Evaluating the WHO Assessment Instrument for Mental Health Systems by comparing mental health policies in four countries

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Abstract Mental health is a low priority in most countries around the world. Minimal research and resources have been invested in mental health at the national level. As a result, WHO has developed the Assessment Instrument for Mental Health Systems (WHO-AIMS) to encourage countries to gather data and to re-evaluate their national mental health policy. This paper demonstrates the utility and limitations of WHO-AIMS by applying the model to four countries with different cultures, political histories and public health policies: Iraq, Japan, the Philippines and The former Yugoslav Republic of Macedonia.

WHO-AIMS provides a useful model for analysing six domains: policy and legislative framework; mental health services; mental health in primary care; human resources; education of the public at large; and monitoring and research. This is especially important since most countries do not have experts in mental health policy or resources to design their own evaluation tools for mental health systems. Furthermore, WHO-AIMS provides a standardized database for cross-country comparisons. However, limitations of the instrument include the neglect of the politics of mental health policy development, underestimation of the role of culture in mental health care utilization, and questionable measurement validity.

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Introduction

Countries across the globe have long overlooked the issue of mental health and mental illness. Countries spend little on mental health, especially developing countries that allocate less than 1% of their gross domestic product (GDP), while developed countries only spend about 5% of their GDP.[1] These figures are remarkable given that one single mental illness, unipolar major depression, is today one of the top five leading causes of disability worldwide and is expected to be the second leading cause of disability worldwide by 2020.[2]

In 2003, almost half (40–50%) of low- to middle-income countries did not have mental health policies.[3] In response, WHO developed the Assessment Instrument for Mental Health Systems (WHO-AIMS), designed to gather information on specific components of a country's mental health system and its infrastructure, in order to promote the development of mental health policies.[4]

WHO-AIMS may have a significant influence on how developing countries view the "model" mental health system. The WHO-AIMS tool provides a template for regional mental health care experts to enter essential data regarding six domains of mental health care systems: policy and legislative framework; mental health services; mental health in primary care; human resources; education of the public at large; and monitoring and research.

The initial instrument was piloted in several countries. While the overall conclusion of the pilot test was that WHO-AIMS was useful, the initial length of the instrument precluded several countries from completing it. Currently, 50 countries have agreed to use WHO-AIMS as an instrument to assess their mental health care systems. However, although WHO-AIMS has been used in many countries, its utility has never been evaluated. This paper examines the utility of the WHO-AIMS instrument in developing and developed countries by applying it to the mental health systems of Iraq, Japan, the Philippines and The former Yugoslav Republic of Macedonia. These four countries have distinct cultural and historical circumstances, which make it especially interesting to use the WHO-AIMS model to compare their mental health systems and policies. These comparisons allow us to demonstrate how WHO-AIMS may be used in countries with different political and cultural situations, and to assess its possible limitations given these differences.

Mental health systems in four countries

Iraq, the Philippines and The former Yugoslav Republic of Macedonia, are three low- to middle-income countries that are currently in the process of evaluating their mental health systems through the application of the WHO-AIMS instrument (Table 1).

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Policy and legislative framework

WHO-AIMS provides a useful model for evaluating the mental health policy of each country. As reported in Table 1, The former Yugoslav Republic of Macedonia is the only country without any policy on mental health; however, it does have provision for coverage of mental health under primary care.[5] In the last two years, with the establishment of policy institutes such as the Center for Research and Policy Making, its health-care services are being utilized in mental health care.[6]

The Philippines has a mental health policy that is hampered by a miniscule budget and limited legislative authority.[7,8] No mental health law has been established.[9] Its mental health budget is only 0.02% of its total health budget, the latter being 3% of its GDP.[7]

Like the Philippines and The former Yugoslav Republic of Macedonia, Iraq is also in the early stage of developing a mental health system. With the help of the Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States of America, the United Kingdom's National Health Service and WHO, Iraqi mental health policy-makers have started to develop a detailed plan for implementing a policy on mental health. In 2005, Iraq passed mental health legislation focusing on the rights of consumers, patients' families, and caregivers (e.g. access of care, determination of capacity, guardianship, voluntary and involuntary hospitalizations, law enforcement, and mechanisms for implementing legislation).

Japan, on the other hand, has passed several mental health laws since 1900. In 1995, it passed a mental health act that for the first time legally defined mental illness as a disability, and established strict criteria for involuntary hospitalization. This law promotes the concept of "normalization", viewing mental illness as a disability and encouraging the integration of psychiatric inpatients into the community.[10,11] Relative to the three developing countries, Japan has a higher expenditure on mental health, spending 0.5% of its GDP on mental health (and a total of 8.6% of its GDP on health).[12] Although spending on mental health is higher in Japan than in the other three countries, it is still a small percentage of total health spending, considering the large impact of this disability. This demonstrates a global trend of mental health continuing to have a low priority, regardless of the country's culture, economic strength and resources.

Mental health services

Compared to Japan, the other three countries' mental health services are meagre. The number of psychiatric beds in Japan is the highest in the world.[13] In 2000, the ratio of psychiatric beds per 10 000 individuals in Japan was 28.4, three times higher than in the United Kingdom, and there was also a 95% occupancy of these beds.[5] The former Yugoslav Republic of Macedonia has the next highest ratio of inpatient psychiatric beds, at 8.2 per 10 000 individuals, with Iraq and the Philippines having 0.6 and 0.9 per 10 000 individuals, respectively.[5] The distribution of inpatient psychiatric beds in all four countries is similar, with the majority of beds located in cities. In the Philippines, 77% are located in the national capital[8] and in Iraq, 97% are located around its three largest cities (Baghdad, Basra and Mosul). Although Iraq, the Philippines and The former Yugoslav Republic of Macedonia are shifting towards de-institutionalization, very few community mental health programmes and social services exist.

In all three of the developing countries, psychotropic medication is very limited. In Iraq, the current state of violence prevents distribution of goods and limits access to medication. As a result of the low appropriations designated for mental health services in Iraq, the Philippines and The former Yugoslav Republic of Macedonia, psychopharmacologic agents, although listed in the country's essential drug list, are often in short supply.[8]

Mental health in primary care

Given the stigma and lack of resources allocated to mental health care, WHO has encouraged mental health policy-makers to shift the responsibility to the primary care sector. All four countries need to improve in this particular domain. Although professional training in mental health for primary care workers exists in Japan, it is not rigorously evaluated.[14] In the Philippines, there was a push in the 1990s for psychiatric care to be integrated within the general health services and, as a first step, the country's National Mental Health Programme proposed opening acute psychiatric units and outpatients in 72 general hospitals under its Department of Health. However, as of 2004, only 10 of those hospitals opened outpatient clinics due to a lack of funds.[8] In Iraq, only 7% of primary care physicians and 1% of nurses receive postgraduate training in mental health. Only 1–20% of the physician-based primary care clinics, and no non-physician based primary care clinics, have protocols for management of mental illness or dispense psychotropic medication.

All four countries lack data on how primary care or mental health facilities are currently linked with alternative care practitioners, yet these latter groups are the ones who, in certain instances, have initial contact with the mentally ill.

Human resources

Among the four countries, Japan has the highest per capita ratio of individuals providing mental health services.[14] Despite the fact that Japan has 13–23 times more psychiatrists than Iraq and the Philippines, it still has an inadequate number of mental health staff providing community care; this has slowed its progress in carrying out its de-institutionalization policy. Of the three developing countries, The former Yugoslav Republic of Macedonia has the highest ratio of psychiatrists per 100 000 individuals.[5,15]

All four countries lack data on refresher training for mental health staff, as well as data on the number of organizations, associations or nongovernmental organizations (NGOs) involved in mental health policies, legislation or advocacy. Having data in these areas would help service planning and resource allocation.

Public education and links with other sectors

Iraq, Japan, the Philippines and The former Yugoslav Republic of Macedonia have education and awareness programmes on specific mental health issues. The Iraqi mental health council has published brochures and participated in media campaigns to promote mental health. In the Philippines, the National Mental Health Programme launched an advocacy programme, *Lusog Isip* (Mental Health), which con-

ducts annual mental health celebrations including seminars for government (nationwide and local) and nongovernmental offices, symposia and radio programmes.[16] There are no published data regarding the efficacy of these efforts.

Monitoring and research

In all three developing countries, limited monitoring and research exists. Iraq, the Philippines and The former Yugoslav Republic of Macedonia lack both epidemiological and area catchment studies of the mentally ill, and thus have no empirical basis for determining where their resources should be allocated. In the Philippines, in addition to funding difficulties, there are sociocultural reasons why little attention has been paid to either the documentation of mental illness or the evaluation of its treatment. Filipinos have traditionally viewed mental illness as a form of evil possession, sorcery or punishment for wrongdoing, and relatives with mental illness are often sent to traditional healers or priests for exorcism.[17]

The Philippines' Department of Health is beginning to make some progress, albeit at a very slow pace. The crafting of the national mental health policy is a potentially important first step, as is the national registration of persons with disabilities. Established in the 1990s, its goal is to identify individuals with disabilities, including those with mental illness, and to develop rehabilitation programmes and raise awareness. Unfortunately, only 12% of the estimated numbers of individuals with disabilities have registered.[18]

In contrast to the three developing countries, the Japanese Ministry of Health provides more resources for research and monitoring its mental health system, including patients' rights and quality of mental health care. Japan's updated national database has been useful in guiding the existing mental health policy and evaluating new policies.

Comments

Utility and application of WHO-AIMS

WHO-AIMS allows for multidimensional evaluation and provides much-needed evidenced-based data, which can be used to inform public mental health policy. WHO-AIMS provides information about financing, provision of services, management, and other key components of the mental health system of each country. Since the WHO-AIMS criteria are standardized, we were able to effectively compare our four countries as well as evaluate their mental health systems' strengths and weaknesses. The synchronization of mental health data between countries in a systematic uniform method allows for cross-regional comparisons that facilitate a useful exchange of information and experience.[19] For instance, the WHO-AIMS data revealed that the integration and improvement in primary care, provision of care for special populations (e.g. children, the elderly), community mental health services, and training in mental health are sorely lacking in Iraq, the Philippines and The former Yugoslav Republic of Macedonia. In politically unstable countries, such as Iraq and The former Yugoslav Republic of Macedonia, where there is a high turnover of administration, including in the Ministry of Health, WHO-AIMS creates a centralized information resource that provides experts with critical mental health data that they can analyse. Furthermore, collaboration with mental health experts from other countries has played a large role in informing policy and service development in all four countries.

Another advantage of WHO-AIMS is that it is comprehensive and easy for non-specialists to use. This is especially useful in countries such as Iraq, the Philippines and The former Yugoslav Republic of Macedonia, where public health institutions lack resources and experts. The domains covered by WHO-AIMS were determined by hundreds of global health policy experts over many years. Developing countries presumably do not have the resources to develop, as well as pilot, such a comprehensive model for assessing mental health systems. In spite of its comprehensiveness, WHO-AIMS provides a template for local professionals to collect information relatively quickly, with minimal training and at little cost.

Limitations of WHO-AIMS

While the parameters used in the WHO-AIMS model are useful in assessing mental health systems, they do not include critical dimensions such as cultural values and political processes within the country under study. Furthermore, the WHO-AIMS parameters have limited ability to describe the scope or degree of problems in a country or region's mental health services and policies.

Cultural dimension

WHO-AIMS lacks a section detailing the cultural context of the region of interest. Societies have their own distinct idioms of distress as well as indigenous methods for coping, some of which are quite effective. For instance, several WHO-sponsored, international multicentre studies have suggested that in developing countries cultural factors may influence the course of schizophrenia. In some cultures, such as Filipino and Iraqi, extended family systems and support networks are thought to improve integration and resilience among the mentally ill. Evidence of the impact of culture is illustrated by the work of Kulhara et al.,[20] who found that the presence of extended family systems increased social integration, and higher expectations contributed to better prognosis in patients from some Asian and Middle Eastern countries compared to those from Europe and North America.

In many cultures, changes in mood are attributed to social or spiritual stressors, which can often be addressed by the social support systems, alternative caregivers and traditional healers as opposed to, or in conjunction with, psychotropic medications. Traditional healers, for instance, are commonly used in Iraq, the Philippines and The former Yugoslav Republic of Macedonia with minimal or no integration with the mental health system.[15,21] Indigenous and religious healers are often the first people contacted by patients or their families, especially in the rural areas. Their role in referring the patient to mental health services needs to be further explored. Lieban[21] looked at the role traditional healers played in the treatment of people living in Cebu, the second largest city in the Philippines. Despite a relatively high concentration of modern medical resources in this city, Lieban found the practice of folk medicine by shamanistic healers and other practitioners quite robust, with practitioners treating 25–100 patients a day.

Table 1. **Mental health system comparisons across four countries**[a]

WHO-AIMS	Iraq	Japan	Philippines	The former Yugoslav Republic of Macedonia
1. Policy and legislative framework				
Mental health policy	Yes	Yes	Yes	No
Mental health policy (1st, latest) year	1982, 2005	1950, 1995	1990, 2001	n/a (draft 2005)
Mental health programme	Yes	Yes	Yes	No
Law in mental health	Yes (1982)	Yes (2000)	No	No
Insurance policy	No	Universal coverage	Poor policy	Yes – not comprehensive
Financing mental health – main method	Tax-based	Tax-based	Tax-based	Social insurance
Mental health budget/health budget	n/a	5%	0.02%	n/a
Substance abuse policy	Yes (1966)	Yes (1953)	Yes (1972)	Yes (1999)
Therapeutic drug policy – essential list of drugs	Yes	No	Yes	Yes
Inspecting human rights	No	Yes	No	No
2. Mental health services				
Disability benefits for mental health	Yes	Yes	Yes	Yes
Community care in mental health	Yes	Yes	No	Yes
Psychiatric beds/10 000 individuals	0.63	28.4	0.9	8.2
Psychiatric beds in general hospitals/ 10 000 individuals	0.06	7.8	0.3	2
Psychiatric beds in mental hospitals/ 10 000 individuals	0.55	20.6	0.56	6.2
Disproportion services (city)	Yes	Yes	Yes	Yes
Medication	Limited access	Adequate	Short/limited	Short/limited
3. Mental health in primary care				
Treatment for severe mental disorders in primary care	Yes	No	No	No
Mental health care facilities in primary care	Yes	Yes	Yes	Yes
Training for primary care personnel in mental health	Yes	Yes	Yes	Yes
Trained physician interaction of primary doctor with mental health services	No information	No information	No information	No information
Links between mental health facilities and alternative practitioners	No information	No information	No information	No information
4. Human resources				
Psychiatric training	Yes	Yes	Yes	Yes
Psychiatrist/100 000 individuals	0.7	9.4	0.4	7.5
Psychologist in mental health/100 000 individuals	0.05	7	0.9	2
Social workers in mental health/100 000	0.2	15.7	16	1.5
Psychiatric nurses/100 000 individuals	0.1	59	0.4	24
Family/consumer association involvement in policies and plans	No information	No information	No information	No information
5. Public education and links with other sectors				
Mental health policy promotion	Few	Yes	Few	No information
Mental health policy advocacy	Yes	Yes	Yes	No information
NGO in mental health	Yes	Yes	Yes	Yes
Mental health care for prisoners	Minimal	Yes	None	No information
6. Monitoring and research				
Mental health monitor/inspection system	Yes/poor monitor	Yes	No monitor	Yes/inspection
Research	Few	Yes/larger scale	Few	Few
Data collection system in mental health	Yes	Yes (periodically)	No	No
Reporting system for mental health	Yes	Yes	No	Yes

n/a, not applicable; NGO, nongovernmental organization; WHO-AIMS, WHO Assessment Instrument for Mental Health Systems.

[a] Statistical data were gathered from WHO website (2005) and from the Ministries of Health of Iraq, Japan, the Philippines and The former Yugoslav Republic of Macedonia.

WHO-AIMS does not take into account these valuable social and cultural mechanisms, which may impact on the utilization of services and the course of illness.

Political process

Kingdon described "three streams" that form or change policies: problem defining, proposal generating, and political shifts; clearly, these are unique in each region.[22] Iraq, the Philippines and The former Yugoslav Republic of Macedonia all have distinct colonial histories that have shaped their political and, consequently, health-care systems. Recent wars and multinational interventions in Iraq and in The former Yugoslav Republic of Macedonia[23] continue to force the restructuring of the overall health-care system, not to mention its mental health-care component. In the Philippines, the end of the Marcos government brought about significant improvements in the country's mental health system. The Philippines' Department of Health organized a task force to implement the National Programme for Mental Health. As this programme was a "favourite" of the then secretary of health, it was allocated resources, despite not having a specific budget from the Department of Health. Owing to a shift in political power, the programme increasingly lost support to the point of termination. However, with the introduction of another administration in 2002, the programme was revived and renamed the National Mental Health Programme.[8] These simplified examples demonstrate how a country's mental health system cannot be adequately analysed without taking into account its political climate.

Questionable measurement validity

Another concern of the WHO-AIMS instrument is the accuracy and validity of its measurements. Many of the WHO-AIMS items are written in broad terms that do not provide adequate information about the quality of the item measured (Table 2). For example, items 1.4.4 and 1.4.5 are designed to explore the level of training of mental health professionals and primary care providers, yet there is no attempt at measuring the quality of training or the impact of the level of training on quality of care. In items 1.5.4, 1.5.5 and 2.10, WHO-AIMS assesses the availability and accessibility of psychotropic medications, but an assessment of a country's regulations regarding medications is not included. In Iraq, the Philippines and The former Yugoslav Republic of Macedonia, dispensing of psychotropic medication (including tranquillizers, antipsychotics, sedatives and anxiolytics) is poorly controlled and these medications may be purchased freely at local pharmacies. Inadequate regulations may lead to substance misuse or abuse, thereby increasing morbidity and mortality. Under the WHO-AIMS criteria, a

Table 2. **Sample items WHO-AIMS**

Item	Detail
Item 1.4.4	**Training staff in mental hospitals on human rights protection of patients**
Definition	Proportion of mental hospitals with at least one-day training, meeting or other type of working session on human rights protection of patients in the last two years
Measure	Proportion; UN = unknown; NA = non applicable
Numerator	Number of mental hospitals with at least one-day training, meeting or other type of working session on human rights protection of patients in the last two years
Denominator	Total number of mental hospitals (#)
Item 1.4.5	**Training staff in community-based inpatient psychiatric units and community residential facilities on human rights protection of patients**
Definition	Proportion of community-based inpatient psychiatric units and community residential facilities with at least one-day training, meeting or other type of working session on human rights protection of patients in the last two years
Measure	Proportion; UN = unknown; NA = non applicable
Numerator	Number of community-based inpatient psychiatric units and community residential facilities with at least one-day training, meeting or other type of working session on human rights protection of patients in the last two years
Denominator	Total number of community-based inpatient psychiatric units and community residential facilities (#)
Item 1.5.4	**Free access to essential psychotropic medications**
Definition	Proportion of population with free access (at least 80% covered) to essential psychotropic medicines
Measure	Proportion; UN = unknown; NA = non applicable
Numerator	Number of people with free access (at least 80% covered) to essential psychotropic medicines
Denominator	Number of people in general population
Notes	This item is specific for psychotropic drugs (in many countries psychotropic drugs are not covered by government or insurance schemes) Free access to essential psychotropic medicines means that essential psychotropics – once prescribed – are provided to people with mental disorders free of cost or with reimbursement equal or more than 80% of the retail price. The funding sources for free access/reimbursement may be the government or insurance schemes (employment, social or private)
Item 2.10.3	**Availability of medicines in mental health outpatient facilities**
Definition	Proportion of mental health outpatient facilities in which at least one psychotropic medicine of each therapeutic category (antipsychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic medicines) is available in the facility or in a nearby pharmacy all year long
Measure	Proportion; UN = unknown; NA = non applicable
Numerator	Number of mental health outpatient facilities in which at least one psychotropic medicine of each therapeutic category is available in the facility or in a nearby pharmacy
Denominator	Total number of mental health outpatient facilities (#)

WHO-AIMS, WHO Assessment Instrument for Mental Health Systems.

country could misleadingly score well on psychotropic medication availability, yet that very "availability" could contribute to an increase in mental health problems.

WHO provided an exceptional service to mental health policy-makers by developing WHO-AIMS, theoretically a sophisticated, data-driven framework, but its neglect of assessing social histories, cultural strengths and political processes limits its usefulness. Its overemphasis on the biomedical model and pharmacological therapies tends to undervalue cultural models and coping mechanisms for mental distress. Many studies in developing countries have demonstrated that there are other variables that can contribute to a better prognosis in patients with mental illnesses such as schizophrenia.[24–28] Without taking social history, cultural strengths and political processes into account when assessing a country's mental health system, we can only have a restricted picture of mental health systems.

WHO-AIMS, while limited in scope, is useful as an initial tool for assessing mental health systems. Following complaints by participants in initial pilot studies, the authors of WHO-AIMS decreased the number of questions, yet key, especially qualitatively, questions need to be included. Mental health policy-makers in the developing world need to recognize the limitations of WHO-AIMS and acquire more qualitative data tailored to their own region. ■

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Résumé

Evaluation de l'instrument d'évaluation des systèmes de santé mentale de l'OMS par comparaison des politiques de santé mentale de quatre pays

La santé mentale est faiblement prioritaire dans la plupart des pays du monde. Au niveau national, les travaux de recherche et les moyens qui lui sont consacrés sont très limités. En conséquence, l'OMS a développé l'instrument d'évaluation des systèmes de santé mentale WHO-AIMS pour encourager les pays à recueillir des données et à réévaluer leur politique nationale de santé mentale. Le présent article met en évidence l'utilité et les limites de l'instrument WHO-AIMS en appliquant le modèle à quatre pays dont les cultures, les histoires politiques et les politiques de santé publique diffèrent, à savoir l'Iraq, le Japon, les Philippines et l'ancienne République yougoslave de Macédoine.

L'instrument WHO-AIMS fournit un modèle utile pour analyser six domaines : cadre politique et législatif, services de santé mentale, santé mentale dans les soins primaires, ressources humaines, éducation du public au sens large, surveillance et recherche. Son existence est particulièrement importante dans la mesure où la plupart des pays ne disposent pas d'experts en politique de santé mentale ou des ressources pour concevoir leurs propres outils d'évaluation des systèmes de santé mentale. En outre, le WHO-AIMS donne accès à une base de données standardisées pour les comparaisons entre pays. Cependant, cet instrument comporte des limites et notamment néglige les stratégies de développement des politiques de santé mentale, sous-estime le rôle des facteurs culturels dans le recours aux soins de ce type et fournit des mesures d'une validité discutable.

Resumen

Análisis del instrumento OMS de evaluación de los sistemas de salud mental mediante la comparación de las políticas de salud mental en cuatro países

La salud mental es un tema poco prioritario en la mayoría de los países del mundo. La investigación y los recursos invertidos en salud mental a nivel nacional son mínimos. En consecuencia, la OMS ha desarrollado el Instrumento de Evaluación de los Sistemas de Salud Mental (OMS-AIMS), que tiene por objeto alentar a los países a reunir datos y reevaluar sus políticas nacionales en materia de salud mental. En este artículo se ponen de relieve la utilidad y las limitaciones de OMS-AIMS aplicando el modelo a cuatro países con distintas culturas, antecedentes políticos y políticas de salud pública; a saber: el Iraq, el Japón, Filipinas y la ex República Yugoslava de Macedonia.

OMS-AIMS proporciona un valioso modelo para analizar seis dominios: marco normativo y legislativo; servicios de salud mental; salud mental en la atención primaria; recursos humanos; educación de la población en general; y vigilancia e investigación. Esto reviste especial importancia dado que la mayoría de los países carecen de expertos en políticas o recursos de salud mental para diseñar sus propios instrumentos de evaluación de los sistemas de salud mental. Además, OMS-AIMS proporciona una base de datos estandarizada para poder hacer comparaciones entre países. El instrumento presenta sin embargo algunas limitaciones como son la ignorancia de las políticas de desarrollo normativo en materia de salud mental, la infravaloración del papel de la cultura en el uso de los servicios de salud mental y una validez cuestionable de las mediciones.

ملخص

تقييم أداة منظمة الصحة العالمية لتقييم نظم الصحة النفسية من خلال مقارنة سياسات الصحة النفسية في أربعة بلدان

تلقى الصحة النفسية أولوية متدنية في معظم بلدان العالم، فعلى المستوى الوطني يتم استثمار أقل قدر من البحوث والموارد في الصحة النفسية، مما حدا بمنظمة الصحة العالمية إلى إعداد أداة لتقييم النظم المعنية بالصحة النفسية بغية تشجيع البلدان على تجميع المعطيات، وإعادة تقييم سياساتها الوطنية الخاصة بالصحة النفسية. ومن ثم تظهر هذه الورقة البحثية مدى جدوى وقصور أداة تقييم نظم الصحة النفسية من خلال تطبيقها على أربعة بلدان تتفاوت في ثقافاتها، وتاريخها السياسي، والسياسات الصحية وهي العراق، واليابان، والفلبين، وجمهورية مقدونيا اليوغوسلافية السابقة. والحاصل أن أداة تقييم نظم الصحة النفسية تمثل نموذجاً مفيداً لتحليل ستة مجالات هي: السياسات والإطار التشريعي، خدمات الصحة النفسية، الصحة النفسية في الرعاية الأولية، الموارد البشرية، والتعليم لدى عامة الناس، والرصد والبحوث. ولهذا الأمر أهمية كبيرة نظراً لافتقاد معظم البلدان للخبراء في مجال سياسات الصحة النفسية أو مواردها اللازمة لتصميم أدوات خاصة بهم لتقييم نظم الصحة النفسية. كما تقدم أداة منظمة الصحة العالمية لتقييم نظم الصحة النفسية قاعدة معطيات معيارية للمقارنات بين بلد وآخر، إلا أن أوجه القصور التي تحد من فعالية هذه الأداة هي إهمال السياسات المتبعة في إعداد سياسات الصحة النفسية، والتقليل من أهمية دور الثقافة في الانتفاع بالرعاية الصحية النفسية والشك في مدى مصداقية القياسات.

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