabilitation activities.**

Occupational therapy and rehabilitation activities are meant to help patients, not to exploit them, and should never be imposed upon them; they should never be "prescribed" as a means of keeping patients "busy". If any money or value is derived from these activities, they should go to the patient and not to the facility or the caregiver. The cost of basic goods can of course be deducted from the final value of the product. Guidelines should indicate the range of activities available to patients and the system for cost-evaluating them. [0 - 2]

64. **Treatment plans are written down for each patient and followed by all staff.**

Treatment plans should be appropriate for the patient's clinical condition and age. All the staff should comply with and enforce the plan written down in the patient's file. [0 - 2]

65. **Meetings are held regularly for staff to discuss individual patient care plans.**

Ideally, meetings should be held more often than weekly; this is a bare minimum. All caregiving staff should attend these meetings (except for those who are supervising or are in other meetings with patients, and this duty should be rotated) and they should feel free to speak and participate in the discussions.

Rate 1 for meetings held at least once a week and 2 for more frequent meetings. [0 - 1 - 2]

66. **Patients are kept informed about their own progress.**

Patients should be informed on the reasons and the goals of the admission, on what is expected from them. They should also be regularly and periodically - e.g. at every medical evaluation - informed on their progress in relation to those goals.

Rate 2 if both initial and periodical information are provided; rate 1 if only one of them; rate 0 if none. [0 - 1 - 2]

67. **Help and support are quickly available if violence breaks out.**

All staff (not only caregiving staff) have to be trained on the management of a violent patient or of collective violence without endangering their own security and without necessarily involving other patients. They should be instructed on how to react in case of, for instance, being grabbed around the neck or by the hair or tie, attacked with a sharp weapon or threatened with a fire arm. Training in therapeutic physical control should be available on a regular and periodic basis to all staff to be used when:

i) a patient makes an attack on another person;
ii) a patient becomes disturbed to the extent he/she is considered a danger to him/herself and/or others; and
iii) the use of force as an emergency measure is needed to give essential treatment.

Rate 2 if both initial and periodical training are provided; rate 1 if only one of them; rate 0 if none. [0 - 1 - 2]

68. **Staff have access to specialist medical help in case of an emergency.**

Such as when a patient is badly scalded. This medical help can exist in the same facility or at an external service, in which case the means and the process for transferring patients have been established and made known to all relevant staff. [0 - 2]

69. **Patients who are able are encouraged to take up work of a suitable kind.**

This should be done in coordination with the occupational therapy programme, under supervision of the occupational therapist. *In no way should patients be exploited as "cheap labour force".* [0 - 2]

70. **No patient is kept locked in an individual room.**

When a patient - due to clinical or other conditions - has to be kept in isolation from other patients, he/she should *never be left alone*; in this case a staff member, or relative or other patient should stay with him/her. It is highly doubtful whether keeping someone in a locked individual room has any therapeutic value and *this practice should be strongly discouraged.* [0 - 2]

INTERACTION WITH FAMILIES

71. **Upon request, family members have a chance to discuss the patient's care with a responsible member of staff.**

Ideally there should be regular meetings to which families are invited to discuss

patients' progress and to obtain orientation from the staff. As a bare minimum, visiting family members should have access to a responsible member of the staff (e.g. charge nurse, doctor) able to inform them on the patient's progress and to answer their doubts in relation to the patient and the disease. [0 - 2]

72. **Family members are encouraged to be involved in the patient's treatment programme.**

A maximum score for this criterion means not only that family members are encouraged to do these things but also that they actually do them, i.e. accompany the patient in some of the internal activities, take the patient out for some outings, participate in organized social activities, volunteer their services for help with special activities and attend family meetings. [0 - 2]

73. **When needed, help and support are made available by staff to family members.**

Caring for a person with mental disorders can be a highly burdensome activity. In addition to this having someone mentally ill in the family can create a great deal of anxiety and uncertainty. Staff should make themselves available to discuss a family member's doubts and anxieties about the treatment and about the implications of mental illness. [0 - 2]

74. **Home visits are carried out for improving caring and coping skills of families of some selected patients.**

Some patients pose specific difficulties which can be best managed when families are instructed on how to act and react, and how to deal with them. Home visits for families with these specific difficulties represent a good opportunity not only for transmitting these instructions but also for strengthening the collaboration between staff, patient and family. [0 - 2]

DISCHARGE AND FOLLOW-UP

75. **Discharge plans are discussed by all staff and with the patient concerned.**

As soon as the situation which resulted in the admission is resolved or conditions to treat the patient outside of the facility are met, discharge should take place. All caregiving staff involved in the patient's treatment should be heard in this respect and the patient be kept informed on the discharge plans. [0 - 2]

76. **When discharged, patients are thoroughly oriented in terms of follow-up and social services available in their community.**

Patients and families should obtain clear information on what to do after discharge. Information on drug treatment, on facilities where to continue with the treatment and on recommended social services should be available in writing to be given to both patient and family at the time of discharge. [0 - 2]

77. **When a patient is discharged family members are instructed about measures to take in case of relapse or reappearance of symptoms.**

Information on the immediate measures to be taken in case of relapse and on where to obtain quick help in case of need particularly in hours when the facility is not open to the public should also be given in writing to the patient and family. They should also be specifically informed on where the patient's treatment is to be continued. [0 - 2]

78. **Upon discharge, a standard information form is sent to the health facility responsible for follow-up.**

The same information (at least on maintenance medication; social, occupational and family needs; special areas of attention; and specific risks) should be written in duplicate: one copy to be given to the patient and the other copy to be sent to the facility responsible for the follow-up of the patient, with which this facility is expected to be in regular contact. [0 - 2]

79. **Upon discharge, a standard information form is given to the patient.**

The patient and/or his/her family are to be requested to present this form (with the same content as described in criterion 77 above) during the first visit to the health facility responsible for follow-up. [0 - 2]

F . THE RESIDENTIAL FACILITY FOR THE ELDERLY MENTALLY ILL GLOSSARY

PHYSICAL ENVIRONMENT

1. **The facility has been officially inspected and meets local standards for the protection of the health and safety of the residents and staff.**

This criterion should be scored even in regions which have no state or local laws or regulations pertaining to hospitals or nursisng-homes. In such cases, the observer/interviewer is expected to use standards based on knowledge of conditions in other facilities that provide care. Last inspection must have taken place within the last 18 months. It is important to ensure that the facility has an adequate number of exits from the building. Other important safety factors, apart from emergency exits should also be checked, such as staircases (banisters), windows (large panes of glass or screens), etc.

Rate 2 only if the facility passed the inspection; otherwise rate 0. [0 - 2]

2. **There are no more than 30 residents living in the facility.**

International experience has shown that this is the limit for keeping an adequate quality standard for independent units or wards of this type of facility.

Rate 2 if within this limit, 1 if the number of residents per unit or ward is between 31 and 50, and 0 if above 51. [0 - 1 - 2]

3. **The ward space is sufficient for the number of residents admitted.**

In many regions, four to six square meters per resident is considered a reasonable amount of indoor space; this amount should be adjusted for local residential standards. [0 - 2]

4. **There is reasonable space for specific activities.**

For instance, for admission, medical examinations, occupational therapy activities; conditions which ensure privacy and confidentiality are essential to rate this criterion . The same space can be used for different therapeutic purposes, but *not* at the same time. Consider also the adequacy of the space, in terms of size, lighting and whether sound-proof. [0 - 2]

5. **There is reasonable space for recreational activities.**

It is important that communal rooms are arranged to allow residents to follow their chosen hobbies or interests.

Rate 2 when space for both indoor and outdoor activities is available; rate 1 when only one is available; otherwise rate 0. [0 - 1 - 2]

6. **There is reasonable space for receiving visitors.**

This criterion should be rated according to local usage in terms of privacy and seating accommodations. [0 - 2]

7. **Adequate space is provided for residents to store their personal belongings.**

This does not have to be an expensive or highly formalized arrangement; there must be at least some safe space for storing a few pieces of clothing and some toiletries. [0 - 2]

8. **The facility is arranged in such a way that each resident has a small piece of territory which is seen as his/hers.**

The important aspect of this criterion is that each resident should have some little space that is identified as a "personal space" that is respected by everyone in the hospital. [0 - 2]

9. **The layout, decor and furnishing of the facility have been designed to minimize confusion.**

The use of different colours particularly for each bedroom and bathroom door is very helpful, as well as different types and styles of furniture, preferably in a non-institutional way (see also criterion 44 below). Frequent changes and substitutions should be avoided. The distribution and arrangement of the furniture should also facilitate mobility. [0 - 2]

10. **Floors in residents' rooms are covered in non-slip materials.**

Also, when there are carpets these should not have frayed edges or raised surfaces at joins. [0 - 2]

11. **Toilets are in good working order for all residents.**

This also includes state of cleanliness of toilet basins and floors. Assessment is to be made chiefly on the basis of observations, in addition to interviewing residents. [0 - 2]

12. **The location and fittings of bathrooms and toilets are planned to minimize the effects of disability.**

They should facilitate and enable residents to achieve the greatest degree of safety, independence and privacy possible, and yet take into account some people's need for regular or occasional assistance. [0 - 2]

13. **A reasonable daily supply of water is available for residents.**

Availability of both drinking and washing water is to be assessed, taking into account local climatic conditions. [0 - 2]

14. **There is reasonable privacy for relevant bodily functions.**

Both toilets and bathrooms have doors that can be locked from the inside. Staff, however, need to have the means of opening these doors in case of emergencies. [0 - 2]

15. **The facility has adequate lighting and temperature control.**

There should be enough light in the rooms for residents to see well enough to carry out their ordinary activities. Particular attention should be given to avoiding sharp differences in temperature between bedrooms, communal rooms and bathrooms. [0 - 2]

16. **The facility is cleaned daily.**

The type of cleaning process will depend on the floor material. Rate 2 only if floor is washed or brushed every day and the waste is removed accordingly. Rate 1 if cleaning is done less than daily, but at least once a week; otherwise rate 0. [0 - 1 - 2]

17. **Sufficient and appropriate bedding equipment is available for use by the residents.**

Local usage (e.g. bed, mattress, hammock) should be taken into account when assessing this criterion . Bed linen should be changed at least once every week or whenever soiled by bodily fluids or excreta. There should be at least one bed (or equivalent) per resident. [0 - 2]

18. **Sufficient and appropriate seating equipment is available for use by the residents.**

Local usage (e.g. seating or squatting) should be taken into account when assessing this criterion. When seating is the local preference there should be a seat for every resident. [0 - 2]

19. **Sufficient and appropriate eating utensils are available for use by the residents.**

Local usage (e.g. cutlery, sticks, fingers) should be taken into account when assessing this criterion. Also adequacy of eating utensils for type of food served and for clinical conditions of residents. Clean utensils should be available for every resident at every meal. [0 - 2]

20. **A first-aid kit is available in the facility ward.**

This includes anti-septic (e.g. chlorhexidine solution and gentian violet solution), absorbent cotton wool, adhesive tape, elastic bandage, gauze bandage and adhesive compresses. [0 - 2]

21. **All potentially dangerous products are stored out of reach of residents.**

Dangerous products include medicines, syringes and needles, chemicals and cleaning

products. There should be at least one locked cupboard for storage of medical supplies and another one for storage of cleaning products. [0 - 2]

22. **The facility kitchen complies with recommended local standards for hygiene and food service.**

Irrespective of local standards, all cooking and eating utensils should be washed with soap and hot water, after every use and stored away from the reach of insects. The floor of the kitchen and eating-room should be washed and waste removed on a daily basis. [0 - 2]

ADMINISTRATIVE ARRANGEMENTS

23. **A written policy on philosophy and model of care is available.**

This statement does not have to be lengthy or fancy. However, it should inform about programme philosophy specifying its objectives. It should also provide enough information on the degree of expected family involvement in the care of the resident, on the working schedule of the facility and on the limits of displacements of residents within and outside the facility. Information on fees and payments, if any, should also be provided. For residents and family members who do not read well, someone should read the statement to them on more than one occasion, if necessary and/or requested. [0 - 2]

24. **Written policies on conditions of service for staff are available.**

These should cover at least salary, sick leave, hospitalization and holidays. Over and above the written contract of labour, the existence of positive benefits for each employee (depending on the conditions in force in each country) should also be considered important. In some cases even though written contracts do exist they do not ensure positive benefits for the employee, while in others, there are no written statements, yet labour relations are positive. [0 - 2]

25. **Job descriptions are specified for all staff.**

Ideally job descriptions should be made in terms of the expected outcomes of functioning of the facility - or of each of its units. Job descriptions could be specified either by professional category or by function. What is important is that each staff member knows exactly what is expected from him/her and the limits of his/her responsibilities and duties, and also that staff skills are matched to tasks needed to reach the facility's objectives and goals. [0 - 2]

26. **At least two-thirds of the caregivers in the facility's staff are employed full-time.**

Caregivers are members of the staff who actually and directly work with residents and may not include other persons present in the facility (director, cleaner, cook, secretary) who might be on the premises but who are not directly involved with residents. *Full-time* work means approximately six to eight hours per day of work or 40 to 50 hours per week. In many

parts of the world, caregiving staff are hired on a part-time basis and come to work at erratic and unpredictable hours (usually due to the accumulation of more than one part-time employment). When a significant proportion of the caregivers are hired in this way, it becomes difficult for the residents to find predictability in the personnel of the facility.

Rate 2 if at least two-thirds of caregivers are employed full-time. Rate 1 if between 40% and 60% of caregivers are full-time employed; otherwise rate 0. [0 - 1 - 2]

27. **Staff have a full medical examination annually.**

Benefits are expected for both staff and residents. Reports should be kept on file. Again, local patterns should be respected. In most developed countries, a bare minimum would include a chest X-ray, however this may not be feasible in some regions. [0 - 2]

28. **Written procedures for the protection of confidentiality of residents' and staff records are available.**

Confidentiality of residents' records is the responsibility of every staff member with access to them, including not only caregivers but also clerks in charge of records. Only the resident - or his/her legal or personal representative - may authorize the disclosure of any of this information to any person, even family members, unless local law determines otherwise. [0 - 2]

29. **Written records are appropriately maintained on all residents.**

Residents records should include all information pertaining to the clinical situation and to all procedures and actions taken by any caregiver in relation to the resident as well as his/her responses and reactions. Information should be recorded in a legible format yet ensure full confidentiality; residents, nevertheless, should have access to their files upon request.

Rate 2 only if the information is recorded and residents have access to their own files; rate 1 if the information is recorded but residents do not have access to their own files; otherwise rate 0. [0 - 1 - 2]

30. **Written records are appropriately maintained on all staff.**

Records on staff should include indication of function and its changes; salary; health status; absences, holidays and sick-leaves; promotions and disciplinary sanctions. They should also be confidential and each staff member should have access to his/her own file upon request.

Rate 2 only if the information is recorded and staff have access to their own files; rate 1 if the information is recorded but staff do not have access to their own files; otherwise rate 0. [0 - 1 - 2]

31. **Written procedures to be followed if a violent episode breaks out are available.**

These written procedures should cover at least the situations described in criterion 57 (see) clearly indicating specific responsibilities during the episode and in its follow-up. [0 - 2]

32. **Written procedures for dealing with complaints from residents and families are available.**

A specific book should exist to this end and a specific staff member should be designated to take up this function. Procedures should also clearly indicate the level of authority expected to deal with complaints. [0 - 2]

33. **Written policies on disciplinary procedures are available.**

Beyond the purely labour contract rules, disciplinary sanctions should be clearly specified in case of abuse of residents and of infringements of residents' rights. The use of *undue* physical force and restraints to control a resident during episodes of violence or retaliatory measures taken afterwards are particular examples of abuse to which specific disciplinary procedures should be indicated. [0 - 2]

34. **Domestic routines aim to meet the needs and preferences of residents rather than being set for convenience of the administration.**

Domestic routines are needed for the smooth running of facilities but they have to take into consideration both individual needs and preferences and the desirability of a lifestyle which is as normal as possible, especially in relation to daily living activities such as bathing, getting up, going to bed and mealtimes. Routines should be applied in a friendly and understanding way and offer maximum possible choice and dignity to residents. See also criterion 50 below. [0 - 2]

35. **All caregiving staff are required to participate in in-service training programmes.**

Such training programmes (also known as staff development) should be made available to them to develop the skills required for working with the elderly mentally ill. Training programmes should be made available according to indications of need. Participation in these training programmes should be recorded in staff's files. [0 - 2]

36. **All caregiving staff have been trained in first aid.**

Training in first aid such as that given by the Red Cross, meets this requirement. [0 - 2]

37. **All caregiving staff have received training in basic nursing skills.**

This includes at least the ability to take care of personal hygiene and to feed residents when their physical or mental conditions do not allow them to do it for themselves. [0 - 2]

38. **Staff have been trained to understand the needs of and to deal with the elderly with mental disorders.**

Many caregivers - even at the professional level - come to work with the elderly with mental disorders without any previous specific training. Therefore, at least one in-service training programme should be regularly provided to those arriving to work in this situation, during which they should be prepared for the tasks pertaining to their functions. Training for the management of violent residents and of episodes of violence is another specific training programme that must be made available.

Rate 2 if staff have been trained both for the identification and treatment of people with mental disorders *and* on management of violence; rate 1 if in only one of these programmes; otherwise rate 0. [0 - 1 - 2]

39. **Opportunities are provided for staff to discuss with their superiors difficulties they may have in working with the residents.**

Daily work with people with mental disorders poses a burden on any person, even on those with adequate background training. Having the opportunity to discuss with a qualified person his/her own difficulties (a process also known as supervision) and possible alternatives to deal with them can greatly reduce the impact of this burden. These opportunities should be available on a regular basis but should also be made available when special situations arise.

Rate 2 if supervision is available in both circunstances; rate 1 when in only one; rate 0 when in none. [0 - 1 - 2]

40. **Annually, staff conduct an internal study to identify strengths and weaknesses in facility's policies and programmes.**

This type of study should lead to the specification of 3 or 4 programme goals for the year. These goals should be written down and anchored to specific objectives so that, at the end of the year, some sort of judgement can be made as to whether they have been achieved (*effectiveness*). All staff should participate in the selection of these goals, and should be involved in the decision as to whether they have been achieved. [0 - 2]

41. **The facility has at least one full-time caregiving staff member per 3 residents during day shifts.**

Consider both professional and non-professional workers, but only those actually on duty. See criterion 26 above for other definitions. [0 - 2]

42. **The facility has at least one full-time caregiving staff member per 10 residents during night shifts.**

Since most of the activities occur during day time, day shifts call for more caregivers than night shifts. See criteria 26 and 41 above for other definitions. [0 - 2]

CARE PROCESS

43. **Prospective residents are able to visit the facility prior to admission.**

Prospective residents should visit the home, so that an informed personal decision on admission can be made. Similarly, it is also desirable that a staff member should visit the prospective resident at his/her present accommodation so as to establish a personal relationship, gain information about his/her way of life and advise on possessions which can be accommodated in his/her room. [0 - 2]

44. **Residents are encouraged to bring personal possessions into the facility.**

Residents should be encouraged to bring with them as many personal possessions as can be accommodated in their rooms and close cooperation should be offered in helping the residents to select such items. All residents' possessions should be treated with care and respect, and any valuable item noted. Care should always be taken to safeguard personal belongings such as dentures, spectacles and hearing aids. [0 - 2]

45. **A full assessment of physical, emotional and social needs is available on admission.**

This assessment should be made or be available prior to or immediately after placement. Special attention should be given to communication needs and difficulties of residents suffering from sensory disabilities and speech disorders. Programme of activities should be based on results of this assessment. [0 - 2]

46. **Residents have a full medical examination at least annually.**

This examination should be made preferably by a physician familiar with the health problems of the elderly - e.g. patients should be routinely screened for breast and cervical cancer or prostate cancer, hypertension, dementia, nutrition disorders, etc. The results of these assessments are to be recorded in the resident's files. [0 - 2]

47. **The special needs of residents showing signs of institutionalization are met.**

Many residents who left psychiatric hospitals are no longer mentally ill, but will have acquired the marks of institutionalization - showing isolation and withdrawal, passive behaviour, difficulty in exercising and making friends - through years spent in hospital. Residents with these signs should benefit from specific care programmes.

Rate 2 if these signs are identified and there are specific programmes addressed to them; rate 1 if they are identified but no specific programmes addressing them exist; otherwise rate 0. [0 - 1 - 2]

48. **Newly arrived residents are made to feel welcome on admission.**

Newly arrived residents are introduced to staff and to other residents; are shown the

premises - with particular indication of washrooms and of his/her bed and locker - and are informed on the main rules of the facility, e.g. meal hours, awakening and silence hours, meeting hours and rooms. [0 - 2]

49. **Staff speak frequently to residents and always in a friendly, positive and courteous manner.**

"Positive" refers to supportive as opposed to critical comments made to residents. The language employed should reveal respect for the residents, just as staff expect the residents to respect them. Staff should address residents politely, preferably using the titles they are given in their community or any other form the residents prefer. [0 - 2]

50. **Rules relating to residents are kept to a minimum.**

Rules - kept to a minimum - should be employed only to promote rehabilitation (under an agreed contract with the resident), fulfill statutory requirements, prevent undue disturbance to other residents or to ensure reasonable standards of safety and hygiene. [0 - 2]

51. **There is adequate attention to personal appearance for those unable to care for themselves.**

Residents are stimulated to take care of their personal hygiene and appearance (e.g. to wash, to toilet, to dress, to comb their hair, to trim nails). Those unable to do so - due to their clinical conditions - should be cared for by the staff, as well those unable to rise, to go to bed, to feed themselves. Ther external aspect of residents can be an indirect indicator of the overall level of care provided by the facility. [0 - 2]

52. **Meals served to residents meet recommended minimum nutritional requirements.**

FAO/WHO joint nutritional standards indicate 2,000 kilocalories and 40 g of proteins as a minimum daily intake for an adult weighing 60 kg. Adjustments of these levels should be made according to the resident's weight, level of activity and physical efforts and to local nutritional standards. At any rate, no resident should receive less than what is reasonably expected because of being admitted to a facility for the elderly. A nutritionist can be helpful in defining local adaptations of minimum nutritional requirements. [0 - 2]

53. **Suitable food is provided for those with special nutritional needs.**

Special nutritional needs can be posed by clinical (e.g. diabetes, hypertension, mania, dementia) or other (e.g. frail) conditions or can be derived from cultural and/or religious prohibitions. Staff need to be aware of special nutritional needs which may be present in some of the residents. Food service personnel may need to consult with nutritionists who are specialists in the compilation of menus, if these do not already form part of the facility's staff. [0 - 2]

54. **An informed consent is obtained prior to starting a planned treatment programme.**

Information on the goals and duration of the treatment, as well as risks involved and side-effects anticipated, should be clearly explained to and discussed with the resident in a language he/she can understand. All this information should exist in writing so that the resident can sign a consent-giving form. When the resident is not in condition to understand the information or to give informed consent, this should be obtained from his/her personal representative. No treatment procedure, except for emergency ones, should be started before these steps have been taken. [0 - 2]

55. **Care plans are written down for each resident and followed by all staff.**

Care plans should be appropriate for the resident's clinical condition and age. All the staff should comply with and enforce the plan written down in the resident's file. [0 - 2]

56. **Meetings are held regularly for staff to discuss care plans for individual residents.**

Ideally, meetings should be held more often than weekly; this is a bare minimum. All caregiving staff should attend these meetings (except for those who are supervising or are in other meetings with residents, and this duty should be rotated) and they should feel free to speak and participate in the discussions.

Rate 1 for meetings held at least once a week and 2 for more frequent meetings. [0 - 1 - 2]

57. **Help and support are quickly available if violence breaks out.**

All staff (not only caregiving staff) have to be trained on the management of a violent resident or of collective violence without endangering their own security and without necessarily involving other residents. They should be instructed on how to react in case of, for instance, being grabbed around the neck or by the hair or tie, attacked with a sharp weapon, threatened with a fire arm . Training in therapeutic physical control should be available on a regular and periodic basis to all staff to be used when:

i) a resident makes an attack on another person;
ii) a resident becomes disturbed to the extent he/she is considered a danger to him/herself and/or others; and
iii) the use of force as an emergency measure is needed to give essential treatment.

Rate 2 if both initial and periodical training are provided; rate 1 if only one of them; rate 0 if none. [0 - 1 - 2]

58. **Staff have prompt access to specialist medical help in case of an emergency.**

Such as when a resident is badly scalded. This medical help can exist in the same

facility or as an external service, in which case the means and the process for transferring residents have been established and made known to all relevant staff. [0 - 2]

59. **All residents have the right of access to health and remedial services provided in the community.**

Admission to the facility in no way diminishes a resident's right of access to health and social services available in the community, including the right to choose his/her own private mental health professionals, if he/she can afford to do so. [0 - 2]

60. **Residents are encouraged to maintain their independence within the facility.**

Residents should be involved as much as possible in making decisions related to the way the facility is run - e.g. defining smoking areas, planning menus and choosing food, introducing new activities - and should be encouraged to maintain their independence within the facility, recognizing that this may involve a certain degree of responsible risk-taking.

Rate 2 if residents both participate in decision making and maintain a reasonable degree of independence; rate 1 if only either of these is found; otherwise rate 0. [0 - 1 - 2]

61. **Positive day-time activity is provided.**

Many residents are former long-stay psychiatric patients who need help and encouragement to make use of opportunities for autonomy and require a gentle introduction to self-determination as part of the process of building up their self-esteem. Such residents are likely to progress to independent living at varying speeds and for some the need to cling to institutional habits may have to be recognized and accepted. Such residents have a particular need to be involved in positive daytime activity and to have use of neighbourhood resources, eventually with the active involvement of specialist voluntary agencies. There is little advantage in leaving a psychiatric hospital where there is a planned programme of activity for a residential facility in which residents simply vegetate. Residents who are able are encouraged to take up work of a suitable kind, but *in no way should residents be exploited as "cheap labour force"*. [0 - 2]

62. **Physical restraint and control by sedation are not used.**

Physical restraint may constitute an assault and should not be used except in extreme emergencies and in the interest of safety of the resident, other people and the environment; in any case it should be temporary and medical advice must be sought at once. Sedation as a means of control or restraint should similarly be avoided and can only be applied by a physician, with close follow-up. [0 - 2]

63. **No resident is kept locked in an individual room.**

When a resident - due to clinical or other conditions - has to be kept in isolation from other residents, he/she should *never be left alone*; in this case a staff member, or relative or other resident should stay with him/her. It is highly doubtful whether keeping someone in a

locked individual room has any therapeutic value and *this practice should be strongly discouraged.* [0 - 2]

64. **The need for support to relatives, staff and other residents when a resident is dying is recognized and met.**

It is not infrequent to have residents in this kind of facility being cared for until death. It gives residents a sense of security to know they will not be sent away to die, unless this is unavoidable or of their preference. Relatives should be informed, and allowed to stay with the resident if they wish to do so. It may be helpful to them - and also to other residents - to talk about their feelings to staff, who should provide the necessary support. Staff should be aware of procedures to be followed when death occurs, which includes informing other residents about the news. Staff themselves will need support on these occasions, to be treated as indicated in criterion 39 above. [0 - 2]

65. **Local, cultural and religious customs surrounding the death of a resident are observed.**

If a resident is aware he/she is dying, he/she should be given the opportunity to express his/her wishes concerning terminal care, funeral or cremation arrangements, although it is preferable to have done this at an earlier stage. If requested or known to be acceptable, contact should be made with an appropriate minister of religion. It may be appropriate to consider also local or cultural customs, which may include giving relatives and friends an opportunity to see the deceased person. Any particular procedures relating to religious or ethnic beliefs should be ascertained and carefully observed. [0 - 2]

INTERACTION WITH FAMILIES AND COMMUNITY

66. **Upon request, family members have a chance to discuss the resident's care with a responsible member of staff.**

Ideally there should be regular meetings to which family members are invited to discuss residents' progress and to obtain orientation from the staff. As a bare minimum, visiting family members should have access to a responsible member of the staff (e.g. charge nurse, doctor) able to inform them on the resident's progress and answer to their doubts in relation to the resident and his/her condition. [0 - 2]

67. **Family members are encouraged to be involved in the resident's treatment programme.**

A maximum score for this criterion means not only that family members are encouraged to do these things but also that they actually do them, e.g. accompany the resident in some of the internal activities, take the resident out for some outings, participate in organized social activities, volunteer their services to help with special activities and attend family meetings. [0 - 2]

68. **Help and support are made available by staff to family members who need them.**

Caring for a person with a mental disorder can be a highly burdensome activity. In addition to this having someone mentally ill in the family can create a great deal of anxiety and uncertainty. Staff should make themselves available to discuss a family member's doubts and anxieties about care and about the implications of mental illness. [0 - 2]

69. **Regular contacts are maintained with community support and treatment services existing in the community.**

Residents have many needs that cannot be satisfied by a single agency, therefore calling for a good coordination of efforts. The number and range of these support and treatment agencies will vary from place to place but usually include housing, labour, welfare education, justice, family affairs, etc. Regular contacts should serve both for staff being updated on the availability of services and for adequate support of actual residents who may need them. [0 - 2]

BACKGROUND INFORMATION

THE PRIMARY HEALTH CARE FACILITY BACKGROUND INFORMATION FORM

Name of the facility: .....

Write the official name of the facility as well as the name by which it is popularly known.

Type of facility: .....

Specify the type of facility, e.g. mental health centre, mental health clinic, community mental health centre, psychiatric ambulatory, etc. Give specific indication when it is annexed to or part of a general health care centre, or of a general or a mental hospital. Indicate also if it has some predominant "speciality" e.g. geriatric, for drug abusers, for children, forensic psychiatry, etc., and whether national, regional or local in coverage.

A. Population served by the facility: 1. Men: ..... 2. Women:..... 3. Total:.....

Indicate the number of population - preferably by sex - served by the facility (catchment area). Try to obtain figures on the actual population which could be cared for at it, e.g. if it does not care for children below, say, the age of 16 years, indicate the number of population above that age only.

B. Number of patients (currently): 1. Men:..... 2. Women:..... 3. Total:.....

This should not be a guess. Indicate the actual number of those who are currently being treated.

C. Service production (year: 19__):
1. Individual visits:.....
2. Group sessions:.....
3. Home visits:.....
4. Other (specify):.....

Total service production during a full year (indicate which year); includes individual and group visits to the facility, home visits and other community activities

D. Admissions: (year: 19__) 1. Men:..... 2. Women:.....

Indicate the total number of patients seen for the first time during the last year for which figures are available (indicate which year).

E. Discharges: (year: 19__) 1. Men:..... 2. Women:.....

Indicate the total number of patients discharged from the facility's programmes, for any reason, e.g. improvement, cure, death, loss of contact, etc. during the last for which figures are available (indicate the year). Whenever possible, specify the reasons for discharge.

F. Number of hours open per day: .....

Indicate the number of hours the facility is open during regular working days.

G. Number of days open per week:.....

Indicate the number of days the facility is open during regular working periods.

H. Staff:

	Physicians:	1. (part-time):..... 2. (full-time):.....
	Nurses:	3. (part-time):..... 4. (full-time):.....
	Social workers:	5. (part-time):..... 6. (full-time):.....
	Nursing aides:	7. (part-time):..... 8. (full-time):.....
		9. Other (specify):.....

Indicate how many of each type of staff by work load, e.g. two psychiatrist working 30 hours per week each, five nurses working 44 hours per week each, one social worker working 30 hours per week and another social worker working 20 hours per week. A *physician* is a graduate from a recognized medical school, registered at the local Board of Physicians. A *nurse* is a graduate from a recognized Nursing School at the university level, registered at the local Board (or equivalent) of Nurses. A *social worker* is a graduate from a recognized School of Social Work at the university level, registered at the local Board (or equivalent) of Social Workers. In case of "9. Other" clearly indicate what type of worker and what function does he/she accomplish, again indicating the work load.

THE OUTPATIENT MENTAL HEALTH FACILITY
BACKGROUND INFORMATION FORM

Name of the facility: .....

Write the official name of the facility as well as the name by which it is popularly known.

Type of facility: .....

Specify the type of facility, e.g. mental health centre, mental health clinic, community mental health centre, psychiatric ambulatory, etc. Give specific indication when it is annexed to or part of a general health care centre, or of a general or a mental hospital. Indicate also if it has some predominant "speciality" e.g. geriatric, for drug abusers, for children, forensic psychiatry, etc., and whether national, regional or local in coverage.

A. Population served by the facility: 1. Men: ..... 2. Women:..... 3. Total:.....

Indicate the number of population - preferably by sex - served by the facility (catchment area). Try to obtain figures on the actual population which could be cared for at it, e.g. if it does not care for children below, say, the age of 16 years, indicate the number of population above that age only.

B. Number of patients (currently): 1. Men:..... 2. Women:..... 3. Total:.....

This should not be a guess. Indicate the actual number of those who are currently being treated.

C. Service production (year: 19__):
1. Individual visits:.....
2. Group sessions:.....
3. Home visits:.....
4. Other (specify):.....

Total service production during a full year (indicate which year); includes individual and group visits to the facility, home visits and other community activities

D. Admissions: (year: 19__) 1. Men:..... 2. Women:.....

Indicate the total number of patients seen for the first time during the last year for which figures are available (indicate which year).

E. Discharges: (year: 19__) 1. Men:..... 2. Women:.....

Indicate the total number of patients discharged from the facility's programmes, for any reason, e.g. improvement, cure, death, loss of contact, etc. during the last for which figures are available (indicate the year). Whenever possible, specify the reasons for discharge.

F. Number of hours open per day: .....

Indicate the number of hours the facility is open during regular working days.

G. Number of days open per week:.....

Indicate the number of days the facility is open during regular working periods.

H. Staff:

Psychiatrists:	1. (part-time):.....	2. (full-time):.....
Nurses:	3. (part-time):.....	4. (full-time):.....
Occupational therapists:	5. (part-time):.....	6. (full-time):.....
Psychologists:	7. (part-time):.....	8. (full-time):.....
Social workers:	9. (part-time):.....	10. (full-time):.....
Nursing aides:	11. (part-time):.....	12. (full-time):.....

13. Other (specify):.....

Indicate how many of each type of staff by work load, e.g. two psychiatrist working 30 hours per week each, five nurses working 44 hours per week each, one psychologist working 30 hours per week and another psychologist working 20 hours per week. A psychiatrist is a medical doctor who has had at least two years of post-graduate training in psychiatry, in a recognized teaching institution. A registered nurse is a graduate from a recognized Nursing School at the university level, registered at the local Board (or equivalent) of Nurses. A certified occupational therapist is a graduate from a recognized School of Occupational Therapy at the university level, registered at the local Board (or equivalent) of Occupational Therapists. A certified clinical psychologist is a graduate from a recognized School of Psychology at the university level, with specialization in Clinical Psychology, and registered at the local Board (or equivalent) of Psychologists. A certified social worker is a graduate from a recognized School of Social Work at the university level, registered at the local Board (or equivalent) of Social Workers. In case of "13. Other" clearly indicate what type of worker and what function does he/she accomplish, again indicating the work load.

THE INPATIENT MENTAL HEALTH FACILITY BACKGROUND INFORMATION FORM

(Psychiatric/mental hospital; psychiatric unit/beds in general hospital)

Name of the facility:.....

Write the official name of the facility as well as the name by which it is popularly known.

Type of facility: .....

Specify whether psychiatric/mental hospital or clinic or psychiatric unit/beds in a general (non-psychiatric) hospital; give specific indication when it is a psychiatric annex to, but physically isolated from, a general hospital (not in the same building; in this case indicate approximate distance from main building). Indicate also if it has some predominant "speciality" e.g. geriatric, for drug abusers, for children, forensic psychiatry, etc., and whether national, regional or local in coverage.

A. Population served by the facility: 1. Men: ..... 2. Women:..... 3. Total:.....

Indicate the number of population - preferably by sex - served by the facility (catchment area). Try to obtain figures on the actual population which could be admitted at it, e.g. if it does not admit children below, say, the age of 16 years, indicate the number of population above that age only.

B. Number of beds available: 1. For men:..... 2. For women:..... 3. Total:.....

This refers to the official maximum capacity of the facility irrespective of being currently occupied or not. In some places this figure indicates the number of people who could be admitted, the number of existing beds being somehow smaller; in these cases indicate both figures.

C. Number of patients (currently): 1. Men:..... 2. Women:..... 3. Total:.....

This should not be a guess. Indicate the actual number of those who are currently admitted, including those on authorized leave.

D. Rate of occupancy (year: 19__): 1. Men:..... 2. Women:..... 3. Total:.....

Most of the facilities have this rate already calculated for some past year. Try to obtain the most recent one; indicate to which year the figures correspond.

E. Admissions (year: 19__): 1. Admissions: 1.1. Men:..... 1.2. Women:.....

2. Re-admissions: 2.1. Men:..... 2.2. Women:.....

Try to obtain information relative to a full year; if there are important variations throughout the year, try to specify. Indicate the year to which the figures correspond. *Admissions* include new admissions and re-admissions, but try to obtain separate figures for these two categories of admissions.

F. Discharges: 1. Men:..... 2. Women:.....

Try to obtain information relative to a full year; if there are important variations throughout the year, try to specify. Indicate the year to which the figures correspond.

G. Average duration of stay in facility: .....days.

Also usually available from most of the facilities' administration, usually in days. Some facilities have a figure for the mobile population - i.e. those patients expected to be discharged - and another for those residing in the facility and for whom no discharge is expected. Indicate which of these is given and to which year they correspond.

H. Percentage of admissions which are compulsory: .....%

Involuntary or compulsory admissions are those determined by a court or a judge's order.

I. Number of inpatient deaths during last year:.....

Suicides excluded. If possible, indicate by sex.

J. Number of inpatient suicides during last year:.....

If possible, indicate by sex.

K. Staff:

	Psychiatrists:	1. (part-time):..... 2. (full-time):.....
	Nurses:	3. (part-time):..... 4. (full-time):.....
	Occupational therapists:	5. (part-time):..... 6. (full-time):.....
	Psychologists:	7. (part-time):..... 8. (full-time):.....
	Social workers:	9. (part-time):..... 10. (full-time):.....
	Nursing aides:	11. (part-time):..... 12. (full-time):.....

13. Other (specify):.....

Indicate how many of each type of staff by work load, e.g. two psychiatrist working 30 hours per week each, five nurses working 44 hours per week each, one psychologist working 30 hours per week and another psychologist working 20 hours per week. A **psychiatrist** is a medical doctor who has had at least two years of post-graduate training in psychiatry, in a recognized teaching institution. A **registered nurse** is a graduate from a recognized Nursing School at the university level, registered at the local Board (or equivalent) of Nurses. A certified **occupational therapist** is a graduate from a recognized School of Occupational Therapy at the university level, registered at the local Board (or equivalent) of Occupational Therapists. A certified **clinical psychologist** is a graduate from a recognized School of Psychology at the university level, with specialization in Clinical Psychology, and registered at the local Board (or equivalent) of Psychologists. A certified **social worker** is a graduate from a recognized School of Social Work at the university level, registered at the local Board (or equivalent) of Social Workers. In case of "13. Other" clearly indicate what type of worker and what function does he/she accomplish, again indicating the work load.

THE RESIDENTIAL FACILITY FOR THE ELDERLY MENTALLY ILL BACKGROUND INFORMATION FORM

Name of the facility:.....

Write the official name of the facility as well as the name by which it is popularly known.

Type of facility: .....

Briefly describe the type of facility. Give specific indication when it is an annex to, but physically isolated from, a general or psychiatric hospital (not in the same building; in this case indicate approximate distance from main building). Indicate also if it has some predominant "speciality" e.g. for drug abusers, forensic psychiatry, etc., and whether national, regional or local in coverage.

A. Number of beds available: 1. For men:..... 2. For women:..... 3. Total:.....

This refers to the official maximum capacity of the facility irrespective of being currently occupied or not. In some places this figure indicates the number of people who could be admitted, the number of existing beds being somehow smaller; in these cases indicate both figures.

B. Number of residents (currently): 1. Men:..... 2. Women:..... 3. Total:.....

This should not be a guess. Indicate the actual number of those who are currently admitted, including those on authorized leave.

C. Rate of occupancy (year: 19__): 1. Men:..... 2. Women:..... 3. Total:.....

Most of the facilities have this rate already calculated for some past year. Try to obtain the most recent one; indicate to which year the figures correspond.

D. Admissions: (year: 19__) 1. Admissions: 1.1. Men:..... 1.2. Women:.....

2. Re-admissions: 2.1. Men:..... 2.2. Women:.....

Try to obtain information relative to a full year; if there are important variations throughout the year, try to specify. Indicate the year to which the figures correspond. *Admissions* include new admissions and re-admissions, but try to obtain separate figures for these two categories of admissions.

E. Discharges: 1. Men:..... 2. Women:.....

Try to obtain information relative to a full year; if there are important variations throughout the year, try to specify. Indicate the year to which the figures correspond.

F. Average duration of stay in facility: .....days.

Also usually available from most of the facilities' administration, usually in days. Some facilities have a figure for the mobile population - i.e. those residents expected to be discharged - and another for those residing in the facility and for whom no discharge is expected. Indicate which of these is given and to which year they correspond.

G. Number of resident deaths during last year:.....

Suicides excluded. If possible, indicate by sex.

H. Number of resident suicides during last year:.....

If possible, indicate by sex.

I. Staff:	Physicians:	1. (part-time):..... 2. (full-time):.....
	Nurses:	3. (part-time):..... 4. (full-time):.....
	Occupational therapists:	5. (part-time):..... 6. (full-time):.....
	Psychologists:	7. (part-time):..... 8. (full-time):.....
	Social workers:	9. (part-time):..... 10. (full-time):.....
	Nursing aides:	11. (part-time):..... 12. (full-time):.....
	13. Other (specify):.....	

Indicate how many of each type of staff by work load, e.g. one physician working 10 hours per week, two nurses working 44 hours per week each, one occupational therapist working 30 hours per week. A *physician* is a graduate from a recognized medical school, registered at the local Board of Physicians; indicate specialty, e.g. gerontologist, psychiatrist, internist, etc. A **registered nurse** is a graduate from a recognized Nursing School at the university level, registered at the local Board (or equivalent) of Nurses. A certified **occupational therapist** is a graduate from a recognized School of Occupational Therapy at the university level, registered at the local Board (or equivalent) of Occupational Therapists. A certified **clinical psychologist** is a graduate from a recognized School of Psychology at the university level, with specialization in Clinical Psychology, and registered at the local Board (or equivalent) of Psychologists. A certified **social worker** is a graduate from a recognized School of Social Work at the university level, registered at the local Board (or equivalent) of Social Workers. In case of "13. Other" clearly indicate what type of worker and what function does he/she accomplish, again indicating the work load

RATINGS

MENTAL HEALTH POLICY RATING SCORE

Good	34 - 42
Fair	25 - 33
Barely acceptable	17 - 24
Unacceptable	0 - 16

MENTAL HEALTH PROGRAMME RATING SCORE

Good	56 - 70
Fair	42 - 55
Barely acceptable	28 - 41
Unacceptable	0 - 27

PRIMARY HEALTH CARE FACILITY RATING SCORE

Good	76 - 94
Fair	59 - 75
Barely acceptable	38 - 58
Unacceptable	0 - 37

OUTPATIENT MENTAL HEALTH FACILITY RATING SCORE

Good	85 - 106
Fair	64 - 84
Barely acceptable	43 - 63
Unacceptable	0 - 42

INPATIENT MENTAL HEALTH FACILITY RATING SCORE

Good	127 - 158
Fair	96 - 126
Barely acceptable	64 - 95
Unacceptable	0 - 63

RESIDENTIAL FACILITY FOR THE EDERLYL MENTALLY ILL RATING SCORE

Good	110 - 138
Fair	83 - 109
Barely acceptable	57 - 82
Unacceptable	0 - 56

BACKGROUND REFERENCES

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The main background references to these instruments, in addition to some unpublished manuscripts from SEARO and Istituto "Mario Negri", are:

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4. WHO (1992) **Mental health programmes: concepts and principles** (Doc.:WHO/MNH/92.11) Geneva, WHO.

5. WHO (1991) **Quality Assurance in Mental Health: draft checklists, glossaries and recording forms. A. Mental Health Policy** (Doc.: MNH/MND/91.8) Geneva, WHO.

6. WHO (1991) **Quality Assurance in Mental Health: draft checklists, glossaries and recording forms. B. Mental Health Programme** (Doc.: MNH/MND/91.9) Geneva, WHO.

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14. WHO (1990) **WHO Child care facility schedule** (Doc.: WHO/MNH/PSF/90.3) Geneva, WHO, 1990.

15. Ministère de la Santé et des Services sociaux (1990) **Mental Health Policy**. Québec, Ministère de la Santé et des Services sociaux.

16. Ministério da Saúde (1990) **Orientação para funcionamento e supervisão dos serviços de saúde mental**. Brasília, Ministério da Saúde.

17. WHO (1989) **Consumer involvement in mental health and rehabilitation services** (Doc.: WHO/MNH/MEP/89.7) Geneva, WHO.

18. WHO (1988) **An hospital looks at itself** (Doc.: MNH/EVA/88.2) Geneva, WHO.

19. **Danish Medical Bulletin**. (Gerontology; Special Supplement Series, No. 5), 1987.

20. Centre for Policy on Ageing (1984) **Home life: a code of practice for residential care**. London, Centre for Policy on Ageing.

21. The Quality Assurance Project (1982) A methodology for preparing "ideal" treatment outlines in Psychiatry. **Australian and New Zealand Journal of Psychiatry, 16**:153-158.

22. WHO (1981) **"Health For All" Series**. (Nos. 4, 6 and 8). Geneva, WHO.