
PROGRAMME ON MENTAL HEALTH

Quality Assurance in Mental Health Care

Check-lists & Glossaries

Volume 2



DIVISION OF MENTAL HEALTH AND
PREVENTION OF SUBSTANCE ABUSE
WORLD HEALTH ORGANIZATION

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QUALITY ASSURANCE IN MENTAL HEALTH CARE CHECK-LISTS & GLOSSARIES

VOLUME 2

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.

This volume contains instruments for the assessment of forensic psychiatric facilities, community-based support services, day-hospitals, day-hospitals for the elderly, day centres (psychosocial rehabilitation centres) and the respect of rights of users of mental health services. It complements a previous volume which contains instruments on mental health policy, mental health programmes, primary health care facilities, outpatient facilities, inpatient facilities and residential facilities for the elderly mentally ill.

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

DIVISION OF MENTAL HEALTH AND
PREVENTION OF SUBSTANCE ABUSE
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FOREWORD

It gives us a special pleasure to publish the second volume of **Quality Assurance in Mental Health Care: check-lists and glossaries**; Volume 1 was exceedingly well received and went out of print much earlier than it could have been anticipated. In addition, and more importantly, it made a major impact in terms of the development among mental health personnel of what has been termed "evaluative culture" .

Indeed, in several places, workshops and conferences were convened with the specific purpose of discussing not only its specific content but, also, the concept of quality assurance put forward in Volume 1. As a result, many mental health services, at different levels, are now operating according to these guidelines, with criteria, indicators and norms agreed on by different segments of society.

In many of the above-mentioned meetings, there was a constant request for some additional conceptual information, which, although easily available to those with a specific interest in quality assurance, may not be so easily accessible to mental health workers and managers on the ground. Therefore, in the Annex a paper provides some information on the rationale for programmes on quality assurance in mental health care.

At variance with the methodology utilized for the development of modules included in Volume 1, modules included in this second volume were not extensively field tested. The reason for this is two fold: on the one hand, extensive field tests of draft modules included in Volume 1 resulted in very few modifications (less than 3% of either modification, deletion or addition of existing items); on the other hand, no funds were made available for the field testing of modules included in Volume 2, contrary to what happened with those in Volume 1.

Therefore, the version of modules presented here represents the balanced and average opinion of well qualified experts. In some cases they result from group discussions. At any rate only items on which there was full agreement among those experts were retained.

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CHECK-LISTS

G¹ - RIGHTS OF USERS OF MENTAL HEALTH SERVICES' CHECK-LIST

GENERAL PRINCIPLES

1. Every person with a mental disorder, or who is said to have a mental disorder, or who is being treated as such has, like any other person, the right to exercise all civil, political, economic, social and cultural rights recognized in the Universal Declaration of Human Rights and other related UN documents.
2. There is no discrimination on the grounds of mental disorders.
3. Every patient receives such health and social care as is appropriate to his or her health needs, in accordance to the same standards as other ill persons.
4. All patients registering at a mental health (or psychiatric) service (inpatient or outpatient) are informed of their rights and are guaranteed respect of these rights and of their person.

NATIONAL LEGISLATION

5. There are legal provisions concerning the respect of the rights of users of mental health services and their relatives¹.
6. There are legal provisions governing both involuntary and voluntary psychiatric treatment and hospitalization.
7. There is a time limitation to involuntary psychiatric treatment and hospitalization.
8. There is a legal mechanism whereby patients can appeal to a judicial or other independent authority about any decision involving involuntary treatment or hospitalization.
9. There is a legal mechanism whereby any decision involving involuntary treatment or hospitalization is automatically and periodically reviewed by a competent body.

MONITORING BODIES

10. There is an ombudsperson, at least at the national level.
11. There is a body specifically charged, at the national level, with monitoring the respect of the rights of users of mental health services and their relatives.

¹ Sections A to F are found in WHO. **Quality Assurance in Mental Health Care. Check-lists & Glossaries. Volume 1** (Doc.: WHO/MNH/MND/94.17). Geneva, WHO, 1994.

12. The national medical (or psychiatric) association (college/board) has a section particularly dedicated to human rights.
13. The national association (college/board) of psychologists has a section particularly dedicated to human rights.
14. The national association (college/board) of nurses has a section particularly dedicated to human rights.
15. The national association (college/board) of social workers has a section particularly dedicated to human rights.
16. The national association (college/board) of occupational therapists has a section particularly dedicated to human rights.

EQUITY AND ACCESS TO TREATMENT

17. Health resources are equitably distributed.
18. Everyone in need has access to basic mental health care.
19. At least 20% of all psychiatric beds are located in general hospitals.

CARE PROCESS

20. An informed consent is obtained prior to starting a planned treatment programme.
21. The care available is of adequate quality.
22. Staff speak frequently to patients and always in a friendly, positive and courteous manner.
23. Written records are appropriately maintained for all patients, who are entitled to have access to their own records.
24. Written procedures for the protection of confidentiality of patients' records are available.
25. Written policies on disciplinary procedures concerning staff who disrespect the human rights of patients are available.
26. Written procedures for dealing with complaints from patients and families are available.
27. No patient is kept locked in isolation in an individual room.
28. Help and support are made available by staff to family members who need them.

29. Meals served to patients meet recommended minimum nutritional requirements.
30. No person with a mental disorder shall be subjected to sterilization against his/her will, or for reasons related to his/her psychiatric status.
31. Psychosurgery and other intrusive and irreversible treatments for mental disorders are never carried out on an involuntary patient and without informed consent from that patient.
32. Clinical trials and experimental treatments are never carried out on an involuntary patient and without informed consent from that patient.

SPECIFIC FACILITIES

33. At any given facility, the space is sufficient for the number of patients.
34. Jails are not used to house people with mental disorders due to lack of health care facilities.
35. There are appropriate facilities for the care of criminal offenders with mental disorders.
36. There are appropriate facilities/services for the care of children/adolescents with mental disorders.
37. There are provisions for the education of minors with mental disorders admitted to psychiatric hospitals/institutions.
38. There are appropriate facilities for the care of the elderly with mental disorders.

H - COMMUNITY-BASED SUPPORT SERVICES' CHECK-LIST

POLICY AND PROGRAMMES

1. The mental health policy acknowledges the importance of support services in the community.
2. Regional and local mental health programmes include the development and harmonization of support services in the community.
3. Representatives of users, local authorities and other community leaders are involved in the development and management of support services in the community.

PRINCIPLES

4. Mechanisms are set for the promotion of the rights and full citizenship of people with mental disorders.
5. There are programmes promoting tolerance and acceptance of people with mental disorders in the community.
6. Community-based mental health services are fully integrated with existing in-patient services.

RANGE OF ACTIONS

7. Every person with a mental disorder has access to adequate accomodation.
8. Persons with a mental disorder have access to transport adequate to their situation.
9. Persons with a mental disorder have access to health care.
10. Persons with a mental disorder have to access to health promotion and disease prevention programmes.
11. Persons with a mental disorder have access to support programmes aimed at ensuring food and clothing, as well as income support necessary to sustain life with dignity.
12. Persons with a mental disorder have access to appropriate training programmes on daily living activities and the development of social skills.
13. Persons with a mental disorder have access to appropriate educational programmes.

14. Persons with a mental disorder have access to appropriate vocational rehabilitation programmes.
15. Persons with a mental disorder have access to leisure and recreational programmes in the community.
16. Persons with a mental disorder have the possibility of being accompanied by someone, should this be necessary in order to carry out their community activities.
17. Relatives responsible for people with mental disorders, as well as those who have regular contact with them, have access to support services adequate to their needs.
18. There are mechanisms to support self-help/mutual aid groups and advocacy groups related to people with mental disorders.
19. Services are available for crisis intervention.

I - DAY-HOSPITALS' 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 in-patients 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. Adequate space is provided for patients to store their personal belongings.
6. Toilets are in good working order for all patients.
7. A reasonable supply of water is available for patients daily.
8. There is reasonable privacy for relevant bodily functions.
9. The ward has adequate lighting.
10. The facility has adequate temperature control and ventilation.
11. The ward is cleaned daily.
12. Sufficient and appropriate seating equipment is available for use by the patients.
13. Sufficient and appropriate eating utensils are available for use by the patients.
14. The facility has an adequate supply of basic psychiatric drugs.
15. A first-aid kit is available.
16. All potentially dangerous products are stored out of reach of patients.
17. The facility kitchen complies with recommended local standards for hygiene and food service.
18. Measures have been taken to protect the rights of patients.

ADMINISTRATIVE ARRANGEMENTS

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

20. Job descriptions are specified for all staff.
21. Staff is multidisciplinary.
22. At least two-thirds of the caregivers in the facility's staff are employed full-time.
23. At least two-thirds of the administrative staff in the facility's staff are employed full-time.
24. Staff have a full medical examination annually.
25. Staff are provided with space and time to be away from patients at appropriate periods during the day.
26. Written procedures for the protection of confidentiality of patients and staff records are available.
27. Written records are appropriately maintained on all patients.
28. There are clear written guidelines on the indications and use of all kinds of therapies employed at the facility.
29. Written procedures to be followed if a violent episode breaks out are available.
30. Written procedures for dealing with complaints from patients and families are available.
31. All caregiving staff are required to participate in in-service training programmes.
32. All caregiving staff have been trained in first aid.
33. All caregiving staff have received training in basic nursing skills.
34. Staff have been trained for dealing with and treating patients with mental disorders.
35. Opportunities are provided for staff to discuss with their superiors difficulties they have in working with people with mental disorders.
36. Annually, staff conduct an internal study to identify strengths and weaknesses in facility's policies and programmes.
37. At least one qualified professional staff member is on duty in the ward at all times.
38. Staff have access to an internist, whenever necessary.
39. At least 10% of each staff member's working time is dedicated to training, supervision and administrative activities.

40. The facility is open at least five days a week.

CARE PROCESS

41. Newly arrived patients are made to feel welcome on admission.
42. Staff speak frequently to patients always in a friendly, positive and courteous manner.
43. Every newly admitted patient has a full evaluation within the first 24 hours after admission.
44. Treatment plans are written down for each patient and followed by all staff.
45. An informed consent is obtained prior to starting a planned treatment programme.
46. Meetings are held regularly for staff to review individual patient care plans.
47. There is a daily control of patients' attendance.
48. Patients are kept informed about their own progress.
49. At least 60 minutes are allocated for each weekly therapeutic group activity with patients.
50. Patients participate in the day-to-day management of the hospital.
51. Leisure and free-time activities are included in the plan of treatment.
52. Meals served to patients meet recommended minimum nutritional requirements.
53. Suitable food is provided for those with special nutritional needs.
54. The facility provides at least one meal per day.
55. Help and support are quickly available if violence breaks out.

INTERACTION WITH FAMILIES AND COMMUNITY AGENCIES

56. Family members who so request have a chance to discuss the patient's care with a responsible member of staff.
57. Family members are encouraged to be involved in the patient's treatment programme.
58. Help and support are made available by staff to family members who need them.

59. Regular contacts are maintained with community support and other treatment services existing in the community.
60. Regular contact is maintained with other health and social care agencies.
61. Representatives of users, family members, local authorities and other community leaders are involved in the planning, development and evaluation of the service.

DISCHARGE AND FOLLOW-UP

62. Discharge plans are discussed by all staff and with the patient and relatives concerned.
63. Upon discharge patients are thoroughly oriented in terms of follow-up and social services available in their community.
64. Upon discharge the patient and family members are instructed about measures to take in case of relapse or reappearance of symptoms.
65. Upon discharge, a standard information form is sent to the health facility responsible for follow-up.
66. Upon discharge, a standard information form is given to the patient.

J - DAY-HOSPITALS FOR THE ELDERLY' CHECK-LIST

PHYSICAL ENVIRONMENT

1. The facility has been officially inspected and meets local standards for the protection of health and safety of patients 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. Adequate space is provided for patients to store their personal belongings.
6. The layout, the architectural conception, the decor and furnishing of the facility have been designed to promote orientation and adaptation.
7. Floors in the facility are covered in non-slip and non-shining materials.
8. Toilets are in good working order for all patients.
9. The location, the number and fittings of bathrooms and toilets are planned to minimize the effects of disabilities of patients.
10. A reasonable supply of water is available for patients daily.
11. There is reasonable privacy for relevant bodily functions.
12. The facility has adequate lighting, ventilation, acoustic and temperature control.
13. The facility is cleaned daily.
14. At least one adequate resting equipment is available for use by each patient.
15. Sufficient and appropriate seating equipment is available for use by the patients.
16. Sufficient and appropriate utensils for activities of daily living are available for use by the patients.
17. The facility has an adequate supply of basic medical drugs.
18. The facility has an adequate supply of basic psychiatric drugs.
19. A first-aid kit is available in the facility.

20. All potentially dangerous products are stored out of reach of patients.
21. The facility kitchen complies with recommended local standards for hygiene and food service.

ADMINISTRATIVE ARRANGEMENTS

22. A written policy on philosophy and model of care is available.
23. Priorities have been defined.
24. Written policies on conditions of service for all staff are available.
25. Job descriptions are specified for all staff.
26. Caregiving staff is multidisciplinary.
27. A certain employment stability of the caregiving staff is necessary.
28. All staff have a full medical examination annually.
29. Caregiving staff are provided with space and time to be away from patients at appropriate periods during the day.
30. Written procedures for the protection of confidentiality of patients and staff records are available.
31. Written records are appropriately maintained on all patients.
32. Written records are appropriately maintained on all staff.
33. Written procedures to be followed if a violent episode breaks out are available.
34. Written procedures for dealing with complaints from patients and families are available.
35. Written procedures to be followed in case of fire or other catastrophes are available.
36. Written policies on disciplinary procedures are available.
37. Domestic routines aim to meet the needs and preferences of the patient rather than the administrative convenience.
38. All caregiving staff are required to participate in in-service training programmes.
39. All caregiving staff have been trained in first aid.

40. All caregiving staff have been trained in basic fire fighting and controlling other catastrophes.
41. All caregiving staff have received training in basic nursing skills.
42. All staff have been trained to understand and to deal with the needs of the elderly mentally ill.
43. All caregiving staff have been trained specifically for the management of geriatric psychiatry emergencies.
44. At least 10% of each caregiving staff's working time is dedicated to training, supervision and administrative activities.
45. Opportunities are provided for caregiving staff to discuss with their peers about the difficulties they have in working with the elderly mentally ill.
46. Opportunities are provided for caregiving staff to discuss with a qualified person about difficulties they have in working with the elderly mentally ill.
47. Annually, all staff conduct an internal study to identify strengths and weaknesses in the facility's policies and programmes.

STAFFING

48. The facility has at least the equivalent of one full-time psychiatrist per 20 patients per day and per 40 patients hospitalized.
49. The facility has at least the equivalent of one full-time registered nurse per 20 patients per day and per 40 patients hospitalized.
50. The facility has at least the equivalent of one full-time qualified occupational therapist per 20 patients per day and per 40 patients hospitalized.
51. The day hospital has at least the equivalent of one full-time qualified clinical psychologist per 20 patients per day and per 40 patients hospitalized.
52. The hospital has at least the equivalent of one full-time qualified social worker per 20 patients per day and per 40 patients hospitalized.
53. The facility has at least one full-time caregiving staff member per 5 patients per day and per 10 patients hospitalized.

ADMISSION PROCESS

54. All admission requests should be supported by a mental health professional, according to local procedures.
55. An interview between the patient (and his/her representative), the Day Hospital's psychiatrist and at least one caregiving multidisciplinary staff representative is organized before admission.
56. A full assessment of potential social, physical and emotional needs, as well as a full risk assessment, is available on admission.
57. An informed consent is obtained prior to starting a planned treatment programme.
58. Patients are made to feel welcome on admission.

CARE PROCESS

59. Caregiving staff speak frequently to patients always in a respectful, positive and understanding manner but, if necessary, with determination.
60. Transport should be assured at least for the most disabled elderly patients.
61. There is adequate attention to personal appearance for those unable to care for themselves.
62. Meals served to patients meet recommended minimum nutritional requirements.
63. Suitable food is provided for those with special nutritional needs.
64. Every newly admitted patient has a full medical evaluation within five days of admission.
65. Both individual interviews and group activities are available to every patient.
66. After a month of admission, at the latest, indication and goals of hospitalisation are reviewed, with the participation of the patient.
67. Meetings are held regularly for staff to discuss individual patient care plans.
68. Patient's evolution is discussed between staff and patient at least every two months, after the first evaluation described in item 66.
69. Patients are encouraged to develop and to maintain their independence and autonomy.
70. There are clear written guidelines on the indications and use of drug therapies.

71. There are clear written guidelines on the indications and use of electroconvulsive therapy.
72. There are written guidelines on the role and on the goals of occupational therapy/rehabilitation activities.
73. Treatment plans are written down for each patient and followed by all caregiving staff.
74. Help and support are quickly available if violence breaks out.
75. Caregiving staff have access to specialist medical help in case of an emergency.

INTERACTION WITH FAMILIES

76. Upon request, family members have a chance to discuss the patient's care with a responsible member of caregiving staff.
77. Family members are encouraged to be involved in the patient's treatment programme, except special situations.
78. When needed, help and support are made available by staff to family members.
79. Home visits are carried out for improving caring and coping skills of families of some selected patients.

OUTREACH

80. Regular contact is maintained with other social agencies in the facility's area.
81. Regular contact is maintained with other health facilities.

DISCHARGE AND FOLLOW-UP

82. Discharge plans are discussed by all caregiving staff and with the patient concerned.
83. When discharged, patients are thoroughly oriented in terms of follow-up and social services available in their community.
84. When a patient is discharged, family members (and legal representative) are instructed about measures to take in case of relapse or reappearance of acute symptoms.
85. Upon discharge, a standard information form is always sent to another facility whenever a patient is referred to it, after a first oral contact.
86. Upon discharge, a standard information form is given to patients whenever they are referred to another facility.

K - DAY CENTRES (PSYCHOSOCIAL REHABILITATION CENTRES) 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 architectural lay out of the facility is organized in such a way as to create a welcoming and pleasant environment.
3. The space is sufficient for the number of patients admitted.
4. There is reasonable space for procedures inherent to psychosocial rehabilitation activities.
5. Workshops are adequately equipped.
6. Toilets are in good working order for all patients.
7. A reasonable supply of water is available for patients daily.
8. The ward has adequate lighting.
9. The facility has adequate temperature control and ventilation.
10. The ward is cleaned daily.
11. Sufficient and appropriate seating equipment and other furniture is available for use by the patients.

ADMINISTRATIVE ARRANGEMENTS

12. Measures have been taken to protect the rights of patients.
13. A written policy on philosophy and model of care is available.
14. Job descriptions are specified for all staff.
15. Quarterly, staff and users conduct an internal study to identify strengths and weaknesses in facility's policies and programmes.

STAFFING

16. Staff is multidisciplinary.

17. At least one-half of the caregivers in the facility's staff is employed full-time.
18. At least one-half of the administrative staff in the facility's staff is employed full-time.
19. The facility has an adequate number of professionals for the number of patients cared for.
20. Staff have a full medical examination annually.
21. Staff are provided with space and time to be away from patients at appropriate periods during the day.
22. Written procedures for the protection of confidentiality of patients and staff records are available.
23. Written records are appropriately maintained on all patients.
24. Written procedures for dealing with complaints from patients and families are available.
25. All caregiving staff are required to participate in in-service training programmes.
26. All caregiving staff have been trained in first aid.
27. Written procedures to be followed in an emergency or violent episode are available.
28. Staff have been trained for dealing with and treating patients with mental disorders and to develop psychosocial rehabilitation programmes.
29. Opportunities are provided for staff to discuss with their superiors difficulties they have in working with the mentally ill.
30. Before admission the case is presented for discussion by the person or service referring the patient.
31. There are clear written guidelines on the role and on the goals of occupational therapy/rehabilitation activities.
32. Individual plans are written down for each patient and followed by all staff.
33. Patients are encouraged to be involved in their rehabilitation programme.
34. Newly arrived patients are made to feel welcome on admission.
35. Staff speak frequently to patients always in a friendly, positive and courteous manner.
36. Every newly admitted patient has a brief functional evaluation done by a professional within the first 24 hours after admission.

37. Each patient has a designated staff member responsible for the implementation of the Individual Rehabilitation Plan.
38. Meetings are held weekly for staff to discuss individual patient care plans.
39. Regular contact is maintained with other health and social care agencies.
40. Patients are kept informed about their own progress.
41. Family members who request it have a chance to discuss the patient's care with a responsible member of staff, upon informed consent from the patient.
42. Family members are encouraged to be involved in the patient's treatment programme.
43. Help and support are made available by staff to family members who need them.

DISCHARGE AND FOLLOW-UP

44. Discharge plans are discussed by all staff and with the patient concerned.
45. Upon discharge patients are thoroughly oriented in terms of follow-up and social services available in their community.
46. Upon discharge, a standard information form is sent to the health facility responsible for follow-up.

L - FORENSIC PSYCHIATRIC FACILITIES' CHECK-LIST

ETHICS

1. Patients' rights are upheld.
2. Clinical staff will not be used to obtain police information.
3. Independent bioethics review boards approve all research involving mentally ill offenders.

PHYSICAL ENVIRONMENT

4. The facility has been officially inspected and meets local standards for the protection of the health and safety of the patients and staff.
5. Space is sufficient for the number of patients admitted.
6. There is reasonable space and equipment for specific treatment procedures.
7. There is reasonable space and equipment for recreational activities.
8. Sanitation facilities must meet the local standard for cleanliness and public health.
9. The facility has adequate daylight and appropriate lighting.
10. The facility is cleaned daily.
11. The facility has an adequate supply of basic medical drugs.
12. The facility has an adequate supply of basic psychiatric drugs.
13. A first aid kit is available in the facility.

SECURITY

14. The unit is secure.
15. Traffic of patients to and from the secure area is minimized.
16. Reasonable alarm systems and procedures are in place to cover medical and security emergencies.
17. Restraints are available in areas where violence can potentially occur.

18. Rooms are visually monitored from a central location.
19. Dangerous objects are removed.
20. Doors of patient areas (e.g. bedrooms, toilets) cannot be locked from the inside and cannot be barricaded.
21. Procedures are in place to prevent harassment or violence to patients.
22. Drugs and medical equipment are stored securely.

ADMINISTRATIVE ARRANGEMENTS

23. Assessment and treatment are based on a written statement of the facility's philosophy and model(s) of care.
23. Written policies and procedures are required.
24. Regular quality assurance reviews are conducted.

STAFFING

26. A reasonable staff-to-patient ratio is maintained.
27. Prevention activities are in place to protect the mental health of staff working in maximum security psychiatric environments.
28. Staff have reasonable access to medical and mental health care for occupational health-related problems.

CARE PROCESS

29. Psychiatric service staff assess, plan, implement and evaluate clinical care.
30. Patient care is documented.
31. Practice guidelines are available for the use of specialized treatments.
32. Reasonable access to hospital-based or other specialty care is available.
33. Solitary confinement is used responsibly.
34. Adults and young offenders are not mixed.
35. Prison psychiatric services are considered part of the community-based mental health network.

GLOSSARIES

G - RIGHTS OF USERS OF MENTAL HEALTH SERVICES' GLOSSARY

GENERAL PRINCIPLES

1. **Every person with a mental disorder, or who is said to have a mental disorder, or who is being treated as such has, like any other person, the right to exercise all civil, political, economic, social and cultural rights recognized in the Universal Declaration of Human Rights and other related UN documents.**

Other UN documents relevant to the human rights of people with mental disorders include the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the Declaration on the Rights of Disabled Persons, the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, the Convention against Torture and other Civil, Inhuman or Degrading Treatment or Punishment and the Standard Rules on the Equalization of Opportunities for Persons with Disabilities. The Declaration of Caracas, issued by PAHO/WHO is, *inter alia*, another such relevant document. More specifically, persons with mental disorders are entitled to the following rights:

- a. to marry;
- b. to own property;
- c. to freedom of thought, conscience and religion;
- d. to vote;
- e. to freedom of opinion and expression;
- f. to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment;
- g. to an education;
- h. to have children and to maintain parental rights;
- i. to freedom of movement and choice of residence (assuming the individual has not been involuntarily committed);
- j. to qualified legal assistance to protect their rights, and to have their condition taken fully into account in any legal proceedings;
- k. to access to one's own medical records;
- l. to freedom from cruel, inhuman or degrading treatment or punishment. [0 - 1 - 2]

2. **There is no discrimination on the grounds of mental illness.**

"Discrimination" means any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights. Special measures solely to protect the rights, or secure the advancement, of persons with mental illness shall not be deemed to be discriminatory. Discrimination does not include any distinction, exclusion, or preference, undertaken and necessary to protect the human rights of a person with a mental illness or of other individuals or society at large. All persons with a mental illness, or who are being treated as such persons, are treated with humanity and respect for the inherent dignity of the human person and are protected from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment. [0 - 1 - 2]

3. **Every patient receives such health and social care as is appropriate to his or her health needs, in accordance with the same standards as other ill persons.**

Standards of care here refer to those available to people with physical, i.e. non-mental, illness, in terms of equity of resources' distribution (see also item 17) , access to health and social care (see also item 18) and its quality (see also item 21). Other useful indicators are, for instance, the level of hygiene of patients in psychiatric hospitals as compared to those in general hospitals and the possibility (for voluntary patients) of leaving the hospital, irrespective of the diagnosis.

[0 - 1 - 2]

4. **All patients registering at a mental health (or psychiatric) service (inpatient or outpatient) are informed of their rights.**

All patients registering in a mental health or psychiatric facility shall be informed, as soon as possible, in a form and a language which they understand, of all their rights, and the information shall include an explanation of those rights and how to exercise them.

[0 - 2]

NATIONAL LEGISLATION

5. **There are legal provisions concerning the respect of the rights of users of mental health services and their relatives'.**

Depending on the legal system of the country, the legislation may be found in different types of legal instruments (e.g. constitutions, international agreements, laws, decrees, regulations, orders) and/or in past court rulings (precedents). The law applicable is the law in force at the time in question, as opposed to retroactive or draft legal instruments. The law in force should be public, accessible and understandable.

Main international references in this regard are the UN Resolution 46/119 on Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, adopted by the UN General Assembly on 17 December 1991, and the UN Resolution 48/96 on Standard Rules on the Equalization of Opportunities for Persons with Disabilities, adopted by the UN General Assembly on 20 December 1993.

[0 - 1 - 2]

6. **There are legal provisions governing both involuntary and voluntary psychiatric treatment and hospitalization.**

To the extent that involuntary hospitalization is considered acceptable, legislation provides rules regulating such practices. In these cases, a person may be admitted involuntarily to a mental health facility as a patient or, having already been admitted voluntarily as a patient, be retained as an involuntary patient if, and only if, a qualified mental health practitioner authorized by law for that purpose determines, in accordance with internationally accepted medical standards, that that person has a mental illness and considers:

- (a) That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or

- (b) That, in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.

In the case referred to in subparagraph (b), a second such mental health practitioner, independent of the first, should be consulted where possible. If such a consultation takes place, the involuntary admission or retention may not take place unless the second mental health practitioner concurs. [0 - 1 - 2]

7. There is a time limitation to involuntary psychiatric treatment and hospitalization.

Involuntary admission or retention shall initially be for a short period as specified by domestic law for observation and preliminary treatment pending review of the admission or retention by the review body. In principle, it should not be longer than the average length of stay of voluntary patients in similar facilities. The grounds for the admission shall be communicated to the patient without delay and the fact of the admission and the grounds for it shall also be communicated promptly and in detail to the review body, to the patient's personal representative, if any, and, unless the patient objects, to the patient's family.

[0 - 1 - 2]

8. There is a legal mechanism whereby patients can appeal to a judicial or other independent authority about any decision involving involuntary treatment or hospitalization.

There should be a review procedure (e.g. appeal) available for any decision made by official (judge) or surrogate (representative, e.g. guardian) decision-makers and by health care providers concerning the integrity (treatment) and/or the liberty (hospitalization) of persons with mental disorders. The procedure should be available in a timely fashion (e.g. within 3-7 days of the decision), at the request of interested parties, including the person involved. The patient should not be prevented from access to the review procedure on the basis of his or her health status, and should be given an opportunity to be heard in person. Should a patient experience difficulties in appreciating the implications of a decision, he or she should benefit from the assistance of a knowledgeable third party of his or her choice.

[0 - 1 - 2]

9. There is a legal mechanism whereby any decision involving involuntary treatment or hospitalization is automatically and periodically reviewed by a competent body.

In the case of decisions affecting integrity (treatment) and/or liberty (hospitalization) with a long-lasting impact, there should be an automatic periodical review mechanism. These reviews should take place automatically, at reasonable intervals (e.g. each time a six-month period has elapsed) and be conducted by a qualified decision-maker acting in official capacity.

[0 - 1 - 2]

MONITORING BODIES**10. There is an ombudsperson, at least at the national level.**

An ombudsperson is an individual officially appointed to investigate citizens' complaints against public authorities; as such, he/she should report to the parliament rather than to authorities in executive power. In many instances, complaints received by the ombudsman refer to abuse of human rights. In places where the figure of the ombudsman does not exist, some of the functions can be supplied by the office of the Attorney General. Rate 2 only if there is an ombudsman who deals with complaints related to the human rights of people with mental disorders. [0 - 1 - 2]

11. There is a body specifically charged, at the national level, with monitoring the respect of the rights of users of mental health services and their relatives'.

In many places this body is represented by non-governmental organizations, such as advocacy groups, consumer groups, family associations or professional associations; in other places a governmental agency - usually in the Ministry of Justice or in the Office of the President, the First Lady or the Prime Minister - performs this task. [0 - 1 - 2]

12. The national medical (or psychiatric) association (college/board) has a section particularly dedicated to human rights.

In many professional associations, the same section looks after questions related to ethics and human rights. If this is the case, rate 1. Rate 2 only if there is a section exclusively dedicated to human rights of patients. [0 - 1 - 2]

13. The national association (college/board) of psychologists has a section particularly dedicated to human rights.

See item 10 above for some explanations and ratings. [0 - 1 - 2]

14. The national association (college/board) of nurses has a section particularly dedicated to human rights.

See item 10 above for some explanations and ratings. [0 - 1 - 2]

15. The national association (college/board) of social workers has a section particularly dedicated to human rights.

See item 10 above for some explanations and ratings. [0 - 1 - 2]

16. The national association (college/board) of occupational therapists has a section particularly dedicated to human rights.

See item 10 above for some explanations and ratings. [0 - 1 - 2]

EQUITY AND ACCESS TO TREATMENT

17. **Health resources are equitably distributed.**

This includes ensuring that 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. It can be assessed by:

(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 both (a) and (b) above are present; 1 if only either (a) or (b) is present.

[0 - 1 - 2]

18. **Everyone in need has access to basic mental health care.**

All persons have the right to the best available mental health care, which is part of the health and social care system. By this is understood a comprehensive meaning and includes biological, psychological and psychosocial interventions. Basic mental health care of adequate quality preserves the dignity of the patient; takes into consideration and allows for techniques which help patients to cope by themselves with their mental health impairments, disabilities and handicaps; provides accepted and relevant clinical and non-clinical care aimed at reducing the impact of the disorder and improving the quality of life of the patient and maintains a mental health care system of adequate quality (including primary health care, outpatient, inpatient and residential facilities). Mental health care should be available on a voluntary basis, as for health care in general.

[0 - 1 - 2]

19. **At least 20% of all psychiatric beds are located in general hospitals.**

Twenty percent is a bare minimum. Ideally, most, if not all, people with mental disorders in need of hospitalization should be treated in a general hospital, adequately prepared to do so, both in terms of staff, physical environment and other resources. Rate 0 if less than 20% of all psychiatric beds are in general hospitals; rate 1 if between 20% and 60% and rate 2 only if more than 60% of all psychiatric beds are located in general hospitals.

[0 - 1 - 2]

CARE PROCESS

20. **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. Except for life-saving procedures, no treatment should be started before these steps have been taken. The patient shall have the right to make advanced directives regarding any future treatment. [0 - 2]

21. The care available is of adequate quality.

Patients have the right to receive such health and social care as is appropriate to their health needs, and are entitled to care and treatment in accordance with the same standards as other ill persons. They should be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort. Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others. The treatment and care of every patient should be based on an individually prescribed plan, discussed with and agreed to by the patient, reviewed regularly, revised as necessary and provided by qualified professional staff. It should always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards such as the Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, and those adopted by the United Nations General Assembly for the protection of prisoners and detainees, and against torture and other cruel, inhuman or degrading treatment or punishment. Mental health knowledge and skills shall never be abused. The treatment of every patient shall be directed towards preserving and enhancing personal autonomy and the assessment of quality of care involves taking into account user-based criteria. WHO's documents on Quality Assurance in Mental Health Care provides useful criteria for and indicators of good quality mental health care. [0 - 1 - 2]

22. 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, in a language they understand, preferably using the titles they are given in their community or any other form the patients prefer. However, patients' wishes to remain alone and in silence should also be respected. [0 - 2]

23. Written records are appropriately maintained for all patients, who are entitled to access their own records.

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; they should also be allowed to have their own comments figure in the records and to have any errors corrected, according to the general rules governing records, subject only to restricted and specified exceptions. Patients are entitled to receive copies of their records.

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]

24. **Written procedures for the protection of confidentiality of patients' 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 information to any person, even to family members, unless local law determines otherwise.

[0 - 2]

25. **Written policies on disciplinary procedures concerning staff who disrespect the human rights of patients 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 force medication on a patient or 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]

26. **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]

27. **No patient is kept locked in isolation in an individual room.**

Treatment of mental disorders should be provided in the least restrictive manner. 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]

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

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]

29. **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. Personal nutritional needs and requirements should be met. A nutritionist can be helpful in defining local adaptations of minimum nutritional requirements. [0 - 2]

30. Sterilization is never carried out as a treatment of mental disorders.

Although there may, under domestic law, exist legitimate reasons for sterilization being performed on a person with a mental disorder, there is no justification for carrying it out as a form of treatment of any mental disorder. At any rate, sterilization and abortion should never be performed without written informed consent from the patient or the patient's guardian; an independent external body has satisfied itself that there is genuine informed consent and that the intervention best serves the health needs of the patient. The same applies to any other intervention potentially harmful to the fetus. In addition, sterilization and abortion may be carried out only where it is permitted by domestic law. [0 - 1 - 2]

31. Psychosurgery and other intrusive and irreversible treatments for mental disorders are never carried out on an involuntary patient and without informed consent.

Psychosurgery, other major medical or surgical procedures, or other intrusive and irreversible interventions (including shock therapies) shall never be carried out on an involuntary patient. In addition, they may be carried out on a person with mental illness only where it is permitted by domestic law, where the patient has given informed consent, an independent external body has satisfied itself that there is genuine informed consent and that the treatment best serves the health needs of the patient. [0 - 1 - 2]

32. Clinical trials and experimental treatments are never carried out on an involuntary patient and without informed consent.

Clinical trials and experimental treatment shall never be carried out on any patient without informed consent, except that a patient who is unable to give informed consent may be admitted to a clinical trial or given experimental treatment, but only with the approval of a competent, independent review body, specifically constituted for this purpose, and provided the clinical trial or the experimental treatment aims directly at providing beneficial effects for the same patient. [0 - 1 - 2]

SPECIFIC FACILITIES

33. At any given facility, the space is sufficient for the number of patients.

Space here refers to areas dedicated to specific treatment procedures (for instance, for admission, medical examinations, occupational therapy activities), space for both indoor and outdoor recreational and personal activities, for receiving visitors and some safe space for storing a few pieces of clothing and some toiletries belonging to patients. 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. 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 - 1 - 2]

34. **Jails are not used to house people with mental disorders due to lack of health care facilities.**

Prisoners, once they manifest some form of mental disorder which needs hospitalization, should be transferred to either a prison hospital or to another appropriate facility. A jail should not be used to house persons with a mental disorder beyond the strict minimum period necessary for their transfer to a health care facility. [0 - 1 - 2]

35. **There are appropriate facilities for the care of criminal offenders with mental disorders.**

Prisoners who become mentally ill, or offenders found to be mentally ill, sentenced or not, should be cared for and treated in special facilities which take into account both their health and legal situations. Care here is understood in its comprehensive meaning, and includes biological, psychological and psychosocial interventions. The appropriateness of the facility should be assessed both in terms of staff, of physical characteristics and of other needs of this special group. Another module (on Forensic Facilities) in this Volume provides useful criteria for and indicators of good quality mental health care specific for this type of facility. [0 - 1 - 2]

36. **There are appropriate facilities/services for the care of children/adolescents with mental disorders.**

Children and adolescents with mental and behavioural disorders have special needs in terms of general and psychiatric care. For them, care based in the community is the preferred modality of treatment and institutionalization should be used only as a last resort. Treatment here is understood in its comprehensive meaning, and includes biological, psychological and psychosocial interventions. Appropriate educational programmes and training of the staff dealing with this group are of particular concern. [0 - 1 - 2]

37. **There are provisions for the education of minors with mental disorders admitted to psychiatric hospitals/institutions.**

There should be provisions for the education for minors with mental disorders both within mental health care facilities and in the community. This is particularly relevant to institutionalized minors or those subject to prolonged hospitalization. These school programmes should be accredited in the same manner as are other schools in the community. [0 - 1 - 2]

38. **There are appropriate facilities for the care of the elderly with mental disorders.**

Elderly people with mental disorders have special needs in terms of general and psychiatric care. Care here is understood in its comprehensive meaning, and includes biological, psychological and psychosocial interventions. WHO's series on Quality Assurance in Mental Health Care has one module on residential facilities (in Volume 1) and another one on day-hospitals (in this Volume) which provide useful criteria for and indicators of good quality mental health care specific to this group of patients. [0 - 1 - 2]

H - COMMUNITY-BASED SUPPORT SERVICES' GLOSSARY

POLICY AND PROGRAMMES

- 1. The mental health policy acknowledges the importance of support services in the community.**

The national mental health policy (or programme) clearly specifies that the community is the natural living environment for people with or without mental disorders; therefore, the policy (or programme) calls for the establishment of support services in the community.

[0 - 2]

- 2. Regional and local mental health programmes include the development and harmonization of support services in the community.**

These programmes identify as a priority the development and harmonization of a whole range of support services in the community necessary for the full citizenship of people with mental disorders, particularly in the context of deinstitutionalization or non-institutionalization.

[0 - 2]

- 3. Representatives of users, local authorities and other community leaders are involved in the development and management of support services in the community.**

In order to ensure that services respond to the real needs of users, and that local authorities and community leaders in general play an active role, the close participation of all these three types of leaders is obtained in the planning and implementation of support services in the community.

[0 - 1 - 2]

PRINCIPLES

- 4. Mechanisms are set for the promotion of the rights and full citizenship of people with mental disorders.**

It must be ensured that people with mental disorders enjoy the same rights as any other citizen. Mechanisms are in place so that people with mental disorders have the right to vote, to take part in the life of the community, and to appeal should any of those rights be denied to them.

[0 - 1 - 2]

- 5. There are programmes promoting tolerance and acceptance of people with mental disorders in the community.**

Programmes on information, awareness, etc. are available which decrease misinformation about mental disorders, thus decreasing discrimination and stigma attached to mental disorders.

[0 - 1 - 2]

6. Community-based mental health services are fully integrated with existing inpatient services.

In view of the need for an occasional admission to a hospital bed in some cases, inpatient care should be organisationally and professionally integrated with community -based services in order to ensure continuity of care of individual users of those services.

[0 - 1 - 2]

RANGE OF ACTIONS

7. Every person with a mental disorder has access to adequate accommodation.

These lodgings are safe, healthy and non-discriminatory; support to daily living activities (e.g. personal hygiene, housekeeping, shopping) is available.

[0 - 1 - 2]

8. Persons with a mental disorder have access to transport adequate to their situation.

Adequate transport is available to attend health care facilities, with someone to accompany them when necessary.

[0 - 1 - 2]

9. Persons with a mental disorder have access to health care.

Every person with a mental disorder has access to regular health care (including medical, dental and pharmaceutical care). Mental health care services are available within the primary health care network. Should these persons not be in a position to take care of their own health status, screening, diagnostic and follow-up services are available so that people will not miss those services.

[0 - 1 - 2]

10. Persons with a mental disorder have access to health promotion and disease prevention programmes.

Strategies for the promotion of healthy life styles and for the primary (specific) and secondary prevention (early treatment) of specific diseases include people with mental disorders.

Rate 2 only if programmes on both promotion and the two types of prevention are available.

[0 - 1 - 2]

11. Persons with a mental disorder have access to support programmes aimed at ensuring food and clothing, as well as income support necessary to sustain life with dignity.

Persons have access to financial help or support programmes when their own or their families' resources do not provide for their basic needs (e.g. food and clothing).

[0 - 1 - 2]

12. Persons with a mental disorder have access to appropriate training programmes on daily living activities and the development of social skills.

These programmes are aimed at maintaining or improving functional capability of those people and to facilitate their access to socially valued roles. As much as possible, training for these abilities should take place in the natural environment. Abilities included in the training may range from personal hygiene and other daily living activities to the self-management of medication, budget and displacements. [0 - 1 - 2]

13. Persons with a mental disorder have access to appropriate educational programmes.

Persons have access to current or special programmes aimed at the acquisition of basic education (e.g. reading writing, calculating), normal schooling or returning to school, after an interruption. [0 - 1 - 2]

14. Persons with a mental disorder have access to appropriate vocational rehabilitation programmes.

There is a wide range of work-related programmes, from learning a specific skill to improving attitudes at the workplace. These programmes can be related to either sheltered workshops or protected employment or to the open job market. [0 - 1 - 2]

15. Persons with a mental disorder have access to leisure and recreational programmes in the community.

These programmes should be affordable and adapted to the needs of those persons. [0 - 1 - 2]

16. Persons with a mental disorder have the possibility of being accompanied by someone, should this be necessary in order to carry out their community activities.

Those persons can rely on help to physically and administratively access all services mentioned above: housing, health care, financial help, rehabilitation, etc. [0 - 1 - 2]

17. Relatives responsible for people with mental disorders, as well as those who have a regular contact with them, have access to support services adequate to their needs.

Families and people in contact with persons with a mental disorder have access to the desired and needed information, technical support as needed, and respite, if necessary. [0 - 1 - 2]

18. There are mechanisms to support self-help/mutual aid groups and advocacy groups related to people with mental disorders.

All those groups have access to different forms of financial, clinical, technical and material help. [0 - 1 - 2]

19. Services are available for crisis intervention.

Resources are available on a permanent basis (24 hours a day, seven days a week) to bring a quick response in case of a crisis: telephone hot-lines; intervention in the natural environment, temporary lodgings, temporary foster families, etc. [0 - 1 - 2]

I - DAY-HOSPITALS' GLOSSARY

PHYSICAL ENVIRONMENT

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

This item 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 knowledge of conditions in other facilities that provide care. Last inspection must have taken place within the last 18 months. It is important to check to make certain 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 item. Particular importance should be given to appropriate rooms for group therapy. 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.**

It is important that space is provided to allow patients to follow their chosen hobbies or interest. 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. 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]

- 6. 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.

[0 - 2]

7. A reasonable 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]

8. 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 of opening those doors in case of emergencies. [0 - 2]

9. 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]

10. The facility has adequate temperature control and ventilation.

Particular attention should be given to avoiding sharp differences in temperature between bedrooms, communal rooms and bathrooms. [0 - 1 - 2]

11. The ward is cleaned daily.

The type of cleaning process will depend on the floor material. Record maximum score (2) only if floor is washed or brushed every day and the waste is removed accordingly. [0 - 1 - 2]

12. 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 item. When seating is the local preference there should be a seat for every patient. [0 - 2]

13. 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 item. 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]

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

15. A first-aid kit is available.

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

16. 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 where such materials can be kept. [0 - 2]

17. 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]

18. Measures have been taken to protect the rights of patients.

These rights are those referred to by the Universal Declaration of Human Rights, adopted and proclaimed by the UN General Assembly in 10 December 1948, and include both political and civil rights (such as the right to vote, to marry, to own property, to keep parental rights, to access one's own record, to be free from cruel, inhuman or degrading treatment or punishment) and social and cultural rights (such as to be treated with dignity and without discrimination, to be informed on one's own diagnosis and prognosis, to be informed about and to give or withdraw consent to treatment, right to privacy, etc.). [0 - 2]

ADMINISTRATIVE ARRANGEMENTS

19. 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 displacement 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. [0 - 2]

20. Job descriptions are specified for all staff.

Ideally, job descriptions should be made in terms of the expected outcome 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]

21. Staff is multidisciplinary.

A complete multidisciplinary mental health team is usually composed of at least one of each professional such as a psychiatrist, a clinical psychologist, a nurse, an occupational therapist and a social worker. Each of these latter three should have training in psychiatry or mental health. A multidisciplinary team for a day-hospital should comprise at least three of these five types of professionals, of which a psychiatrist is mandatory. [0 - 2]

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

Caregivers are members of the staff who actually work directly with patients and may not include other persons present in the facility (director, cleaner, cook, secretary) who might be on the premises but are not directly involved with 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 or less and come to work on an erratic and unpredictable basis (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]

23. At least two-thirds of the administrative staff in the facility are employed full-time.

The same comments and scoring criteria presented above on caregivers also apply to the administrative staff. [0 - 1 - 2]

24. 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. In the rare instances in which such examinations might be contraindicated by law or local regulation, record "Not indicated". [0 - 2]

25. Staff are provided with space and time 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 at main meal times. A maximum score on this item should also indicate that there is a separate bathroom for caregivers, a separate place to eat their food (when they are not on lunch duty with patients) and a place where they can physically be away from the patients during their breaks. [0 - 2]

26. 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 the records. This includes 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 information to any person, even to family members, unless local law determines otherwise. [0 - 2]

27. 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 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]

28. There are clear written guidelines on the indications and use of all kinds of treatments employed at the facility.

Therapies most frequently used are drug therapy, psychotherapy, sociotherapy and occupational therapy. These guidelines should include as a minimum: an indication of each class of therapy by clinical diagnosis; contraindications; posology; range of doses (with specification of maximum dose authorized, particularly for drugs); schedules for introducing and for withdrawing the treatment; measures in case of adverse effects; persons authorized to prescribe and persons authorized to administer the treatment. [0 - 1 - 2]

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

These written procedures should cover at least the situations described in item 55 below (see) clearly indicating specific responsibilities during the episode and in its follow-up. [0 - 2]

30. 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]

31. 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 all caregiving staff to enable them to develop the skills required for working with the mentally ill. Training programmes should be made available according to indications of need. Participation in these training programmes should be recorded in staff files. [0 - 2]

32. 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]

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

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

34. 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 for episodes of violence is another specific training programme that must be made available.

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

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

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 one's own difficulties (a process also known as supervision) and possible alternatives to deal with these difficulties 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 circumstances; rate 1 when in only one; rate 0 when in none. [0 - 1 - 2]

- 36. Staff conduct an internal study to identify strengths and weaknesses in facility's policies and programmes annually.**

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. 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]

- 37. At least one qualified 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 to deal with urgent matters, admitting patients, making necessary referrals, receiving and informing family members and authorizing leave or discharging patients, on behalf of the competent authority. [0 - 2]

- 38. Staff have access to an internist, whenever necessary.**

This medical help (which could be provided by an internist, general practitioner or family physician) 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]

- 39. 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 item 31) or in training outside the facility in activities such as those mentioned in items 32-34. [0 - 2]

- 40. The facility is open at least five days a week.**

This minimum includes mornings and afternoons. Obviously it could be open during the whole week, and also during additional hours, depending on the needs of patients and the availability of staff. [0 - 2]

CARE PROCESS

- 41. 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 their individual beds and lockers - and are informed of the main rules of the facility, e.g. meal hours, awakening and silence hours, meeting hours and meeting rooms. [0 - 2]

42. Staff speak frequently to patients 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 respect from the patients. Staff should address patients politely, preferably using the titles they are given in their community or any other form the patients prefer. [0 - 2]

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

This applies to every admission, even re-admissions of a patient recently discharged. Full 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 needed actions taken thereafter. [0 - 2]

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

Treatment plans (including goals and duration) should be individualized and appropriate for the patient's clinical condition and age. Patients should participate actively in the design of their individual treatment plans, including decisions concerning the activities in which they will participate. All the staff should comply with and enforce the plan written down in the patient's file. [0 - 2]

45. 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 condition to understand the information or to give informed consent, this should be obtained from his or her personal representative. No treatment procedure, except for emergency procedures, should be started before these steps have been taken. [0 - 2]

46. Meetings are held regularly for staff to review 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 who are in other meetings with patients, and this duty should be rotated) and they should be free to speak and participate in the discussions. Care plans should be updated according to the patient's condition and needs.

Rate 1 for meetings held at least once a week and 2 for more frequent meetings.

[0 - 1 - 2]

47. There is a daily control of patient attendance.

This should cover all activities in which the patient should take part. Should patients fail to attend, efforts should be made to locate them and ascertain the reasons for absence. [0 - 2]

48. Patients are kept informed about their own progress.

Patients should be informed about the reasons and the goals of admission and on what is expected from him/her. They should also be regularly and periodically - e.g. at every evaluation - informed on their progress in relation to those goals. [0 - 2]

49. At least 60 minutes are allocated for each weekly therapeutic group activity with patients.

Therapeutic 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. The frequency of this activity should be at least weekly for individual patients.

Rate 2 if weekly group activities last for at least 60 minutes, 1 if they last between 30 and 59 minutes or are not weekly and 0 if they last for less than 30 minutes and are not weekly. [0 - 1 - 2]

50. Patients participate in the day-to-day management of the hospital.

Their participation can be better incorporated when management and decision-making meetings ("assembly"-like) involving all staff (caregiving and administrative) and patients are regularly held. [0 - 2]

51. Leisure and free-time activities are included in the plan of treatment.

These should be flexible and accommodate as much as possible patients' preferences and choices. They should, nevertheless, be coherent with the overall treatment plan. [0 - 2]

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

FAO/WHO joint nutritional standards indicate 2,000 kilocalories and 40 g of protein 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 the fact of being admitted to a psychiatric facility. A nutritionist can be helpful in defining local adaptations to 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 and/or the elderly) conditions or can be derived from cultural

and/or religious prohibitions. The staff needs 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]

54. The facility provides at least one meal per day.

Usually this is the main meal of the day, but this and other lighter meals should be provided according to local customs and usage. [0 - 2]

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

All staff (not only caregiving staff, for this purpose) 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: a) a patient makes an attack on another person; b) a patient becomes disturbed to the extent he/she is considered a danger to him/herself and/or others; and c) 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 AND COMMUNITY AGENCIES

56. Family members who request it have a chance to discuss the patient's care with a responsible member of staff.

Ideally there should be regularly held 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 able to answer their doubts in relation to the patient and the disease. [0 - 2]

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

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

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

Caring for a mentally ill person 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 family member's doubts and anxieties - either individually or in groups - about the treatment and about the implications of mental illness.

[0 - 2]

59. Regular contacts are maintained with community support and other 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]

60. Regular contact is maintained with other health and social care agencies.

This contact should be 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]

61. Representatives of users, family members, local authorities and other community leaders are involved in the planning, development and evaluation of the service.

In order to ensure that services respond to real needs of users, and that local authorities and community leaders in general play an active role, the close participation of all these three types of leaders is obtained in the planning and implementation of support services in the community.

[0 - 1 - 2]

DISCHARGE AND FOLLOW-UP

- 62. Discharge plans are discussed by all staff and with the patient and relatives concerned.**

As soon as the situation which resulted in the admission is solved 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 and relatives be kept informed on the discharge plans. [0 - 2]

- 63. Upon discharge 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 on a printed leaflet to be given to both patient and family at the time of discharge. [0 - 2]

- 64. Upon discharge the patient 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 written to the patient and family. They should also be specifically informed on where the patient's treatment is to be continued. [0 - 2]

- 65. 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 to be given to the patient and the other one 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]

- 66. Upon discharge, a standard information form is given to the patient.**

The patient and/or his/her family are requested to present this form (with the same content as described in item 76 above) during the first visit to the health facility responsible for follow-up. [0 - 2]

J - DAY-HOSPITALS FOR THE ELDERLY MENTALLY ILL GLOSSARY

PHYSICAL ENVIRONMENT

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

This criterion should be scored even in regions which have no state or local laws or regulations pertaining to day hospitals. 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 day hospital has an adequate number of exits from the building and if they are adapted for the elderly mentally ill. Other important safety factors, apart from emergency exits should also be checked such as staircases (banisters), windows (large panes of glass or screens), etc., respecting sight, hearing and locomotion disabilities frequently present in elderly mentally ill patients.

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.**

Space here refers to places for communal activities, waiting and resting rooms, toilets and space for administrative functions. As elderly persons frequently need more space to move than other adults, four to six square meters per patient should be considered a reasonable amount of indoor space; this amount should be adjusted to local standards. [0 - 2]

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

This item refers to the types of treatment provided by the facility, for instance, for admission, medical examinations, family interviews, group therapy, occupational therapy activities, 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 for elderly disabilities, in terms of size, lighting and whether sound-proof. [0 - 2]

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

It is important that communal rooms are arranged to allow patients to follow their chosen hobbies or interests.

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

- 5. 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 some safe space for storing a few pieces of clothing and some toiletries. [0 - 2]

6. The layout, the architectural conception, the decor and furnishing of the facility have been designed to promote orientation and adaptation.

It is important to promote for the elderly mentally ill, spacial orientation by for example, the use of different colours, particularly for toilet doors, as well as different types and styles of furniture, preferably in a non-institutional way. Temporal orientation should also be promoted by the use of visible calendars and watches in the most frequented rooms. Sound isolation is important to avoid the increase of hearing disabilities. Frequent changes and substitutions should be avoided. The distribution and arrangement of the furniture should facilitate patient mobility. All these arrangements should promote patient adaptation. [0 - 2]

7. Floors in the facility are covered in non-slip and non-shining materials.

The use of non-slip materials to cover floors of the facility should avoid locomotion difficulties and prevent falls. Carpets should not have frayed edges or raised surfaces at joints. Non-shining materials avoid the increase of visual difficulties for patients with sighting disabilities. [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 patients. [0 - 2]

9. The location, the number and fittings of bathrooms and toilets are planned to minimize the effects of disabilities of patients.

They should facilitate and enable patients to achieve the greatest degree of safety, independence and privacy possible, taking into account some people's need for regular or occasional assistance. [0 - 2]

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

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

11. 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 of opening these doors in case of emergencies. [0 - 2]

12. The facility has adequate lighting, ventilation, acoustic and temperature control.

There should be enough light in the facility for patients to see enough to carry out their ordinary activities. Particular attention should be given to avoiding sharp differences in temperature across communal rooms, bathrooms and toilets. Ventilation should assure air circulation without provoking draughts. Acoustic control should be implemented by sound isolation everywhere in the facility as well as by the control of sound production (TV, radio, etc.) [0 - 2]

13. 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 - 2]

14. At least one adequate piece of resting equipment is available for use by patients.

Resting equipment should be used only for special situations. A table for medical examination is not considered resting equipment. [0 - 2]

15. 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]

16. Sufficient and appropriate utensils for activities of daily living are available for use by the patients.

All utensils for activities of daily living must be adequate for the type of usage, adapted for patients and respecting local usages. Clean eating utensils should be available for every patient at every meal. [0 - 2]

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

The supply should include at least essential drugs for the most frequent clinical conditions of elderly patients, (e.g. diarrhoea, constipation, 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]

18. 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; carbamazepine, tablet; biperiden, tablet and injectable), or their available equivalent. 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]

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

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

20. 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]

21. 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 of the eating-room should be washed and waste removed on a daily basis.

[0 - 2]

ADMINISTRATIVE ARRANGEMENTS

22. 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 displacement 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]

23. 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. dementia, depression, functional psychoses, medical and social disorders, alcoholism, 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 efficient and affordable means of treatment of (or for effectively dealing with) the problem. [0 - 2]

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

These should cover at least salary, sick leave, hospitalization, holidays, vacation issues. 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 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 responsibility and duties, and also that staff's skills are matched to tasks needed to reach the facility's objectives and goals. [0 - 2]

26. Caregiving staff is multidisciplinary.

Caregivers are members of the staff and/or of the domiciliary surroundings who actually and directly deal with patients and may not include other persons present in the facility or in the domicile (director, cleaner, cook, secretary) who might be on the premises but not directly involved with patients. A complete multidisciplinary mental health team is usually composed of at least one of each of the 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 a day hospital for the elderly mentally ill should comprise at least one representative of each one of these five types of professionals.

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

27. A certain employment stability of the caregiving staff is necessary.

Elderly mentally ill patients are very sensitive to environmental changes. They spend more time establishing therapeutical interpersonal links with caregivers and they need more time than other adults to reach the goals of a treatment project. For these reasons it is important that they can be cared for by caregivers able to assure the longest possible follow-up. A certain employment stability is necessary for these caregivers.

Rate 2 if all caregiver categories are employed for at least 2 years; rate 1 if only some of them are; otherwise rate 0. [0 - 1 - 2]

28. All 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. In the rare instances in which such examinations might be contraindicated by law or local regulation, record "Not indicated".

[0 - 2]

29. Caregiving staff are provided with space and time to be away from patients at appropriate periods during the day.

The care of the elderly mentally ill is very demanding and caregiving staff should be given regular breaks during the day. There should be at least a 15-minutes 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 lunch duty with patients) and a place where they can be physically away from the patients during their breaks.

[0 - 2]

30. 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 information to any person, even to family members, unless local law determines otherwise.

[0 - 2]

31. 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 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]

32. Written records are appropriately maintained on all staff.

Records on all 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]

33. 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 74 (see) clearly indicating responsibilities during the episode and in its follow-up. [0 - 2]

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

35. Written procedures to be followed in case of fire or other catastrophes are available.

Elderly mentally ill patients may need special help to be quickly secure in case of fire and other natural catastrophes. Written procedures should cover all possible dangerous situations. [0 - 2]

36. 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 restraints to control a patient during episodes of violence or retaliatory measures taken afterwards are particular examples of abuse for which specific disciplinary procedures should be indicated. [0 - 2]

37. Domestic routines aim to meet the needs and preferences of the patient rather than administrative convenience.

Domestic routines are needed for the smooth running of facilities but they have to take into consideration both individual needs and preferences and desirability of a lifestyle which is as normal as possible, especially in relation to daily living activities such as bathing, mealtimes, periods for resting etc. Routines should be applied in a respectful, positive and understanding way and offer maximum possible choice and dignity to patients. [0 - 2]

38. 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 staff 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 files. [0 - 2]

39. 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]

40. All caregiving staff have been trained in basic fire and other catastrophes fighting.

Training in basic control of fire and other catastrophes such as that given by the local fire brigade meets this requirement. All staff should conduct security exercises with patients, at least twice per year. [0 - 2]

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

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

42. All staff have been trained to understand and to deal with the needs of elderly mentally ill.

Many caregivers - even at the professional level - come to work with the elderly 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 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 only one of these programmes; otherwise rate 0. [0 - 1 - 2]

43. All caregiving staff have been trained specifically for the management of geriatric psychiatry 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). Caregiving staff should know how to handle patients and families, how to medicate, and how and where to refer these patients. Somatic emergencies (cardiovascular and metabolic disorders, traumatic accidents, etc.) are frequent in elderly mentally ill patients and caregiving staff must also be prepared to deal with them.

Rate 2 if training covers both psychiatric and somatic emergencies; rate 1 if only one and 0 if none. [0 - 1 - 2]

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

This time could be spent in either in-service training (see item 40) or in training outside the facility (e.g. those mentioned in items 41-45), and in activities such as those mentioned in items 47-49).

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

45. Opportunities are provided for caregiving staff to discuss with their peers about the difficulties they have in working with the elderly mentally ill.

Caring for the elderly mentally ill may produce a wide variety of problems for any person, including those with adequate background training. Caregivers should have opportunities to discuss with their peers or with the multidisciplinary caregiving staff to find solutions to these problems and to prevent them (staff meetings). These opportunities should be available on a regular basis but they should also be made available when a special situation arises.

Rate 2 if meetings are available in both circumstances; rate 1 when in only one; rate 0 when in none. [0 - 1 - 2]

46. Opportunities are provided for caregiving staff to discuss with a qualified person about difficulties they have in working with the elderly mentally ill.

The daily work with the elderly mentally ill 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 circumstances; rate 1 when in only one; rate 0 when in none. [0 - 1 - 2]

47. Annually, all 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

- 48. The facility has at least the equivalent of one full-time psychiatrist per 20 patients per day and per 40 patients hospitalized.**

A psychiatrist is a medical doctor who has had at least two years of post-graduate training in psychiatry, in a recognized teaching institution. Consider patients irrespective of their status being acute or chronic. Full-time work means approximately six to eight hours per day of work or 40 to 50 hours per week; 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]

- 49. The facility has at least the equivalent of one full-time registered nurse per 20 patients per day and per 40 patients hospitalized.**

A registered nurse is a graduate from a recognized Nursing School at university level, registered at the local Board (or equivalent) of Nurses. Consider patients irrespective of their status being acute or chronic. See item 50 for full-time definition.

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

- 50. The facility has at least the equivalent of one full-time qualified occupational therapist per 20 patients per day and per 40 patients hospitalized.**

A certified occupational therapist is a graduate from a recognized School of Occupational Therapy at university level, registered at the local Board (or equivalent) of Occupational Therapists. See item 50 for full-time definition.

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]

- 51. The day hospital has at least the equivalent of one full-time qualified clinical psychologist per 20 patients per day and per 40 patients hospitalized.**

A certified clinical psychologist is a graduate from a recognized School of Psychology at university level, with specialization in Clinical Psychology, and registered at the local Board (or equivalent) of Psychologists. See item 50 for full-time definition.

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]

- 52. The hospital has at least the equivalent of one full-time qualified social worker per 20 patients per day and per 40 patients hospitalized.**

A certified social worker is a graduate from a recognized School of Social Work at university level, registered at the local Board (or equivalent) of Social Workers. See item 50 for full-time definition.

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]

- 53. The facility has at least one full-time caregiving staff member per 5 patients per day and per 10 patients hospitalized.**

See item 50 above for definition. In this case they include both professionals mentioned above and non-professionals, such as nursing-aides, health assistants, etc. [0 - 2]

ADMISSION PROCESS

- 54. All admission requests should be supported by a mental health professional, according to local procedures.**

Mental Health professionals supporting a patient's (or his/her representative's) request for admission to the Day Hospital are invited to relate their observations and experiences about the patient's difficulties, the reasons for the treatment, the main factors which can interact with treatment, etc. [0 - 2]

- 55. An interview between the patient (and his/her representative), the Day Hospital's psychiatrist and at least one caregiving multidisciplinary staff representative is organized before admission.**

An interview is organized by the Day Hospital before admission. The goals, the expected duration, the frequency, transport, the risks and side effects of the treatment must be discussed in a language that the patient can understand. The patient should express his/her desires and expectatives, explain some details of his/her way of life and identify his/her most important difficulties in the activities of daily living. This interview should be made at the Day Hospital: a presentation of the facility should be made at this moment. In some particular situations the interview should be made where the patient is living (patient's hospitalisation in a full time service, for example). The patient (and his/her representative), the Day Hospital's psychiatrist and at least one caregiving multidisciplinary staff representative should be present at this interview. If there is an external caregiver, he/she is also welcome. [0 - 2]

- 56. A full assessment of potential social, physical and emotional needs, as well as a full risk assessment, is available on admission.**

This assessment should be made or be available prior to or immediately after hospitalization. Special attention should be given to communication needs and difficulties of

patients suffering from locomotion and sensory disabilities and speech disorders. Specific risk assessment should include, e.g. likelihood of wandering and self-harm. It is also important to take into account the main relative carer's needs. [0 - 1 - 2]

57. 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 during an for emergency, should be started before these steps have been taken. [0 - 2]

58. 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 toilets - and are informed on the main rules of the facility, e.g. meal hours, arriving and leaving hours, transport conditions, meeting hours and rooms. [0 - 2]

CARE PROCESS

59. Caregiving staff speak frequently to patients always in a respectful, positive and understanding manner but, if necessary, with determination.

"Positive" refers to supportive as opposed to critical comments made to patients. In some conditions, it can be in the patient's interest to show respectful determination. The language employed should always reveal respect for the patient, just as staff expect respect from patients. Staff should address patients politely, preferably using the titles they are given in their community or any other form the patient prefers. [0 - 2]

60. Transport should be assured at least for the most disabled elderly patients.

There is no Day Hospital for the elderly mentally ill without adequate transport possibilities. Day Hospitals should prepare for each patient a transport plan and for the most disabled elderly patients transport facilities should be furnished: private Day Hospital vehicle with the presence of one accompanist, private or voluntary transport services, etc. Family members could be encouraged to help patient transport. Each time it is possible a patient's autonomy in transport should be encouraged by caregiving staff: for these patients, a rehabilitative plan for public transport should be developed. [0 - 2]

61. 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 take

a 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]

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

Personal nutritional needs should be evaluated for each elderly mentally ill patient. His/her nutritional requirements should be adjusted according to the patient's weight (or nutritional status), level of activity and physical efforts and to local nutritional standards. At any rate, no elderly patient should receive less than what is reasonably expected from the fact of being admitted to a geriatric psychiatry facility. A nutritionist can be helpful in defining local adaptations of minimum nutritional requirements. [0 - 2]

63. 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 members need to be aware of special nutritional needs which may be present in some of the elderly 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 day hospital's staff. A nutritionist can be helpful in defining local adaptations of minimum nutritional requirements. [0 - 2]

64. Every newly admitted patient has a full medical evaluation within five days of 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 elderly patient. Data and conclusions from the evaluation must be appropriately recorded in the patient's file and needed actions taken thereafter. [0 - 2]

65. Both individual interviews and group activities are available to every patient.

The Day Hospital should offer patients individual interviews with different caregivers of the multidisciplinary staff in order that they benefit from each different professional competence. Different group activities, directed by at least one representative of the caregiving staff, should have rehabilitative aims and they should be of easy access to every patient.

Rate 2 if both possibilities are available; rate 1 if just one of them is available; otherwise rate 0. [0 - 1 - 2]

66. After a month of admission, at the latest, indication and goals of hospitalisation are reviewed, with the participation of the patient.

At the end of the first month of hospitalisation, the indication of the Day Hospital treatment is reviewed in the presence of the patient (and of his/her representative) and, if possible, in the presence of all exterior caregivers as well as the Mental Health professional who

supported the request for the treatment. The patient's evolution is discussed, the treatment is readjusted and a new therapeutical plan is prepared. An abstract should be prepared and it should be sent to all invited persons who were unable to be present at the meeting. [0 - 2]

67. 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 those who are supervising or who are in another meeting with patients, and this duty should be rotated) and they should be 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]

68. Patients' evolution is discussed between staff and patient at least every two months, after the first evaluation described in item 66.

Frequently the geriatric psychiatry treatment at a Day Hospital for the elderly mentally ill is quite long. The rhythm for an evaluation every 2 months is enough and is adequate to control treatment effects. Patient, Day Hospital's psychiatrist and at least one caregiver's representative as well as all exterior caregivers should participate in the evaluation. [0 - 2]

69. Patients are encouraged to develop and to maintain their independence and autonomy.

A treatment plan project to develop and to maintain a patient's independence and autonomy should be carried out. A range of treatment modalities (i.e. biological and psychosocial) should be made available. Global treatment evaluation should include the estimation of its capacity to increase a patient's independence and autonomy as well as to prevent dependence and heteronomy. Hospitalism should be prevented from the first day of hospitalisation by, for example, the discussion about the length of hospitalisation and by the regular and periodical evaluation meetings. Patients 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 patients 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]

70. 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 for elderly patients;
- 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]

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

Informed consent (by the patient or by his/her 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 a 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, and of persons authorized to prescribe and to administer ECT. In no case should ECT be used without medical supervision or for punishment. [0 - 2]

72. There are 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]

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

Treatment plans (as referred to in item 69) 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]

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

All staff (not only caregiving staff) have to be trained in 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 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 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]

75. Caregiving 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. If the patient's internist wasn't contacted to help the patient in this situation, he/she should be informed about the incident as quickly as possible. [0 - 2]

INTERACTION WITH FAMILIES

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

77. Family members are encouraged to be involved in the patient's treatment programme, except special situations.

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, attend families meetings. There are written guidelines describing special situations when family members should not be involved in the patient's programme. [0 - 2]

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

Caring for an elderly 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. Caregiving 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]

79. 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]

OUTREACH

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

Elderly mentally ill 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, welfare, education, justice, family etc. Regular contact should serve both as an update on the availability of services and as adequate support of actual patients who need these services.

[0 - 2]

81. Regular contact is maintained with other health facilities.

Day Hospitals are situated at the intersection of a mental health network, between outpatient and full time inpatient facilities. They play an inter-institutional liaison role preventing full time hospitalisations and accelerating full time hospitalisation discharges. The aim of regular contact with other health facilities is not only to follow-up patients being currently seen in both facilities but also to facilitate future referrals and back-referrals.

[0 - 2]

DISCHARGE AND FOLLOW-UP

82. Discharge plans are discussed by all caregiving 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]

83. 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 the patient, the family and the initial referrer, at the time of discharge.

[0 - 2]

84. When a patient is discharged, family members (and legal representative) are instructed about measures to take in case of relapse or reappearance of acute 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]

85. Upon discharge, a standard information form is always sent to another facility whenever a patient is referred to it, after a first verbal contact.

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, as well as to the initial referrer/family doctor, with which this facility is expected to be in regular contact. [0 - 2]

86. Upon discharge, a standard information form is given to patients whenever they are referred to another facility.

The patient and/or his/her family and representative are requested to present this form (with the same content as described in the item 89 above) during the first visit to the health facility responsible for follow-up. [0 - 2]

K - DAY CENTRES (PSYCHOSOCIAL REHABILITATION CENTRES) 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 item 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 knowledge of conditions in other facilities that provide care. Last inspection must have taken place within the last 24 months. It is important to check to make certain 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 architectural lay out of the facility is organized in such a way as to create a welcoming and pleasant environment.**

This implies both an "open door" policy and physical characteristics (e.g. adequate furniture and interior design, absence of physical barriers, etc) which, in addition to creating a welcoming and pleasant environment contributes to a full participation of users in the services' activities. [0 - 2]

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

Given the diversity of activities which may be developed at the facility, it is not easy to quantify the space needed. At any rate, space should be sufficient for performing all activities in a therapeutic, safe and pleasant manner. [0 - 2]

4. **There is reasonable space for procedures inherent to psychosocial rehabilitation activities.**

For instance, rooms for interviews, medical examinations, group meetings, occupational therapy activities and conditions which ensure privacy and confidentiality are all essential to rate this item. 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. **Workshops are adequately equipped.**

This implies both machinery and equipment, and materials necessary for performing activities. [0 - 2]

6. 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. [0 - 2]

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

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

8. 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]

9. The facility has adequate temperature control and ventilation.

Particular attention should be given to avoiding sharp differences in temperature between bedrooms and communal rooms and bathrooms. [0 - 1 - 2]

10. The ward is cleaned daily.

The type of cleaning process will depend on the floor material. Record maximum score (2) only if floor is washed or brushed every day and the waste is removed accordingly. [0 - 2]

11. Sufficient and appropriate seating equipment and other furniture is available for use by the patients.

Local usage (e.g. seating or squatting) should be taken into account when assessing this item. When seating is the local preference there should be a seat for every patient. Other furniture and equipment (e.g. cups, glasses, dishes, etc.) will depend on the exact type of activity performed at the facility. [0 - 2]

ADMINISTRATIVE ARRANGEMENTS

12. Measures have been taken to protect the rights of patients.

These rights include both political and civil rights (such as the right to vote, to marry to own property, to keep parental rights, to access one's own record, to be free from cruel, inhuman or degrading treatment or punishment) and social and cultural rights (such as to be treated with dignity and without discrimination, to be informed on one's own diagnosis and prognosis, to be informed about and to give or withdraw consent to treatment and right to privacy, etc.). [0 - 2]

13. 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 the displacement 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. [0 - 2]

14. Job descriptions are specified for all staff.

Ideally job descriptions should be made in terms of the expected outcome 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 in order to reach the facility's objectives and goals. [0 - 2]

15. Quarterly, staff and users conduct an internal study to identify strengths and weaknesses in facility policies and programmes.

This type of study should lead to the specification of goals. These goals should be written down and anchored to specific objectives so that some sort of judgement can be made as to whether they have been achieved. All staff and users 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

16. Staff is multidisciplinary.

A complete multidisciplinary mental health team is usually composed of at least one of each professionals such as a psychiatrist, a clinical psychologist, a nurse, an occupational therapist and a social worker, each of the latter three with training in psychiatry or mental health. A multidisciplinary team for a day centre should comprise at least three of these five types of professionals. [0 - 2]

17. At least one-half of the caregivers in the facility's staff is 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 not directly involved with 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 or less and come to work during 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 one half of caregivers are employed full-time. Rate 1 if between 25% and 50% of caregivers are employed full-time; otherwise rate 0. [0 - 1 - 2]

18. At least one-half of the administrative staff in the facility's staff is employed full-time.

The same comments and scoring criteria presented above on caregivers also apply to the administrative staff. [0 - 1 - 2]

19. The facility has the number of professionals adequate for the number of patients cared for.

Given the nature of the work done at a psychiatric day-centre, among its staff occupational therapists, workshop monitors and foremen acquire a particular relevance. They should be adequately trained for working with people with mental disorders and be present during the opening hours of the centre in numbers compatible with the number of patients attending the facility. [0 - 2]

20. 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. In the rare instances in which such examinations might be contraindicated by law or local regulation, record "Not indicated". [0 - 2]

21. Staff are provided with space and time 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 at main meal times.

A maximum score on this item (2) should also indicate that there is a separate bathroom for caregivers, a separate place to eat their food (when they are not on lunch duty with patients) and a place where they can be physically away from the patients during their breaks. [0 - 1 - 2]

22. 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]

23. Written records are appropriately maintained on all patients.

Patient records should include all information pertaining to the clinical situation and 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]

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

25. 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 mentally ill. Training programmes should be made available according to indications of need. Participation in these training programmes should be recorded in staff files. [0 - 2]

26. 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]

27. Written procedures to be followed in an emergency or violent episode are available.

All staff (not only caregiving staff, for this purpose) have to be trained on the management of different types of emergency without endangering their own security and that of patients. These emergency situations include, for instance, fire, other catastrophic situations and individual or collective violence. 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: a) a patient makes an attack on another person; b) a patient becomes disturbed to the extent he/she is considered a danger to himself/herself and/or others; and c) the use of force as an emergency measure is needed to give essential treatment.

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

28. Staff have been trained for dealing with and treating patients with mental disorders and for developing psychosocial rehabilitation programmes.

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 for both the identification and treatment of people with mental disorders, **and** psychosocial rehabilitation. Rate 1 if in only one of these programmes; otherwise rate 0. [0 - 1 - 2]

29. Opportunities are provided for staff to discuss with their superiors difficulties they have in working with persons with mental disorders.

Daily work with persons 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 circumstances; rate 1 when in only one; rate 0 when in none. [0 - 1 - 2]

30. Before admission the case is presented for discussion by the person or service referring the patient.

The reason for this presentation is two-fold: to explore the adequacy of the referral and to enable the staff in the centre to be acquainted with the case. [0 - 2]

31. 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 patients; they should never be "prescribed" as a means of keeping patients "busy". If any money or value is derived from these activities, this 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]

32. Individual plans are written down for each patient and followed by all staff.

These plans (including goals and duration) should be individualized and appropriate for the patient's clinical condition and age. Patients should participate actively in the design of their individual treatment plans, including decisions concerning the activities in which they will

participate. All the staff should comply with and enforce the plan written down in the patient's file. [0 - 2]

33. Patients are encouraged to be involved in their rehabilitation programme.

A maximum score for this item means not only that patients are encouraged to do these things but also that they actually do them. [0 - 1 - 2]

34. 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 their individual beds and lockers - and are informed on the main rules of the facility, e.g. meal hours, awakening and silence hours, meeting hours and rooms. [0 - 2]

35. Staff speak frequently to patients 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 respect from patients. Staff should address patients politely, preferably using the titles they are given in their community or any other form the patients prefer. [0 - 2]

36. Every newly admitted patient has a brief functional evaluation done by a professional within the first 24 hours after admission.

This applies to every admission, even re-admissions of a patient recently discharged. A functional evaluation includes assessment of physical, mental and social aspects of the patient, with particular emphasis on the patient's abilities, capabilities and limitations. This evaluation should follow a standardized protocol. Data and conclusions from the evaluation must be appropriately recorded in the patient's file and needed actions taken thereafter. [0 - 2]

37. Each patient has a designated staff member responsible for the implementation of the Individual Rehabilitation Plan

This staff member can be a professional or a monitor who has the responsibility of making sure that the plan is followed and reporting to the team on the progress of the patient. It is also part of the responsibilities of this staff member to suggest modifications in the original plan when the conditions of the patient indicate this need. [0 - 2]

38. Meetings are held weekly 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 be free to speak and participate in the discussions. Care plans should be updated according to the patient's condition and needs.

Rate 1 for meetings held at least once a week and 2 for more frequent meetings.

[0 - 1 - 2]

39. Regular contact is maintained with other health and social care agencies.

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]

40. 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 evaluation - informed on their progress in relation to those goals.

[0 - 2]

41. Family members who request it have a chance to discuss the patient's care with a responsible member of staff, upon informed consent from the patient.

Ideally there should be regularly held 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]

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

A maximum score for this item means not only that family members are encouraged to do these things but also that they actually do them - accompany the patient in some of the internal activities, take the patient out for some outings, participate in organized social activities, volunteer services for help with special activities, attend family meetings.

[0 - 2]

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

Caring for a mentally ill person 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 family members' doubts and anxieties about the treatment and about the implications of mental illness.

[0 - 2]

DISCHARGE AND FOLLOW-UP

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

As soon as the situation which resulted in the admission is solved 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]

45. Upon discharge 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 on a printed leaflet to be given to both patient and family at the time of discharge. [0 - 2]

46. 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 one to be sent to the facility responsible for the follow-up of the patient and with which the facility from which the patient is being discharged is expected to be in regular contact. The following should be included in this form:

- a brief history of the clinical history and of the rehabilitation plan
- maintenance medication; social, occupational and family needs; special areas of attention; specific risks; and
- the name of the staff member responsible for the follow-up of the patient. [0 - 2]

L - FORENSIC PSYCHIATRIC FACILITIES' GLOSSARY

ETHICS

1. Patients' rights are upheld.

Mentally ill offenders bear a heavier jeopardy by virtue of their double stigma. Forensic staff must be more sensitive to these issues and receive additional information and training in the area of human rights. International ethical codes exist and should be considered to represent ideals.

2. Clinical staff will not misuse the therapeutic relationship to obtain police or correctional information.

In order to make impartial assessments and treatment decisions, psychiatric forensic personnel must be removed from the police process of determination of evidence. Misuse of the therapeutic relationship creates mistrust. The therapeutic process should not be perverted in order to seek evidence to assist in a police investigation.

3. Independent bioethics' review boards approve all research involving mentally ill offenders.

Research carries both risks and benefits. Compared to other population groups, inmates and mentally ill offenders are vulnerable subjects. They should not bear undue risks of research and should share equally in the benefits. All research projects should be reviewed and approved by an independent bioethics' review board. Ideally, this board should be located in the local University or major hospital.

PHYSICAL ENVIRONMENT

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

Safety and adequacy of building facilities are prerequisites to good clinical care. Where inspections occur, the facility should be inspected by public health personnel to insure that standards are met with respect to fire regulations, food preparation, sanitation and public health. Where inspections are not possible, correctional and health staff must ensure that local standards prevail.

5. Space is sufficient for the number of patients admitted.

Overcrowding facilitates transmission of infectious diseases and contributes to increased levels of tension, anxiety, and violence. Overcrowding is considered a threat to the health of the patients, staff, and larger community and interferes with therapeutic aims. Serious

overcrowding is considered to occur when the number of persons per single cell or dormitory cell exceeds the minimum local standard for acceptable square footage per person.

6. There is reasonable space and equipment for specific treatment procedures.

Space must promote confidentiality and privacy during medical and psychiatric examination and treatment. Privacy and confidentiality are defined with reference to the local custom. Equipment must support the assessment or treatment functions of the facility and meet local safety standards.

7. There is reasonable space and equipment for recreational activities.

Recreation is understood as a means for enjoying both mental health and physical fitness. Recreational space could include internal exercise areas, areas where patients may engage in personal hobbies or communal activities, space for visiting rooms and an open yard for exercise.

8. Sanitation facilities must meet the local standard for cleanliness and public health.

In closed environments, poor sanitation is the major reason for epidemics. Sanitation facilities include latrines, toilet facilities, baths, showers, washing, etc. When the number of persons exceeds the local standard for the number of hygienic facilities, health risk occurs.

9. The facility has adequate daylight and appropriate lighting.

Many mental conditions are exacerbated by inadequate daylight (i.e. SADS) or inappropriate levels of lighting (i.e. Dts). Within security constraints, an ideal facility should have windows to the outside letting in daylight. When daylight is not possible, artificial lighting should be provided.

10. The facility is cleaned daily.

Cleaning is an activity that is considered appropriate for inmates within prisons in order to relieve boredom and sometimes serves as the basis for an incentive system or prison economy (e.g. for cigarettes, candy, etc). Mentally ill offenders should not be deprived of the benefits of industry unless seriously incapacitated.

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

Physical comorbidities are typically high among mentally ill offenders. Facilities for mentally ill offenders should have access to sufficient quantities of medical drugs (e.g. pain killers, antibiotics, antiseptics) and medications for the most frequently occurring conditions.

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

Treatment of psychiatric conditions often demands psychotropic medications. In addition, it may be necessary to use chemical restraint when patients are violent or seriously disturbed. Basic medications for oral and parenteral administration should include neuroleptics (e.g.

chlorpromazine, haloperidol, fluphenazine), hypnotics/tranquilizers (e.g. benzodiazepines), antidepressants (e.g. amitriptyline, imipramine, lithium), and anti-convulsants (e.g. phenobarbital, carbamazepine). Drugs that have a high risk of morbidity and require constant laboratory monitoring should be avoided.

13. A first aid kit is available in the facility.

Suicide attempts, violent incidents and minor accidents are more common among mentally ill offenders. The first aid kit should contain scissors, gauze, cotton, antiseptics, and equipment for minor suturing.

SECURITY

14. The unit is secure.

A forensic facility houses inmates classified at all levels of security. Mentally ill offenders are at risk of abuse from other inmates because their behaviour and psychotic symptoms are poorly tolerated. In addition, they may pose an escape risk. Security must be sufficient to prevent escapes and injuries to other patients and staff.

15. Alarm systems and procedures are in place to cover medical and security emergencies.

By virtue of their mental condition, mental patients tend not to complain about their physical problems and they pose greater safety risks for setting fire, suicide attempts, disturbed or violent behaviour, etc. Proper fire alarms and access to exit doors to other secure areas are important. Procedures for medical emergencies should include training in first aid and medical stabilization for medical and security staff and procedures for transfer to local hospitals for serious cases should be in place.

16. Restraints are available in areas where violence can potentially occur.

Some mental patients, particularly those experiencing psychotic symptoms, are prone to unexpected outbursts of violence against themselves or others and disturbed behaviour. As much as possible violent and disturbed behaviour should be prevented with appropriate observation, assessment of the condition and specific treatment. If an incident occurs, restraints should be part of an overall treatment plan and not simply a reaction to the episode. The best restraint should be via medication or protective clothing. Staff should have comprehensive training in dealing with violent patients.

17. Rooms are visually monitored from a central location.

Proper visual monitoring is part of an overall plan for the primary prevention of untoward incidents. Visual monitoring may be via camera, mirror or open design.

18. Dangerous objects are carefully controlled or removed.

This is a matter of primary prevention of incidents of violence toward others, self-harm or destruction of property. All objects that could be used to inflict harm on the self or others should be carefully controlled or removed from the patient and their living areas and properly stored and secured. This includes articles of clothing, eating utensils, occupational therapy materials or recreational therapy equipment or mirrors.

19. Doors of patient areas cannot be locked from the inside or barricaded.

Patients often lock or barricade their doors in preparation for a suicide attempt or the smoking of contraband drugs. Furniture should be attached to the floors and walls and doors should not be lockable from the inside.

20. Procedures are in place to prevent harassment or violence to patients.

Mentally ill offenders are the target of ridicule, abuse, or attacks by other inmates, co-patients, visitors, staff, or others. Clear policies and procedures must be in place prohibiting and preventing this type of behaviour, and to investigate unusual incidents.

21. Drugs and medical equipment are stored securely.

Drugs and medical equipment are coveted items during riots or disturbances. These items should be stored securely away from inmate living areas. Supplies in excess of the needs of the patients should not be kept.

ADMINISTRATIVE ARRANGEMENTS**22. Assessment and treatment are congruent with a written statement of the facility's philosophy and model(s) of care.**

Statements of philosophy, mission, goals, and objectives define the character of the facility and its staff and provide the standards for evaluation and quality assurance. The facility has a written mission statement and clearly identified clinical goals and objectives and treatment is congruent with these.

23. Written policies and procedures are available.

The intentions and aspirations of the mission statement, goals, and objectives need to be converted into concrete instructions. These are policies and procedures. This conversion tells staff what to do and how to do it. Written policies and procedures should include the following:

- Organizational structure.
- Staffing (hiring, training, job descriptions and governance, conflict resolution, disciplinary procedures, firing, review, etc.).
- Record keeping and confidentiality for both patients and staff.

- Violent and disturbed behaviour, including policies governing the use of restraints and the use of drugs for behaviour control.
- Medical and security emergencies.
- Protection from the transmission of infectious diseases (HIV, Hepatitis, etc.).
- Complaints from patients, families, staff, legal community, etc.
- Security (access, contraband, weapons, personal belongings).
- Safety for patients, staff, visitors, etc.
- Use of solitary confinement for therapeutic reasons.
- Patient, visitor, and staff movement within the facility and externally.
- Consent for treatment.
- Debriefing for unusual incidents.
- Prevention or management of harassment and discrimination.
- Suicide prevention and management of suicidal behaviours.

24. Regular quality assurance reviews are conducted.

Quality assurance activities, conducted both internally and externally, insure that clinical and security goals and objectives are met. As a minimum standard, the review covers major clinical and security incidents such as deaths, suicides, serious suicide attempts, medication errors with serious physical consequences and other serious injuries. With respect to security, escapes, violent incidents, and serious breaches of security regulations (e.g. disappearance of drugs, contraband, etc.). In addition, as a matter of routine, policies and procedures should be reviewed and updated on a regular basis.

STAFFING

25. A reasonable staff-to-patient ratio is maintained.

A reasonable staff-to-patient ratio insures that standards of security and patient care are appropriately upheld. An appropriate staff-to-patient ratio should be judged with reference to local standards for the treatment of people with mental disorders.

26. Prevention activities are in place to protect the mental health of staff working in maximum security psychiatric environments.

Maximum security environments for mentally ill offenders are highly stressful for the staff. Prolonged stress leads to emotional disturbances or psychosomatic illnesses that may interfere with patient care. Flexible scheduling of work shifts and holidays, staff development opportunities, and debriefings of serious incidents comprise the minimum standard. In addition, there should be appropriate support staff to meet administrative requirements.

27. Staff have reasonable access to medical and mental health care for occupational health related problems.

Staff in maximum security environments are at higher risk of occupationally-related illnesses. If primary prevention fails, appropriate occupational health services should be

provided. Access to occupational health should be judged against the local standard. This includes emergency access and first aid in the case of a work-related injury.

CARE PROCESS

28. Psychiatric service staff assess, plan, implement and evaluate clinical care.

Abuse of psychiatry could easily occur in correctional settings through the inappropriate use of psychiatric labels, medications, other treatments, and psychiatric facilities in general. Clinical issues are dealt with by clinical personnel. Medications and psychiatric treatments are not prescribed or administered unless they are clinically indicated. The plan of care is reviewed regularly and revised as necessary. Evaluation includes monitoring of deleterious side effects of neuroleptic medications (e.g. Tardive Dyskinesia).

29. Patient care is documented.

Documentation of patient care is required to insure continuity of care, ongoing evaluation and to assist discharge planning. A legible medical record is kept containing, as a minimum, the following:

- Statement of the problem.
- Results of the medical and mental status examinations.
- Diagnosis following the International Classification of Disease Standard Nomenclature or the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.
- Care plan, including medications, their dose and frequency, and discharge plans.

30. Practice guidelines are available for the use of specialized treatments.

Practice guidelines prevent misuse of treatment and alert to potential untoward effects. Specialized treatments include electro-convulsive therapy, neuroleptic medications, and anti-depressants. Behaviour modification techniques should not include deprivation of the basic necessities of life or medical treatment. Psychosurgery should never be used within a mentally ill prison population.

31. Reasonable access to hospital-based or other specialty care is available.

Forensic facilities do not usually have access to specialists and are not the place for tertiary medical care (high level medical interventions). All but minor medical and dental procedures should be referred to an appropriate facility.

32. Solitary confinement is used responsibly.

Solitary confinement is an appropriate clinical and correctional management technique. Within a therapeutic environment, solitary confinement should be used primarily in response to clinical needs for "time-out" and clear policies governing its use should be in place.

33. Adult and young offenders are not mixed.

Young offenders are vulnerable to predatory behaviour by adult offenders and to being influenced into further criminal activities. In addition, mental conditions and treatment approaches are quite different in these groups. Adult and young offenders should be housed in separate units. The definition of a young offender should be based on local laws.

34. Prison psychiatric services are considered part of the community-based mental health network.

In many countries mental health reforms, without appropriate community support systems, have contributed to the criminalization of the mentally ill thus increasing the prevalence of mental illness in correctional settings. To promote continuity of care, mentally ill offenders require community support and clear discharge planning. There is communication and conjoint discharge planning between the staff of the forensic facility and community mental health agencies. Mentally ill offenders are encouraged to communicate with their families.

RATING SCORES

RIGHTS OF USERS OF MENTAL HEALTH SERVICES' RATING SCORE

Good	60 - 74
Fair	45 - 59
Barely acceptable	26 - 44
Unacceptable	0 - 25

COMMUNITY-BASED SUPPORT SERVICES' RATING SCORE

Good	30 - 38
Fair	23 - 29
Barely acceptable	13 - 22
Unacceptable	0 - 12

DAY-HOSPITALS' RATING SCORE

Good	105 - 132
Fair	80 - 104
Barely acceptable	46 - 79
Unacceptable	0 - 45

DAY-HOSPITALS FOR THE ELDERLY RATING SCORE

Good	138 - 172
Fair	103 - 137
Barely acceptable	60 - 102
Unacceptable	0 - 59

DAY CENTRES' (PSYCHOSOCIAL REHABILITATION CENTRES) RATING SCORE

Good	74 - 92
Fair	55 - 73
Barely acceptable	32 - 54
Unacceptable	0 - 31

FORENSIC PSYCHIATRIC FACILITIES' RATING SCORE

Good	56 - 70
Fair	42 - 55
Barely acceptable	25 - 41
Unacceptable	0 - 24

ANNEX

A FRAMEWORK FOR QUALITY ASSURANCE IN MENTAL HEALTH CARE

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INTRODUCTION

Following the introduction of measures to control and ensure the quality of products in industry, similar ideas were adopted - with the necessary adaptations - by the health sector for the control of the quality of "products" of health services (Donabedian, 1988; Vuori, 1989).

In the health sector quality assurance (QA) has been employed with two distinct but complementary meanings: the first one refers to an assessment process and the second one to a mechanism for action. Indeed, according to Rosen et al (1989) QA is both a "planned and systematic approach to monitoring and assessing the care provided, and the services being delivered", and a "mechanism for taking action to make and maintain improvement".

Depending on the nature of the health activity one or the other meaning has been more stressed. Thus, laboratory and surgical activities have given a greater importance to mechanisms for action, whereas clinical activities have concentrated more on assessments. However, from a managerial point of view these two aspects are complementary and a QA programme should address both to be fully productive.

Figure 1. Steps in quality assurance programmes

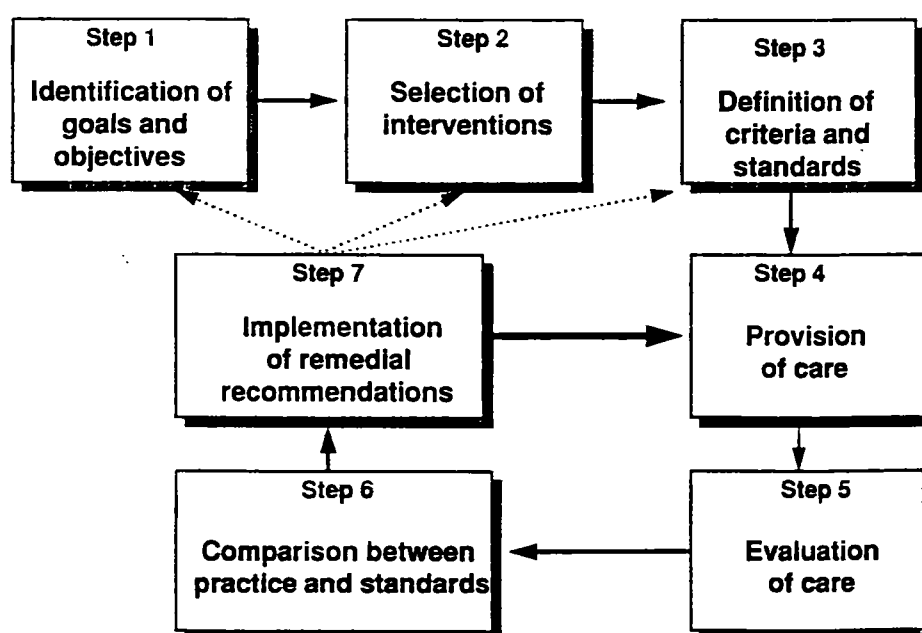


Figure 1 (adapted from Fowkes (1982), Chambers (1985), and Dávalos & Quevedo (1991)) allows for visualization of the QA process cycle. The main steps in the establishment of QA programmes are:

- a) identification of goals and objectives
- b) selection of interventions (for attaining the identified goals and objectives)
- c) definition of criteria and standards (of selected interventions)
- d) provision of care (intervention or practice)
- e) assessment of care provided
- f) comparison between practice and standards
- g) incorporation of remedial recommendations (if any) into care.

In Figure 1, steps: (a) and (b) - and up to a point also (c) - all fall within the area of policy making; both (d) and (g) refer to service implementation; whereas (e) and (f) correspond to evaluation and quality control, strictly speaking.

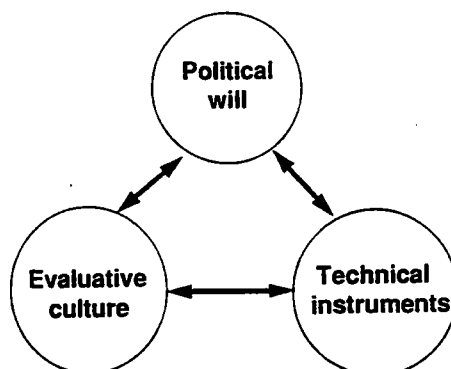
In other words, this model basically revolves around a comparison between observed practices and established standards. It implies two main areas of activity, namely *evaluation* (or assessment) and *quality control*. Evaluation and quality control are the technical components feeding the larger administrative and decisional level represented by QA programmes.

Although not mentioned in the model, there are also the crucial issues of *who* sets the standards, *who* observes practice and *who* implements changes; these aspects will be dealt with ahead.

IMPLEMENTATION OF QA PROGRAMMES

The implementation of quality assurance programmes or of programmes for the improvement of the quality of mental health care can only be envisaged within a framework which includes at least three pre-conditions, seen in Figure 2: the political will to do it, the existence of an evaluative culture among those involved in care delivery and the existence of widely accepted and reliable criteria, standards and indicators of good quality care.

Figure 2.
Pre-conditions for quality assurance programmes



Political will

The first element has until now concerned mostly health authorities, decision-makers, managers and politicians. In the last years we have witnessed a growing interest and empowerment of consumer associations which are not only willing to take part in the process of planning, implementing and evaluating health services, but have already started to do so, in many places. There are some indications that the degree of participation of users in this process is directly correlated with the prevailing level of democracy.

However, the Declaration of Alma-Ata, in Article 4, has affirmed that "people have the right and duty to participate individually and collectively in the planning and implementation of their health care" (WHO-UNICEF, 1978). According to the QA model being proposed here, planning, implementation and evaluation are interconnected aspects of the same endeavour. Community involvement, therefore, should be sought at every stage of the QA process. More comprehensive community involvement could be obtained from:

- (I) service users (those who may be current patients in health care facilities, or may have been patients in the past; these are also designated as primary consumers),
- (ii) family groups,
- (iii) community groups (such as women's groups, groups representing ethnic minorities or groups representing others who are disadvantaged; churches and other religious groups),
- (iv) representatives of local government and health care organizations,
- (v) representatives of trade unions or other professional groups within the health and social care delivery system,
- (vi) special community agencies, and
- (vii) self- and citizen-advocacy groups specifically set up to assist consumers of health services (WHO, 1989).

In mental health - and particularly in community mental health activities - primary consumers are an important segment that ought to be taken into consideration. This is specially relevant in the evaluation of services. Service users groups and advocacy groups are probably among the least involved in this evaluation, worldwide.

Evaluative culture

The second element depends largely on the background of care deliverers, and also on the organizational structure of the services' network and the style of management directing them. Accountability - which has a direct relationship with mode of government - is a key concept determining to which degree staff will share an evaluative culture.

People are crucial in QA. Interests, professional orientation, and personal biases and prejudices of the staff can be highly influential in relation to the direction a QA programme takes. In already established QA programmes, planning and implementation has been mostly a task for professionals, and "peer review" has been the basic model for monitoring (Mattson, 1992).

Insofar as specific methodologies for monitoring QA programmes are concerned, more and more importance has been given to qualitative ethnographic approaches in which consumers opinions can more easily be obtained and incorporated into the final evaluation (Richards & Barham, 1993).

The last few years have witnessed a shift in the trend of assessment of mental health services. On the one hand there has been a shift from quantitative evaluations towards qualitative assessments with important consequences particularly concerning the indicators selected. On the other hand another shift has been seen from the assessment of services -or facilities - towards the assessment of the whole system of which mental health activities are part.

Technical instruments: guidelines, criteria and standards

The third element is mostly a technical one. Without the existence of reliable, efficacious and efficient interventions no effective programmes on quality assurance can be established. It depends greatly on professional organizations and on the technical production from universities and research departments.

LEVELS OF ASSESSMENT

Most of current examples of QA in health care correspond to a "vertical" approach, in the sense of a programme that can be set up in isolation without organic, structural links with the remaining organization of the health services. Mental health activities, on the contrary, are best dealt with using an approach based on full integration into the primary health care system (WHO, 1990a).

To this end one can envisage a three level system of QA (Bertolote, 1992). It has by now been firmly established that a meaningful assessment of mental health services requires the assessment of the mental health programme as a whole rather than only the evaluation of the care available for the mentally ill. Accordingly, the assessment should cover the whole range of mental health activities with three levels of assessment and evaluation, namely, (i) policy and programmes, (ii) specific settings and facilities; and (iii) direct care (see Figure 3).

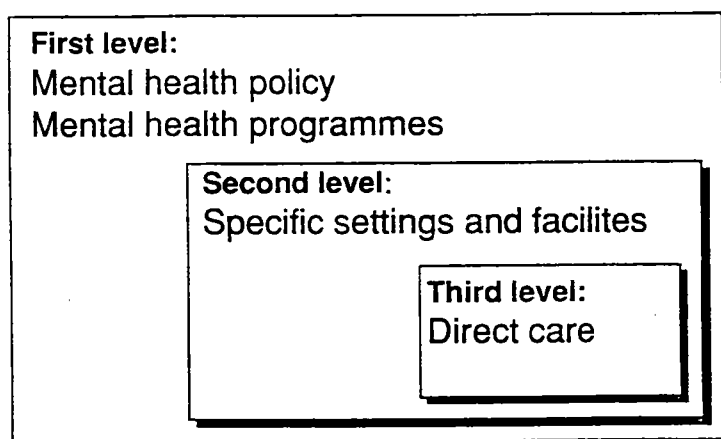
The **first level** looks at the nature of the local (national or regional) mental health policy and its organization, what is now known as mental health programmes (WHO, 1992). Topic areas

for the application of QA in a mental health policy include: decentralization, intersectoral action, comprehensiveness, equity, continuity, community participation, and periodical reviews.

In addition, topic areas for the application of QA to mental health programmes include: range of actions, components of plan of work, monitoring and evaluation, and community participation.

The **second level** deals with specific settings and facilities where mental health care is delivered. These include primary health care facilities delivering mental health care, outpatient psychiatric facilities (e.g. mental health centres, emergency care rooms, crisis intervention centres), inpatient facilities (e.g. mental hospitals and psychiatric wards in general hospitals) and residential facilities (e.g. nursing homes, forensic psychiatric facilities).

Figure 3. Levels of assessment



Finally, at the **third level**, QA is relevant to direct care for the mentally ill, in terms of specific interventions, e.g. for psychopharmacotherapy and psychotherapy, or for the management of specific disorders such as schizophrenia, affective disorders, agoraphobia, etc.

Given the great need to integrate and articulate these three levels from a public mental health perspective, during a consultation held in Geneva in September 1990 (WHO, 1990b) such an approach was discussed. One of the recommendations of that meeting was that strategies and instruments for QA should be developed which take into account the national mental health policy, programmes and structures. Examples and models, however, are available mainly for the third level or for undertakings which are part of hospital or mental health centre accreditation programmes.

In order to develop QA for all levels within an integrated public mental health approach, it is necessary to define guidelines and criteria on which to base standards and indicators, these being the elements with which programmes can be evaluated. With such a public mental health approach, the most relevant areas for the development of criteria, indicators, guidelines and standards are those related to:

1. Service structure and organization.
2. Physical characteristics of facilities.
3. Staffing.
4. Nomenclature and classification.
5. Procedures for clinical examination (structured interviews).
6. Treatment characteristics: modalities, indications and processes.
7. Outcome measures.
8. Legislation.

Table 1 presents an overview of these areas, indicating what already exists and what is needed to be put into effective practice. Several of the existing WHO material has been developed usually in collaboration with NGOs and Collaborating Centres.

INDICATORS

Stressing the importance of indicators for evaluations and in quality assurance programmes is never excessive. By indicators we refer to variables that help to measure change. This measurement may be direct or indirect, and should identify the extent to which the objectives and targets of a programme are being attained. Classically, indicators are classified as indicators of efficacy, effectiveness, efficiency and impact, as well as those combining cost (WHO, 1984). Table 2 presents some examples of indicators and standards in selected domains. This Table also stresses the fact that although WHO can propose guidelines and even suggest standards (WHO-EURO, 1994), it is at the national (or local) level that standards should be finally chosen and eventually transformed into norms.

Following the model indicated in Table 2, one can envisage its application to mental health care, as shown in Table 3 (WHO, 1996).

In the literature related to QA it is now usual to classify indicators in the areas of structure, process and outcome (Donabedian, 1988; Vuori, 1989). In some instances, however, this division may be too limiting. For instance, some programmes for staff in-service training, some legal procedure provisions, or some funding for rehabilitation programmes may, properly, be considered as both "structure" and as "process". Most of the work related to quality indicators in mental health have dealt with what has been called structure and process indicators (Donabedian, 1988). Outcome measures in psychiatry have mostly been developed to measure changes in psychopathology, and to examine the side-effects of therapeutic interventions, but not in other areas.

In addition, care-process indicators, in use in mental health services, have been borrowed from other areas in which the industrial origins of QA programmes are more visible. Assembly line measurements are readily adapted to areas such as those of hospital infections, surgical procedures, and food control. In many mental health activities relevant indicators must examine what has been called "soft variables" - e.g. quality of relationships, overall climate in the ward, subjective well being - that evade simple classification as structure, process or outcome variables (Saraceno et al, 1993).

At any rate, outcome measures have definitely acquired a great relevance and represent a major area of interest for many health authorities. From a public health perspective, justification for most of the infrastructure, inputs, activities, personnel and expenditures should be based on the outcome they produce. As of recently, other outcome indicators - such as patients' and care-givers' satisfaction, family burdens, social integration, and most of all, quality of life - have acquired so great a social importance that a mental health programme which does not take them into account must be regarded as not being fully warranted. In the words of the Council of Medical Service of the American Medical Association:

"... patient outcome reflects the degree of effectiveness with which health professionals combine their own skill and compassion with the use of technology for the patient's benefit. It encompasses both the effects of care on the patient and the proficiency with which such care is provided. Also implicit in the definition is the need to develop more meaningful criteria as to what constitutes a "favorable" outcome." (Concil of Medical Service, 1988)

Notwithstanding the crescent importance appropriately attached to outcome indicators, a grain of caution should be introduced, particularly in relation to evaluations based mainly on outcome measures. Mirin and Namerow have aptly indicted some of the impediments to accomplish it, and have concluded that "whether or not a psychiatric patient experiences clinical symptoms, performs well at school or work, or function appropriately within a family unit is determined not only by the treatment he or she may have received, but also by a multitude of cultural, socioeconomic, and interrelational factors." (Mirin & Namerow, 1991)

In summary, outcome indicators probably represent the most needed components for the establishment of good QA programmes. Therefore, efforts should be directed to their development and improvement. Their inclusion in QA programmes will not only make mental health programmes more comprehensive but will also give them more social relevance and legitimacy.

CONCLUSION

The systemic approach presented aims at assisting in the development of locally derived standards for mental health care.

One final practical remark, however, concerns the introduction of QA programmes. There is always the risk of dissipating efforts through being too ambitious. It is preferable to install a QA programme which focusses on one or two areas, gradually adding others when appropriate, until more complete coverage is achieved. The selection of the initial areas is a delicate task and the more broadly based it is the lesser the dangers of failure and future discontentments. Moreover, QA programmes - like any other component or activity in the health field - should always be evaluated, and appropriate corrective measures introduced, when needed.

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TABLE 1. WHO ELEMENTS FOR QUALITY ASSURANCE IN MENTAL HEALTH

AREA	EXISTING	NEEDED
Service structure & organization	WHO Modules on Quality Assurance Several independent publications	National mental health policies, and national and local mental health programmes
Physical characteristics of facilities	Architectural recommendations WHO Modules on Quality Assurance, and on Day Care for Children	Indicators of ratio of facilities and of services per population
Staffing	Recommendations for curriculum content and for training for some professions WHO Modules on Quality Assurance, and on Day Care for Children	Recommendations for curriculum content and for training for several professions Guidelines on types of professionals needed Indicators of ratio of staff per population
Nomenclature & classification	ICD-10	Translation into local languages and staff training
Interview instruments and schedules	Several for clinical examination (e.g. SCAN, CIDI)	Instruments for the assessment of family burden
Treatment characteristics	Essential drugs list WHO Modules on Quality Assurance, and on Day Care for Children	Guidelines on physical, psychological and psychosocial interventions
Outcome measures	WHO Modules on Quality Assurance	Instruments for the assessment of quality of life and of client's satisfaction
Legislation	Several international resolutions (e.g. UN Principles) and national laws	Guidelines for better access to services integrated with social support systems through legislation Implementation of existing legislation

DOMAIN	CRITERION	INDICATOR	WHO SUGGESTED STANDARD	LOCAL STANDARD
Air quality	SO ₂ content	µg/m ³	40-60	UK < 35
Water quality	Bacterial contamination	coliforms/100 mL	0	Canada 0 USA < 1 Sudan < 3
Human development	Infant mortality	number of deaths in children under one year per 1,000 live births	targets variable according to Region	Japan < 5 Cuba < 11 Tunisia < 45
Access to general health care	Availability of qualified medical expertise	doctors/population	(1/1,000)	Sweden 1/400 Kenya 1/10,000
Access to mental health care	Availability of inpatient treatment facilities	beds/population	(0.5-0.8/1,000)	Japan 1/280 Brazil 1/2,000
	Availability of qualified psychiatric expertise	psychiatrists/population	(0.25-1/10,000)	Sweden 1/10,000 Netherlands 1/43,000

TABLE 3. EXAMPLES OF INDICATORS AND STANDARDS RELEVANT TO MENTAL HEALTH QA PROGRAMMES²

DOMAIN	CRITERION	INDICATOR	SUGGESTED STANDARD (minimum levels)
Human rights	UN Resolutions	Formal adoption	Yes
	Freedom of patients	% of patients kept in a locked individual cell	0%
	Involuntary admissions	% of all admissions which are involuntary	< 10%
Budget	Mental health budget	% of the total health budget allocated to mental health activities	at least 10%
Organization of services	Sectorization	Adoption of the principle of sectorization	at least 75% of all psychiatric hospitals
	Location of beds	% of psychiatric beds in general hospital wards	at least 25%
Access to mental health care	Travelling distance to nearest mental health facility	% of population living more than one hour from nearest mental health facility	< 20%
	Availability of inpatient treatment facilities	Beds/population	0.5 - 0.8/1,000
Staffing	Availability of qualified psychiatrists	Psychiatrists/population	0.25 - 1/10,000
	Availability of qualified psychiatric nurses	Psychiatric nurses / population	0.5 - 4/10,000

² These figures are merely taken as possible examples; they are not WHO official recommendations.

DOMAIN	CRITERION	INDICATOR	STANDARD (minimum levels)
Hospital stay	Length of stay in psychiatric wards	Maximum length of stay in psychiatric wards	15 - 30 days
		% of patients staying beyond the accepted maximum length of stay	< 1%
	Hospitalization	% of outpatient visits which result in admission	< 5%
Time allocation	Administrative load	Time for training and administrative activities	at least 10%
	Locus of activities	Time spent in the community	at least 20%

