

Mental Health in Europe

Country reports from
the WHO European Network
on Mental Health

ABSTRACT

The Mental Health programme of the WHO Regional Office for Europe has, over the past three years, established a network of mental health professionals in the Member States, who have provided the necessary liaison between the Regional Adviser for Mental Health in the Regional Office and the mental health services in the countries. These counterparts have been officially nominated by their ministries of health and are often working in the ministry of health or are the most senior government mental health clinician.

Following the first meeting of mental health counterparts which took place in Stockholm in January 2000, each country was asked to submit brief reports on the mental health situation in their respective countries, both in order to inform the Regional Adviser himself, and also as information to the other members of the network.

This document is a collation of those reports which have been received over this two-year period; not all countries have contributed. The reports are not intended as rigorous documentation of the mental health problems and services, but more as impressionistic descriptions covering the situation in the countries.

Keywords

MENTAL HEALTH SERVICES – organization and administration
MENTAL DISORDERS
EVALUATION STUDIES
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FOREWORD

Country Reports from the WHO European Network on Mental Health

Introduction

During the past three years, the WHO Regional Office for Europe in Copenhagen, has established a network of mental health professionals in its Member States, who have provided the necessary liaison between the Regional Adviser for Mental Health in the Regional Office and the mental health services in the countries. In most cases these counterparts work as the mental health responsible in the ministry of health of the country, others are the most senior government professionals in the field of mental health.

The Regional Adviser for Mental Health asked these counterparts to send him brief reports on the mental health situation in their respective countries, both for his own information as well as for the information of the others in the Network. These reports have been written over the last two years and are reproduced here. Guidelines were given about possible content. The ambition however was to obtain an impressionistic review describing the relevant efforts and shortcomings as experienced by the counterpart and not to make a standardized report.

The issues that they were asked to address were:

- intersectoral cooperation;
- national mental health plans;
- mental health legislation;
- service provision;
- deinstitutionalization and community care; and
- multidisciplinary teamwork.

In addition, the counterparts were asked to highlight a few points of greatest concern, as well as areas of progress. The reports are not intended to be rigorous descriptions of the mental health problems and services, but should be taken more as short briefing contributions covering the situation in the countries. They also include some ideas about how the writers think the services should develop. *They should not be taken as official government documents*, although the views expressed are usually based upon such documents where they exist.

The social and political changes which occurred in central and eastern Europe during the 1990's were enormous and these have affected both the mental health of the populations concerned as well as the way that mental health services are organized. Several governmental, inter-governmental and non-governmental initiatives have been established to help the mental health services of some of the countries deal with the effects of disruption and to adapt to the dramatic changes. These initiatives have come from both within the countries as well as from western Europe. The reports attempt to cover these aspects of the situation.

This unpretentious but informative report gives valuable knowledge and briefing about the mental health state of art and panorama of needs in European countries and can easily be used as a supplement to the standardized country information given by the World Health Report 2001 and the Atlas Report.

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ALBANIA

Background

Treatment for people with mental illnesses is poor in Albania. There are few services and these are mainly institutional with few alternatives to hospital treatment. There is little social support for the mentally ill and they are highly stigmatized. The Ministry of Health strongly supports the modernization of the mental health services in Albania.

The current situation

To understand the situation today in Albania following figures can be of value:

- There are some 830 psychiatric beds in the country (0.23/1000 inhabitants) and most are used for long-term treatment.
- There are some 46 psychiatrists in the country, (one per 78 000 inhabitants).
- There is no special training for nurses working in psychiatry.
- There are few psychiatric outpatient units. There are currently just six nurses in Tirana working in outpatient units for a population around 800 000.
- The first psychologists graduated from the university in 2000.
- Psychologists and social workers are not yet involved in the official mental health services.
- The provision of drugs for people with mental illness is limited.
- The level of the professional knowledge is not in the level of international standard.
- Contemporary psychotherapy is not available in Albania.
- The resources for health care in Albania are low compared to other countries and these are not equally distributed over the country. There are 51 hospitals in the country and the average utilization of the beds is around 60%.
- Many psychiatric patients go to the family doctors of whom there are about one for 2500 inhabitants but the level of knowledge about psychiatric problems among them is low.
- The implementation of the Mental Health reform cannot be done through transformation of resources from just Mental Hospital to Community service. The Mental Health development needs resources from the other areas and the space for Mental Health must increase in the future and probably also the space for Health Care as a whole.

WHO (which has an office in Albania) has a mandate from the Ministry of Health to coordinate activities in the mental health area during this period of reform. To assist in this, a National Steering Committee – for Mental Health (NSC) has been set up, with technical support and coordination provided by the Albanian Development Centre for Mental Health (ADCMH). ADCMH is particularly helping to set up Community Mental Health Centres (CMHC) in various districts, which includes supervision, coordination of nongovernmental (NGOs) activities for mental health, training and working with documentation and evaluation. It also prepares background material for the NSC to help with its work.

During the year 2000 the WHO office in Albania, in close cooperation with the Ministry of Health, and with financial resources from both European Commission Humanitarian Aid

Office (ECHO) and the Swedish International Development Agency (SIDA), has helped to lay the foundation stone for the modernization of Mental Health care in Albania. The Mental Health programme is coordinated by an external consultant, with other external technical support as required.

According to the plan for the project the current situation can be described as follows:

- The ADCMH has been set up and is functioning.
- A pilot community mental health service in Tirana started in December 2000.
- WHO has given responsibility to the Geneva Initiative on Psychiatry (GIP) for the implementation of community mental health services in Elbasan and Gramsh starting in October 2000.
- WHO is also working with UNOPS for the implementation of a community mental health service in both Vlora and Shkodra.
- From December 1999 to September 2000, a training programme for a multidisciplinary team took place. It included a total of seven weeks of training and involved 32 participants. Other conferences and short training courses were also held for the various staff involved in this reform.
- In November 2000, work started on the National Mental Health Plan.
- The necessary infrastructure for the mental health reform has been established, with strong support from the Ministry of Health and its representatives.
- There is a strong organization at National level with NSC and ADCMH as well as a high commitment from the professionals.
- The Mental Health Law will support the development of CMHC.
- Approaches are being made to the local level with local steering committees being set up under responsibility of the director of Public Health. These must be the owners of the development in order to make it sustainable.
- Even if specific resources for Mental Health are limited, the health service as a whole should be providing resources for mental health care.
- The long-term support from external agencies such as SIDA and WHO's mandate for coordination of activities in the Mental Health field gives the project many opportunities to offer training programmes and support to the various professional groups.

There are however a number of constraints in existence, such as the general poverty in the country, the high stigma against the mentally ill, an out-dated educational system and limited access to all the professionals in the small districts with decreasing populations. In addition, most of the existing psychiatric services are old fashioned and under-resourced, whilst many of the sporadic foreign initiatives are not properly coordinated or sustainable.

Summary

During year 2000 the foundation stones were established for the development of the Mental Health Reform. It will need many years of support and effort, but there is a new, young generation with high commitment. Together with a strong support from both the Ministry and the professionals, the implementation can continue and succeed in all the districts.

WHO's mandate for coordination of the programme has had strong support from the Ministry of Health and through the National Mental Health Plan, the quality of the development can be realized.

ANDORRA

Andorra is a sovereign state with its roots in the middle ages, but at the same time, with a modern constitution (1993). Many aspects of the country mix modern and old features in a characteristic way. Located in the middle of the Pyrenees, Andorra has an area of less than 500 square kilometres and a population of 65 000 which has multiplied 12 times over the last 50 years; about 70% of the population are now of migrant origin. Andorra receives more than ten million visitors every year and has a tourism-based economy.

The present state of the Mental Health service network can be summarized as follows:

Intersectoral cooperation

The public and private sectors of medical provision both coexist and cooperate. The only general hospital in the country, Hospital Nostra Senior de Meritxell, combines public services in some of the specialities and private facilities in others (mostly surgery and grammatology). Most doctors in the country have an agreement with the government so that the patient pays 25% of the cost of consultation and the rest is covered by the National Insurance System. If hospitalization is required, the patient pays only 10%.

The mental health team cooperates at different levels with other sectors of health care. It has regular meetings with the Association of General Practitioners, the Social Work Services, and the Nursing Centres Network.

Community-based psychiatry

The Mental Health Services that have been developed since 1998 are based on the general principles of “community psychiatry”. The services, including child psychiatry and geriatric psychiatry, are available to everyone covered by the National Insurance System (the great majority of the population). These services are concentrated in the general hospital, which is located in an area of the main urban zone of the country and has good communications. The Mental Health Centre offers an outpatient unit with psychiatric and psychological services together with a day unit where psychosocial rehabilitation programmes are offered to patients with chronic severe mental disorders.

The acute psychiatric unit of the hospital has a 12-bed ward. Consultation is available for psychiatric emergencies, 24 hours a day, and requests for liaison psychiatry at the hospital are covered.

National mental health plan

So far, Andorra does not have a national mental health plan. However, in 1996, a document was produced by Dr Sampaio Faria from the WHO Regional Office for Europe, describing the relevant needs, services, and possible organizational strategies. The present stage of development of the mental health services reflects these guidelines.

Morbidity and mortality figures

There have not been any specific epidemiological studies on mental health, but a National Inquiry on Health indicated that 10.9% of men and 20.3% of women in the adult population, self-reported some kind of problem related to mental health.

The Sampaio Faria report estimated that 28% of the population would present some mental health problem, which is equivalent to 14 630 probable cases, and 3394 of these would be severe cases. The major drug problem comes from alcohol, with about 300 severe cases of abuse. A study on suicide showed a prevalence of attempted suicide of 60/100 000 (about 40 per year, with two or three consummated suicides).

Deinstitutionalization

This process has not been necessary in Andorra, since there have not been psychiatric institutions up to now. Several Andorran patients are still resident in private psychiatric institutions, either in France or Spain, as this had been the method of management for chronic psychotic disorders in the past.

Multidisciplinary teamwork

The service is presently working on a multidisciplinary teamwork basis. The team includes four psychiatrists, five clinical psychologists, seven psychiatric nurses, a social worker, an occupational therapist, and a music therapist (the two therapists both being on a half-time basis). The staff holds regular weekly meetings to coordinate their activity.

Three matters of greatest concern

1. Developing the structures and programmes which are still lacking, such as a long-stay centre for highly dependent chronic patients, and a drug-addiction programme.
2. Promoting sensitivity towards cultural and social factors which are liable to affect the mental health of the population, among mental health professionals and health professionals in general.
3. Developing mental health legislation.

ARMENIA

Psychiatry is that sphere of public health care which is directly connected with the social conditions of living. As a result of a disastrous earthquake, military conflicts, poverty, political clashes, and the flooding in of refugees, producing many lonely and homeless people, there has been an increased number of persons in Armenia who need the medical-psychiatric and social services in the last ten years. This has resulted in the need to establish appropriate services, to train specialists, and to develop social psychiatry in a number of directions.

The extreme way in which Armenian society and its culture have existed during recent years is likely to be the main reason for a rising level of recorded neurotic and stress reactions. At the same time, the overall rate of mental illness has not changed significantly. At this stage of social development and with the establishment of an independent state, the problem of individual “psychiatric health” has to some extent been transformed into one of the “psychic” health of society. However, the lack of any specific law on psychiatric intervention creates problems in relation to the rights, duties and protection of both patients and medical staff. It is also an important matter for healthy citizens and for society as a whole.

Psychiatric provision in Armenia is provided by both outpatient and inpatient care, through a network of dispensaries, hospitals, and health centres within the various communities. In recent years, the policy of reducing hospital beds has been implemented with new day hospitals being opened and the development of night hostels being proposed. The psychiatric hospitals have been broken up into smaller units, so that whereas they formerly had 500–1000 beds, at present the greatest number of beds in any one is 400. The treatment of patients is mainly organized near to their home, in close cooperation with the local primary care service.

The treatment of psychiatric patients is financed by the state. However, in the situation of slender budgets for public health care, the funding of the psychiatric service is inadequate.

Psychosis (42%) and mental retardation (28.3%) are the most prevalent psychiatric disorders. Though 55.8% of registered patients are of working age, only 6.2% are working. This is connected with the difficult social and economic situation of the country and the limitation of employment opportunities. In 1999, with the assistance of the international organization *Médecins sans frontières*, it became possible to open a rehabilitation workshop at one of the biggest psychiatric hospitals.

Unfortunately, there are no national data on suicide. Individuals with depressive conditions and suicidal tendencies are mostly under the care of general practitioners, who do not always diagnose in time or prescribe adequate treatment.

The principles of reorganization of the psychiatric service are:

- decentralization – but keeping the coordinating role of the state;
- integration of services – providing interrelationships between the different institutions of psychiatric and public health care as a whole, with the aim of providing continuous, accessible, and effective treatment;

- graduation of services undertaken by the united system, including hospital/psychiatric, outpatient care, psychiatrists, psychotherapists, relaxation training, community polyclinics, dispensaries, day hospitals and night hostels, mental health centres, psychiatric departments in general hospitals, and rehabilitation institutions.

The implementation of the reorganization needs the elaboration of a national programme on psychiatric care, the creation of a legal code, and juridical regulation of the inter-relations between patient and doctor as well as of the relationship with society and social institutions.

AUSTRIA

Intersectoral cooperation

Austria has about eight million inhabitants and is a federal republic with health care responsibilities devolved to each of the nine provinces. Though cooperation between different providers of services exists to some degree at the local level, intersectoral cooperation at government level is not well established. The financing of services is fragmented in a complicated way, which is not conducive to this kind of cooperation.

Community-based psychiatry

Since the mid-1970s – starting with the WHO Regional Office for Europe project “Mental health services in pilot study areas” – Austrian psychiatry has gradually moved away from large mental hospitals to community-based services. However, given the federal character of the country, this development has occurred at different speeds in different provinces. Some provinces (Upper Austria, Lower Austria, Vienna, Tyrol) have quite advanced community-based psychiatric services, while others still lag behind.

National mental health plans

There are some mental health plans at the level of the provinces. Since 1995, there has been a national Hospital Plan, which requires individual provinces to fulfil certain obligations, including a few in the area of psychiatry and community services. This plan is being continuously adapted (latest version December 1999) and contains suggestions for the establishment of psychiatric units in general hospitals. However, up to now, only a few such units exist, with some others in the planning stage.

Mental health legislation

No comprehensive Mental Health Act, including an obligation to provide adequate services, yet exists. However, as in many other countries, laws about compulsory admission (1991) and about the legal protection of incapable adults are in force.

Morbidity and mortality figures

In 1997, there were 68 751 admissions to psychiatric hospitals and departments of psychiatry in general hospitals. The number of psychiatric beds was then 4658. The suicide rate in that year was 19.7/100 000.

Deinstitutionalization

The psychiatric hospital population in Austria has declined from around 12 000 in 1974 to below 5000 in the year 2000.

Multidisciplinary teamwork

In community-based services like day hospitals, crisis intervention services, and hostels for psychiatric patients, multidisciplinary teamwork prevails. In some parts of the country, there are procedures for the systematic supervision of such teams.

Mental health promotion

There are still only very few initiatives to promote mental health in relation to positive or negative factors in society. However, the Austrian Society of Psychiatrists is carrying out a destigmatization project for schizophrenia. Some local anti-stigma initiatives exist, for example in a school project in the province of Lower Austria.

BELARUS

Intersectoral cooperation at governmental and local levels

The Health Ministry of Belarus is mainly responsible for developing national policy concerning mental health and the provision of psychiatric health care. Other ministries share this responsibility, such as Social Security and Education. They mainly participate in the development of national programmes and the legislative basis related to mental health.

The coordination of intersectoral activities at a state level is governed by:

1. the Inter-ministerial Commission on drug abuse and crime, under the Council of Security; and
2. the Inter-ministerial Commission on control of drugs and psychotropic substances, under the Council of Ministers.

The Health Ministry collaborates actively with nongovernmental organizations (NGOs) which are working on mental health problems, such as the Byelorussia Psychiatry Association (BPA), which includes a section on drug abuse.

At a local level, this includes cooperation with executive and administrative bodies on issues of the planning and the development of mental health services. Local health bodies, specialized institutions providing psychiatric care, BPA regional branches, and NGOs participate in these activities.

Community-based psychiatry

The national system of psychiatric care has been developed based on the needs of society, as stipulated by the community as a whole and by the consumers of these services in particular. In the past, such care was mainly provided at large psychiatric institutions. At present, it is provided as near as possible to the patient's home, aiming at:

- shifting the provision of care from the inpatient to the outpatient level;
- establishing a network of outpatient clinics, psychotherapeutic facilities, and socio-psychological care at each area polyclinic;
- integration of psychiatric care into GP practice;
- developing cooperation with social services and NGOs.

Unfortunately, there have been some obstacles in the way of the transition from inpatient to outpatient care: economic problems, peculiarities of the system of budget financing, and traditional methods of providing outpatient care.

Planning of mental health at the national level

There is no plan for mental health in Belarus. In the field, this is done within the framework of annually developed general Health Ministry plans.

Some mental health activities are included in various programmes:

- the development of the policy dealing with alcohol related problems;
- the national programme on prevention and control of alcohol abuse and alcoholism;
- the national programme of fighting crime for the years 1999–2000;

- the national programme of comprehensive measures for controlling the abuse of drugs and psychotropic substances and their illegal traffic.

The need remains to develop a long-term mental health care plan, and this is a major task for the Health Ministry. Its development, however, is hindered by the absence of an appropriate epidemiological structure, although some activities are being undertaken by the Health Ministry:

- the establishment of a legislative basis by amendments to the Law of the Republic of Belarus, “On Health Care”, is in the process of development;
- the development of Health Ministry standards on psychiatric care. Some measures have been planned for a transition to the use of ICD-10.

Since 1998, the suicidal behaviour of the population of the city of Minsk has been studied as an indicator of mental health. It is also planned to collect information on suicides and parasuicides throughout the country.

Further reform of the psychiatric services is under way.

The legislative basis for mental health

Providing health care to the population is regulated by the following laws: “On health care”, “On social security for invalids”, “On psychiatric care and citizens’ guarantees for its provision” (1999), as well as by Health Ministry standards.

Suicide mortality

Years	Completed suicides in absolute figures	Suicide incidence per 100 000
1995	2748	26.6
1996	2725	26.5
1997	3128	30.5
1998	3339	32.7

Outpatient care

Since Soviet times, psychiatric care has been provided in hospitals, but at present, it is being shifted from the inpatient to the outpatient level. Outpatient clinics for psychiatry and treatment of drug abuse, telephone contact for emergency psychiatric care, and facilities for treating neurotic and psychosomatic disorders at local hospitals are in the process of being established all over the country. Treatment by psychotherapy is being introduced at outpatient clinics. Child psychiatrists at children’s polyclinics provide psychiatric outpatient care. Child psychiatrists also provide psychiatric care at adult polyclinics on a consultative basis. In rural areas, emergency psychiatric care is provided at GP clinics.

At the same time, the number of inpatient beds is being gradually decreased, with a reduction of 11.7% from 1990 to 1998. Beds for the treatment of addiction were reduced by 28.1% within the same period.

Multidisciplinary teamwork

The following specialist workers contribute to the provision of care at psychiatric and addiction institutions: rehabilitation and social care nurses, psychologists, psychiatrists, and social workers. Lawyers are also present in some of them. Multidisciplinary teams, with the participation of addiction doctors, psychologists, and social workers are working at some addiction institutions, with plans to extend this early experience within the mental health services of the country. The number of psychologists and social workers is still insufficient.

Prevention of mental ill health

Prevention of mental illness is a part of national policy, even though there is no national mental health programme for the country.

Pathogenic factors affecting mental health are:

- Social: economic problems, decrease in quality of life and average income, growth of crime, adverse demographic changes, instability in society, collapse of the family.
- Psychological: uncertainty about the future, concern over personal safety, living in a situation of permanent stress, the failure of individuals to take responsibility for their health.
- Biological: unsatisfactory and irrational nutrition, adverse ecological influences, abuse of alcohol and psychoactive substances, uncertain quality and safety of foodstuffs, poor quality of water and air.

The immediate aims of the mental health services

- Development of outpatient care.
- Establishment of multidisciplinary groups in the services.
- Scientific support of the mental health service, including research in the field.
- Introduction of new technologies, especially for treatment of drug abuse.
- Training of specialists in the field of mental health service provision.
- Establishment of a national legislative basis for the management of mental disorder.
- Transition to the use of ICD-10 in the activities of the service.

BOSNIA and HERZEGOVINA (REPUBLIC OF SRPSKA)

Presently, it is estimated that in the Srpska Republic, there are more than half a million refugees and internally displaced persons (from the former Yugoslavia, Kosovo and the Federal Republic of Yugoslavia). With 1.4 million inhabitants, this represents around 2.0 million people in total.

These refugees are living in collective shelters, in private accommodation, or with relatives and friends all over the country. The vast majority of these people were exposed to various, sometimes very severe experiences of stress. These included: danger to life; psychological and emotional violence; loss of, or separation from family members; loss of people's entire property; radical change of previous socioeconomic status; uncertainty about the future; loss of control over one's life. It is certain that every refugee has been psychologically injured one way or another, and these wounds will take a long time to heal. The more vulnerable subjects have developed serious psychiatric disorders and their psychological health will remain impaired permanently.

In the country, there are only five centres for community-based rehabilitation.

The main clinical problems, which most urgently require attention, are enduring personality change after catastrophic experience (F 62, ICD-10), Post-Traumatic Stress Disorder (PTSD) and suicidal states. Special centres or special programmes within psychiatric clinics are urgently needed to treat these kinds of problems.

The needs, from the point of view of legislation and forensic psychiatry, are for policy documents on mental health care and for better resources for forensic psychiatry whose institutions have a very low status.

The main goals of projects concerned with psychosocial support and rehabilitation of persons with PTSD are:

- education and training for nurses, doctors, psychologists, social workers, teachers, and students of medicine and psychology, as well as volunteers;
- detection of traumatized persons, as a consequence of stressful experiences;
- development of a programme for the treatment and evaluation of each high-risk group;
- psychological and psychiatric help, as well as psychosocial support and rehabilitation for psychologically traumatized persons with symptoms of PTSD or anxious-depressive and psychosomatic reactions;
- prevention of suicide.

A national plan for new activities is being developed which includes the following needs:

- Education needs include seminars on stress, PTSD, trauma psychology, treatment of war trauma.
- Training programmes for staff, including doctors, psychologists, social workers, teachers, and students of medicine and psychology. These require educational videocassettes, reprinting of published books and manuals and compact discs with educational materials.

- Psychiatric and psychological services need to include individual and group counselling, psychotherapy for psychiatric patients, supervision of staff, which in turn needs more trained professionals.
- Mobile professional emergency teams are needed to deal with psychological trauma, including screening for PTSD, depression, suicidal states and managing other kinds of psychiatric emergencies.
- Institutions for forensic psychiatry need to be established.
- The introduction of a telepsychiatry service would be useful, providing an assessment of callers and their reported problems, but considerable technical assistance and finance would be needed for this service.
- A national plan for mental health care is needed, but this would also be dependent on financial and professional support.

BULGARIA

General

Bulgaria is a relatively small country with a population of almost 8 million and about 68% of these living in towns. The percentage of elderly people is growing steadily, but the overall population growth is negative. An important factor for depopulation is the high emigration rate (over 700 000 since 1990).

Psychiatric disability rates are high. Table 1 gives the percentage (from the total number of disabled people) of those who have received a disability pension for psychiatric reasons in the year 1998. These data do not reflect the true prevalence of psychiatric disability, because the statistical system used does not provide information about the number of people who, for instance, had been awarded a disability pension in the year 1997 for a two-year period.

Table 1. Psychiatric disability rates

Age-group	Percentage of disabled who are "psychiatric"
16 – 19	31.3%
20 – 29	18.8% (11.7% due to schizophrenia)
30 – 39	15.3%
40 – 49	6.6%
50 – 59	3.8%
Over 60 years of age	2.3%

Rates of mental illness

Estimates of rates of mental illness in Bulgaria rely almost exclusively on data from routine hospital statistics (number of admissions, number of beds), rather than on outcome and effectiveness data.

Table 2. Rates of mental illness

	1991	1998
Prevalence of mental disorders	26.4 per 1000	28.3 per 1000
Incidence of mental disorders	3.1 per 1000	1.0 per 1000
Mortality among psychiatric patients	8.4 per 1000	10.4 per 1000

Reported data, however, do not reflect the real situation because of problems in the existing system of data collection; minor mental illnesses are particularly badly under-reported.

Mental health services in Bulgaria

Outpatient psychiatric care in Bulgaria is provided by; small outpatient units, which are very few; outpatient clinics (dispensaries) which are either autonomous facilities or attached to general hospitals; and ambulatory units at general polyclinics and hospitals. The latter provide predominantly consultation and referral to psychiatric clinics and hospitals. Inpatient

psychiatric care is provided by large psychiatric hospitals and university clinics and also by psychiatric wards in general hospitals. The overall number of beds is shown in Table 3.

Table 3. Psychiatric beds

	1992	1998
General psychiatry	6843	6242
Child psychiatry	90	80
Drug addition and alcohol	1037	361
Old age psychiatry	180	187
Total	8150	6870

There are also special residential facilities for chronically mentally ill patients, which are under the social welfare administration. This is the only social service available for the mentally disabled in Bulgaria, apart from one day-care centre, opened in 1998 in Sofia.

Table 4. Beds in institutions for the mentally disabled – 1995

Beds for adults	4945
Beds for children and teenagers	2230
Total	7175

The delivery of outpatient services is based on geographical responsibility. The profile of inpatient services is hardly (if ever) described and the provision of care is not structured in terms of treatment programmes or protocols. There is a lack of coordination between hospitals and outpatient services in terms of procedures for referral and follow-up. Most services do not provide their patients with information about available services and thus with an opportunity to make informed choices. There are no procedures for the cost assessment of psychiatric disability or psychiatric care.

Health personnel

Table 5. Mental health personnel

	1992	1998
Psychiatrists	678	692
Nurses	1316	1210
Social workers	30	29
Psychologists	62	77

Mental health needs are defined from a medical point of view. This implies that control of symptoms is the most important service and it underestimates the need for other kinds of intervention programmes – occupational, psychological, etc. The staff composition, in which psychiatrists dominate the treatment process, reveals a paternalistic model of treating patients.

Mental health care reform

Mental health care reform is part of the National Programme for Public Health Reform, which has been proposed for government approval. The main goal is to substitute a network of client-orientated and market-regulated autonomous services with a variety of profiles for the centrally funded, hierarchically administered institutions.

Principles of the reformed services

Public health approach

Psychiatric patients should remain in the community they belong to and all community members should share the burden of their care. Services should have clearly defined clinical profiles, organized in programmes of care and intervention protocols. There should be specified procedures for admission, referral, and specialist consultation, as well as for the evaluation of the effectiveness and accountability of services. The leading principle should be the understanding and practice of health promotion and prevention, with respect for patients' human rights. Services are to be delivered by multidisciplinary teams, covering as much of the patients' needs as possible. Procedures should be adopted for joint work and coordination between teams and with the surrounding social and institutional environment. This will require the establishment and maintenance of working relationships with social services, local government, Ministry of Health, district health funds, professional organizations, NGOs, and general practitioners. The public health approach assumes that medical decision-making is based on evidence about the individual's health and social position, derived from measures of the health and social conditions of the general population.

Shift from institutional to community-based services

At present, many Bulgarian psychiatrists do not practise the components of modern community-based psychiatry in ways that meet international standards. The implementation of these components would require the setting up of pilot projects and the development of new training programmes based on experiences derived from these pilot services.

System approach

Services designed to meet the needs of mental health consumers in any community should be viewed through their inter-relationships. Thus, planning one component, such as emergency beds, requires information about all the other kinds of services available in the community. Psychiatric programmes should be coordinated with others, such as general practice, services for elderly people, social services, social security, vocational guidance, and housing services.

Human rights

For several years past, an increased interest in the human rights of mental patients has been observed with the inclusion of professional ethics and human rights issues in all educational curricula, as well as the establishment of user, lay, and professional organizations. The significance of stigmatization and discrimination because of mental illness is not widely recognized. This leads to a poor quality of life for mentally ill patients and their relatives, as well as to a poor quality of services offered. The recognition of the importance of patients' participation in the decision-making process has only just started. In Bulgaria, the major legislative acts dealing with psychiatry were passed in the late 1960s and 1970s. During the last few years, only partial changes have been made in Bulgaria (such as the exclusion of sections on compulsory admission for alcoholics and drug addicts without psychotic symptoms and compulsory work activity in the course of such treatment). However, a considerable amount of work needs to be done in order to make mental health legislation consistent with international standards and principles. The statutes on psychiatric services

should be in line with that governing the other medical services. This requires that psychiatry should develop an organizational culture and a therapeutic setting by adopting new methods of clinical work.

Mental health priorities

- The recognition and treatment of depression within the primary health care system.
- The improvement of the quality of life of those with chronic psychosis, by providing day care centres, case management, special services in the community, sheltered housing, etc.
- Suicide prevention.

CROATIA

Multidisciplinary teamwork and community-based psychiatry

Community-orientated health services in Croatia are provided by 120 primary health care centres, with more than 1500 general practitioners and 21 public health facilities. These cooperate with local centres for social work and with educational institutions.

Some 222 psychiatrists are employed in the national health institutions, providing out- and inpatient services for a population of 4.7 million. In addition, about 50% of 160 neuro-psychiatrists (who completed their speciality training prior to the splitting of the two disciplines) are also dealing with psychiatric disorders.

In 1998, a total of 360 265 consultations were provided by the outpatient psychiatric services and the number of admissions for mental and behavioural disorders was 39 040, representing 7.2% of all hospital admissions.

Reports from 1998 show that there were 0.22 psychiatric beds per 1000 population in general hospitals with the average length of stay being 17.5 days. In addition to this, there were 0.74 hospital beds per 1000 in hospitals providing services for chronic psychiatric patients, where the average length of stay was 70.1 days. Bed utilization in psychiatric wards was among the highest of all hospital units, reaching the 100% level.

In Croatia, there was a decrease of 21.3% in the total number of hospital beds between 1990 and 1996. The decrease in psychiatric beds was even higher, amounting to 25.3%.

The national Public Health Institute maintains a Register of Psychoses. In 1995, there were 7759 admissions of 5396 schizophrenic patients. Out of this number, 572 patients were in hospital care during the whole year and their share of hospital days represents 36.8% of the total days of hospital treatment for schizophrenic patients.

Intersectoral cooperation

Several government bodies have been formed, some of them permanent and others temporary, to improve a particular service or activity for those with mental disorders. Recently, a Commission has been established to monitor the care of persons with mental disorders. It includes representatives of different government bodies, including the health and social welfare authorities, legal experts, and other professionals dealing with ethics and public relations. One of the tasks of this Commission is to encourage the implementation of mental health promotion programmes.

In 1999, the Ministry of Health formed a special body to develop improvements in the already-existing community-based psychiatry. The Croatian Association of Psychiatrists has also elaborated a draft version of a framework for this.

Several mental health programmes have been considered for further development:

- decreasing the stigmatization of chronic psychiatric patients, particularly of those suffering from schizophrenia;
- the prevention of depression and reduction of suicide rates;
- the deinstitutionalization of long-stay patients.

The Commission for Narcotics is a permanent government body, comprising representatives of all authorities responsible for drug abuse, including the health, education, and social welfare authorities. A strategy on prevention of drug abuse has been accepted by the Croatian Parliament and is currently being implemented.

Several other commissions, with more global tasks, have been formed to examine the possibilities of improvement in the quality of life of particular population groups, such as children and the elderly. These commissions include representatives of various government bodies concerned with the target groups. In view of the high incidence of war-related psychological trauma, a Council of Experts was formed to propose, elaborate, and implement psychosocial programmes for war victims.

In 1999, a joint Committee between the health and social welfare authorities was formed to, among other tasks, improve social care in the community for discharged psychiatric patients, as well as health care for those chronic psychiatric patients who are resident in social institutions. The Ministry of Health, like other ministries, is regularly cooperating with and sponsoring activities of various NGOs dealing with mental health programmes, including those of service providers and consumers.

Mental health legislation

The Law on Protection of Persons with Mental Disorders was approved by the Croatian Parliament in 1997, with some revisions in 2000. It defines the rights of those persons to protection and care, and to equality in health services. It also specifies the conditions when these rights can be limited, elaborates the obligatory procedures related to these limitations, and defines the right to protection from mistreatment. According to this Law, a patient can be admitted to hospital only on the signing of informed consent. This must be in a written form, confirming understanding of its nature, possible consequences, and types of treatment; its withdrawal is permissible at any time. Compulsory hospitalization is subject to court supervision.

Under this Law, a State Commission for the protection of persons with mental disorders was established. Its responsibilities are to elaborate possibilities of further improvements in the status of persons with mental disorders, deal with complaints from psychiatric patients, but also to define mental health promotion programmes. This body was created at the beginning of the year 2000, and detailed mental health promotion programmes were then being elaborated.

CZECH REPUBLIC

Psychiatry and recent changes in the society

The socio-political changes of 1989 started a process of rapid transformation of the whole of Czech society. The system of health care underwent a fundamental reform which affected the organizational structure of services as well as the system of funding and management. The major elements of the transformed health care system are (1) compulsory health insurance and the establishment of health insurance funds; (2) decentralization, diversification and increased autonomy of service providers; and (3) the supervising and regulating role of the government in negotiations between health insurance funds and health care providers on coverage and reimbursement issues. The changes occurring in psychiatric care in the Czech Republic reflect these reforms and the goals formulated by the Commission of the Psychiatric Society of the Czech Medical Association. These were published in 1997 as: Psychiatric care in the Czech Republic – Programme document, and Mental health care policy. This programme defines the status of psychiatry in the health care system and underlines the requirements necessary to keep pace with recent trends in treatment, rehabilitation and the social reintegration of mentally ill people.

Professionals and the network of treatment facilities

In 1999 there were 1184 psychiatrists, 3581 psychiatric nurses and numerous psychologists, social workers, lay therapists and other professionals serving mentally ill patients. The overall number of psychiatric beds was 11 605 and most of these were in psychiatric hospitals (10 007). The total number of beds in residential facilities has decreased markedly within the last ten years (by approximately. 3500 beds) although the number of psychiatric hospitals (21) and the number of psychiatric departments in general hospitals (26) remained the same. There is now about one psychiatric bed per 1000 of population. The average duration of hospitalization decreased during the last ten years from 109 days to 82 days in psychiatric hospitals and from 34 to 25 days in psychiatric departments of general hospitals. The number of outpatient services increased correspondingly, with less than 400 psychiatrists in outpatient services in 1989, to 525 in 1997. (Information provided by the Institute for Health Information and Statistics, Prague.)

Deinstitutionalization, destigmatization, reintegration – dreams and reality

There is no doubts that the trends in psychiatric care in the Czech Republic are similar to those in other European countries, which means less and shorter treatment in hospitals and more intervention in the patient's natural social and familial environment. The data presented above confirm this tendency and it should be added that the changes have substantially improved the quality of treatment provided in hospitals as well as the living conditions of patients. Despite these positive changes, much remains to be done with regard to rehabilitation and social reintegration of mentally ill patients. The current shortcomings are partly due to limited financial resources. The costs of treatment are covered by the health insurance fund, but for other interventions, which are considered to be rather social support than treatment, such wide coverage does not exist. The other obstacle is that the traditional psychiatric treatment facilities are not appropriate to fulfil these tasks. The majority of work in this field was done by various nongovernmental organizations. Despite this new sector growing rapidly, it is still is not able to provide for the demand. It should be added however, that there are a number of very promising initiatives in sheltered housing, sheltered work and reintegration into the community.

Training of professionals and information dissemination to public

Education and training of professionals is an important prerequisite for changes in psychiatric care. In the Czech Republic there is a long tradition of training of health professionals, which concerns not only psychiatrists, but also clinical psychologists, social workers and psychiatric nurses. The Institute for Postgraduate Education in Health Care has a dominant role in the system of training and education, but is currently not the only institution delivering training. For example, the nongovernmental organizations are now active in this field. They organize training seminars tailored to their specific needs, often with participation of partners from abroad.

Mentally ill people are still facing prejudice. Such attitudes are due to ignorance and can be improved by the dissemination of information in appropriate ways. Much has been done over the past ten years. Mental Health Week is a regular activity, which turns the attention of the public to the problems of mentally ill people. The week is organized throughout the country in the form of a cultural festival with many performances carried out in the psychiatric hospitals. There are also other forms of information dissemination, through the mass media, TV, radio, etc. In recent years there have been positive shifts in the attitudes of the public towards mentally ill people and this continuing process should contribute to further destigmatization and better reintegration of patients into the community.

DENMARK

Introduction

During the last ten years, there has been an increasing focus in Denmark on issues concerning mental illness and its care. This includes a growing political awareness of the problem, as well as an increasing political will and commitment with regard to the need for improving mental health services. It has led to the development of two national agreements between the government and the counties, who are responsible for the health care system, including mental health care.

Intersectoral cooperation

Intersectoral cooperation is essential at all levels in the system. First of all, there is a significant degree of cooperation between the counties' social services and health service departments. Usually, the health department is the responsible authority for mental health care. However, in some counties, the social service department is responsible for the management and organization of the mental health care system. This arrangement demonstrates the focus of the last ten years on decentralization and the social psychiatric services. With respect to the individual patient, the major goal is interdisciplinary teamwork (between psychiatrist, psychologist, physiotherapist, occupational therapist, social worker, etc).

There is also an important degree of cooperation between the central health and social service authorities. The Ministry of Health and, to a lesser extent, the Ministry of Social Affairs regularly sponsor activities concerning mental health. The Ministry of Health cooperates with the National Board of Health regarding mental health issues, as it does for other national health questions.

Various consultative groups have been established to deal with mental health, such as an advisory body with expert members within the framework of the National Board of Health. The Ministry of Health has also established a working group including members of other relevant ministries, representatives of the counties and the National Board of Health, with the task of analysing the possibilities of improving the treatment and care of vulnerable children. Statistical reviews and reports about mental illness are prepared continuously, for example, dealing with objectives and treatment for different kinds of psychiatric problems and quality of care.

National health plans

During recent years, the Ministry of Health has completed two major agreements with the counties on psychiatry (in 1997 and 1999). Both these agreements represent a nationwide strategy for the development and improvement of care and treatment offered to patients suffering from mental disorders.

These agreements also contain arrangements for the payment of accepted improvements. The Government set aside a total of 480 million Danish crowns for the Agreement of 1997, and 750 million Danish crowns for the 1999 Agreement. The planned improvements include education of doctors, nurses, and other professional workers, new and modern hospital facilities (including single rooms for psychiatric patients), extension of community-based psychiatry, improvements in the treatment of children with mental illness, etc.

Mental health legislation

At the beginning of January 1999, the Government adopted a revised law regulating the treatment of psychiatric patients. Beside this fundamental law, various Departmental Orders concerning mental health have been introduced during the past decade covering the following issues:

- imprisonment and other forms of coercion as they affect psychiatric patients;
- how to carry out compulsory commitments and involuntary hospitalization;
- the possibilities for complaining in relation to treatment in psychiatric departments;
- guidance about possible revision of the fundamental law of psychiatry;
- patients' advocates;
- laying down standing orders for patients and their advocates.

Morbidity and mortality

In a recent large Danish population survey, 6% of the respondents answered in a way that indicated that they had some kind of mental health problem. It also showed that 34% of general practice consultations concerned mental health problems. It is estimated that there are 40 000–50 000 people in Denmark with a severe psychiatric illness who are receiving treatment for a shorter or longer period.

Deinstitutionalization

The debate about deinstitutionalization has intensified in recent years. The number of psychiatric beds has been reduced from 5850 (corresponding to 1.47 per 1000 inhabitants aged 18 years and above in 1987) to approximately 4000 (0.97 per 1000 adults). During the same time, there has been an enlargement of decentralized psychiatric services, which numbered 120 in 1999. Further improvements in these services were included in the psychiatric plans for 1997–1999 and considerable amounts of money were allocated for that purpose.

National objectives in the next few years include:

- establishing databases of patients to permit quality assurance of psychiatric treatment;
- improving the conditions for those patients with chronic mental disorders;
- continuing education of mental health staff;
- improving the capacity of departments of child and adolescent psychiatry;
- improving the quality of hospital accommodation for acute psychiatric patients.

ESTONIA

In Estonia, mental health services are provided by medical facilities and practitioners, as well as by institutions from the social welfare sector. Central government, local government and private agencies are all represented in this field. Although cooperation between the different sectors is improving, there are still many steps to be taken to provide society with a well-functioning network of mental health services.

The background of mental health reform

Before the last decade, mental health services were characterized by:

- centralized provision;
- large institutions with poor material conditions;
- underdeveloped outpatient services;
- weak connections with primary health care;
- underdeveloped community care services for long-term severely ill patients;
- split between social and health care services;
- lack of relevant legislation;
- a medical model with little psychosocial understanding of illness;
- lack of trained personnel (nurses, social workers);
- the absence of psychotherapy training.

Current services

Psychiatric hospitals and wards provide acute inpatient treatment, but the majority of long-term institutionalized patients are cared for in the psychiatric nursing homes of the social welfare system. The outpatient services are linked either to a psychiatric hospital or to the local general hospital.

There are several NGOs that are active in the field of mental health. Among them are organizations for consumers of the services or their families (Peace of Mind, Estonian Autistic Society, Estonian Society for Rehabilitation of Addicts), professional societies (Estonian Psychiatric Association, Estonian Society of Psychosocial Rehabilitation), and groups for the protection of consumer rights (Psychiatric Patient Advocacy). At the level of local government, there are day centres for psychiatric patients, crisis centres, and telephone hotlines.

Community-based psychiatry

Prior to the 1990s, the institutionalized model of providing psychiatric care was dominant and community psychiatry underdeveloped. The situation has improved slowly; the Estonian Psychiatric Association has developed several proposals for the development of community services, though the implementation of these plans has depended up to now on the understanding of local administrators of psychiatric care. Up until now however, there has been no comprehensive mental health plan. It is expected that with the introduction of the *Hospital Masterplan* for the development of secondary health care services, the government will also decide on the development of more community-orientated services. A task force for the implementation of community-based services for the long-term mentally ill has been inaugurated by the Ministry of Social Affairs and a plan for deinstitutionalization of patients from psychiatric nursing homes is expected to start shortly.

The Swedish East European Committee has supported several projects, including the training of nurses, teamwork in psychiatry, psychosocial rehabilitation, and early intervention in the treatment of psychosis.

The strategy of the Estonian Psychiatric Association

1. To maintain and improve the links with the rest of the health care system.
2. To define responsibilities with the social welfare system:
 - developing community services for the long-term mentally ill;
 - linking the social services with health care.
3. To focus on legislation in order to meet European standards.
4. To improve training of mental health specialists:
 - new standards for psychiatric training;
 - defining continuing medical education and certification;
 - support for the training of nurses, social workers, occupational therapists, and psychotherapists.
5. New structures for the provision of services:
 - psychiatric wards in general hospitals;
 - outpatient units with multidisciplinary teams.

The strategy recognizes that improvements can only be introduced slowly and that a flexible approach is needed, recognizing that only limited resources are available for planning and strategy development at the national level.

Mental health legislation

The Estonian Mental Health Act came into force in 1997. The main principles are:

- Criteria to be given for involuntary treatment (dangerousness to self or others due to mental disorder, other means of treatment not being effective). The procedure through which this is done is:
 - involuntary admission only via a doctor's assessment on reception at the hospital;
 - the agreement of two psychiatrists within 48 hours on the necessity of involuntary treatment;
 - if the necessity for involuntary treatment continues after 14 days, it can be prolonged on the decision of an administrative court.
- Supervision of involuntary treatment is carried out both by the county medical officer and the administrative court.
- The Mental Health Act also lays down the basic requirements for psychiatric treatment, including responsibilities for the provision of services by the community and the state, the rights of patients, and the basic regulations for forensic psychiatry.

Conclusion

The following are still matters of concern regarding mental health:

1. drug abuse among adolescents;
2. high rates of male suicide;
3. slow progress in the development of community psychiatry;
4. the low priority given to mental health at the governmental level.

The following however indicate areas of progress:

1. legislation (a functioning Mental Health Act) ;
2. growing awareness among mental health professionals of psychosocial factors influencing mental health;
3. training and implementation of psychotherapeutic skills and understanding in the provision of mental health services.

FINLAND

The most important legislative basis for mental health and psychiatry in Finland consists of the Mental Health Act, Specialized Health Care Act, Public Health Act, Social Welfare Act, and the Law of Patients' Rights. The Mental Health Act defines "mental health work" as a broad concept in the following way:

"Mental health work refers to the promotion of individual mental wellbeing, functional capacity and personal growth as well as to the prevention, cure, and alleviation of psychotic and other mental disorders. It also includes the development of the living conditions of the population so that they prevent the contracting of mental disorders, enhance mental health work, and support the organization of mental health services."

Intersectoral cooperation

Finnish mental health legislation strongly underlines cooperation and synergy between different sectors. This includes an explicit requirement that the specialized and primary health care services work together, as well as requiring cooperation between the health care and social welfare services.

Social welfare and health care are integrated at the governmental and also at the provincial level. At the national level, the Ministry of Social Affairs and Health has the highest administrative responsibility, and STAKES (The National Research and Development Centre for Welfare and Health) is the active agent in the field of research and development. In every provincial administration, there is a department for social affairs and health.

The new governmental Goal and Action Programme for Social Welfare and Health Care, which was adopted in November 1999, requires as one of the goals for mental health care that every municipality must establish a plan for a seamless and comprehensive mental health service at the local level. For the moment, however, the models and degree of cooperation vary between the different municipalities. In some, the social welfare and primary health care services are joined both at the administrative as well as at the practical level. In others, they still work separately from each other, although there has been, especially during the 1990s, an increasing tendency to better integration.

One practical example of increasing multisectoral cooperation in the area of mental health work is the development of a nationwide programme called "Meaningful Life". The aim of this is to improve the quality of life for people suffering from mental disorders or their threat. This operates at national, regional, and local levels, with almost all ministries participating in its steering group.

The deinstitutionalization process and development of community-based psychiatry

The deinstitutionalization process in Finland started later than in many other developed countries. At the beginning of the 1980s, there were still about 20 000 psychiatric beds (4.2 per 1000 inhabitants), almost all situated in separate psychiatric hospitals. A specific feature of the Finnish situation, however, was that there never were really big hospitals: the 20 000 beds were spread between about 100 hospitals, and in no hospital were there more than 1000.

During the last 20 years, there has been a radical change in the structure of mental health services in Finland. This has been most visible in the number of psychiatric beds: during the

1980s, these decreased from 20 000 to 12 000, and by the end of the 1990s, were only 6200. The total number of hospital days has decreased in proportion, but on the other hand, the annual prevalence of treated patients in these hospitals has remained fairly constant. However, the numbers of long-term patients in continuous hospital care for more than one year has decreased sharply: from 2900 in 1991 to less than 1000 in 1998. This reflects the increased efficacy of hospital treatment, as well as the tendency to transfer these patients to the care of community-based services.

The decrease in the number of psychiatric beds was compensated for by increasing outpatient resources and by developing community-based care. The numbers working in outpatient care doubled from 1982 to 1992, but the economic recession at the beginning of the 1990s seriously hampered this positive development. The number of psychiatric beds continued to decrease, but the personnel in outpatient care actually decreased between 1992–1995, but have now increased so that in 1999, it reached the same level as in 1992.

The main problem in implementing community care is the scarcity of supporting services for long-term patients living in the community. There is a need for more supported housing, day centres, support persons, and guided leisure activities; patients' families also need more help and support. In recent years, there has in fact been a slight increase in these services.

One special feature of the Finnish health care system, since the state subsidy reform in 1993, is that its financing is very decentralized. The financial units are the municipalities which total 450, with an average size of 6000 people. The biggest municipality is Helsinki, with half a million people, but the smallest have only a few hundred inhabitants. Despite this, every municipality has the responsibility to provide all health care, including the most specialized, to their inhabitants, either by organizing this themselves or by buying it from health care districts, other municipalities, or private providers. The municipalities have the right to collect their own taxes. The other part of the needed money comes to municipalities as a state subsidy, but without any specific earmarking for health. This has led to increasing regional and local differences in the provision of mental health care.

Morbidity and mortality figures

The prevalence of mental disorders among Finnish adults has been assessed to be about 20–25% in surveys conducted in the 1980s. No recent epidemiological survey has been carried out, but considering the economic difficulties in the 1990s, there are no grounds to believe that the prevalence would be any lower. In a more recent child psychiatric epidemiological survey, it was found that among 8-year-old children, the prevalence of mental disorders was 17% (23–25% for boys and 7–10% for girls).

According to some studies, the need for mental health care has been established as 17% of the Finnish adult population. More than half this need seems to be unmet, which is a remarkable challenge. However, the treatment situation in psychotic disorders seems to be better (about 85% in treatment), although in depressive disorders, the need was met for only 30%.

The suicide rate was increasing in Finland until 1990, which was the peak year (30.3 per 100 000 inhabitants). After that, it decreased slightly and was 25.7 per 100 000 in 1997 (41.4 for men and 10.8 for women). As in many other European countries, the suicide rate in young males has been especially alarming, but has not increased during the 1990s. In the group of 20–24 year-old men, the rate was 60.3 per 100 000 in 1990 and 53.5 in 1997.

Multidisciplinary teamwork

The Finnish mental health care system is characterized by teamwork in which nurses, social workers, occupational therapists, psychologists, etc. participate with psychiatrists. One prerequisite for this cooperation is the high standard of training among all personnel, so that all staff groups can participate in this cooperation on an equal basis. For instance, many nurses have received formal training in psychotherapy, especially family therapy. At the municipality level, local mental health work is often organized on a multidisciplinary basis.

The Finnish National Schizophrenia Project, which was carried out in the 1980s, recommended that “acute psychosis” teams should be established in every catchment area. Their task is to take care of new psychotic patients in the area by active initial intervention which, whenever possible, includes family participation. The 10-year follow-up of the Project, focusing on the year 1992, verified that most of the catchment areas had established these multidisciplinary teams.

Promotion of mental health

Finland has participated with other countries of the European Union in the enhancement of activities for the promotion of mental health. These same themes have been priority areas at the national level. These have been:

- enhancement of the value and visibility of mental health;
- development of mental health indicators;
- promotion of mental health in children and adolescents;
- promotion of mental health in old age;
- promotion of mental health in relation to working life and employment policy;
- telematics in mental health promotion and substance abuse prevention.

A special challenge for Finnish society has been the high unemployment rate following the deep economic recession in the beginning of the 1990s. At its highest, the rate was about 20%, and is still about 10%, although the Finnish economy has improved rapidly during recent years. Another special concern is the situation of young people. The high suicide rate among young men has already been mentioned and another problem is the increasing drug and alcohol abuse, especially among adolescents.

GERMANY

In West Germany, “Psychiatric Reform” was launched in the late 1960s. Based on a decision of the German Parliament in 1971, a commission of experts was appointed to give a report on the current state of psychiatric care. This report was published in 1975. The commission provided the first systematic outline of the situation and criticized: the inadequate care of mentally ill and disabled persons, often hospitalized for many years; poorly staffed hospitals with sometimes 2000 or more beds, often located in remote areas; and the absence of community-based services, especially for complementary care. It set out the principal conditions for a modern psychiatric care system, which are still valid:

- adequate care for all patients, even for the severely and long-term mentally ill;
- equal rights within the social security system for mentally ill patients as for somatically ill patients for treatment and care covered by the system;
- dehospitalization of long-term inpatients, corresponding with the provision of community-based residential care services, reachable within one hour by public transport in catchment areas of 150 000 to 250 000 inhabitants;
- coordination and cooperation of the various types of services to cover the complex needs of care.

The underlying philosophy was the acknowledgement that mentally ill and disabled persons have the same right as others to the greatest possible self-determination. They should also be enabled to maintain themselves outside hospital and be able to take part in social life in their residential area. The main goal of the Psychiatric Reform was a change from the custodial approach of the past with hospitalization in large state institutions, to care based on therapy and rehabilitation in patients’ home areas.

In the years between 1980 and 1985, a federally funded programme was launched to develop and try out new approaches to an adequate mental health care system. Based on the results of these projects, an expert group published in 1988 recommendations for moving supportive and outpatient services to patients’ areas of residence. These would provide sheltered housing, work, and training activities which could bring structure to the day and participation in social life. The *Bundesländer* (states) and others at the more local level, also started activities to improve the provision for these needs of patients.

Since the beginning of the Psychiatric Reform, the structure of the mental health care system has radically changed and improved:

- The number of psychiatrists has increased fourfold since 1973 and has reached about 4500 (from 3000 in 1990), representing approximately 1:18 000 population, while psychologists/psychotherapists now number more than 1:10 000 population. A considerable number of patients with mental disorder are also treated by general practitioners.
- Hospital beds have been reduced by over 50% from 117 600 in 1973 to 55 000 (in the western part of the country). The optimal number of clinical beds is seen to be between 0.4 and 0.8 per 1000 inhabitants.
- About 150 psychiatric departments attached to general hospitals were established, providing about 40% of all beds in residential areas. Most of these have about 80 beds plus day hospitals that can accommodate about 20 patients each.
- The average stay in a hospital for a psychiatric disorder is between 20–40 days.

- Hospital treatment has been improved by the *Psychiatrie-Personalverordnung* – a federal staffing directive which has brought an additional 6500 multidisciplinary staff members for inpatient treatment since 1991.
- Both psychiatric hospitals and psychiatric departments in general hospitals are legally obliged to operate an outpatient unit (*Instituts Ambulanz*) to provide care, especially for severe and long-term mentally ill patients by a multidisciplinary team of nurses, social workers, occupational therapists, and psychologists in addition to psychiatrists.
- Deinstitutionalization was combined with the development and implementation of community-based care. Many communities have made great efforts to provide social services for daily activities, sheltered living, work, and training.
- The involvement of family members and ex-users, newly organized into groups to design activities, has proved to be extremely useful.

The results of a federally funded project, published in 1996, set the standard for community care for chronic mentally ill persons. Instead of the various institutions selecting and retaining patients “suitable” to their “needs”, the focus for organizing the caring processes (help for self-supported living, work and training, daily activities, and social contacts) became the need of the patient to live in his or her private environment.

Needs and concerns

There are still significant regional and local differences in the implementation of community-based services, especially for long-term patients, and in achieving a uniform standard throughout the country. Although municipalities and communities accept their responsibility for the provision of community-based care, its implementation remains voluntary, with the communities claiming that health insurance should share the responsibility for the costs.

This problem has to be considered in the context of the German social security system, which comprises five separate types of mutually-based funding. These are: health insurance (compulsory for about 90% of the population), state pension fund, accident insurance, unemployment insurance, and nursing insurance. Each of these is only responsible for its defined services and for its own budget. The welfare system (public assistance) is an additional network that helps patients if any of the above-mentioned prior paying insurance organizations fail to cover them. But as public assistance is tax-financed, people have to share in the costs for these services, corresponding to their personal income and assets.

Health insurance is responsible for medical treatment and medical rehabilitation. In the case of mental illness, there has been a traditional separation of medical treatment and psychosocial care. The consequence is that a considerable component of social services for mentally ill patients, especially for chronically ill persons with long-term needs of care, is still considered as social rehabilitation and social re-integration, which are not paid for by health insurance. They are not considered to be medical rehabilitation and treatment, which are covered by health insurance. Because many services are paid for by social welfare, patients and their near relatives have to share in the costs.

For further development, it is essential:

- to solve the problem of financing; the partners of the security system have to agree on mutually responsible funding;
- to improve the coordination and cooperation of the various institutions with professionals providing services, including the use of case/care management;

- to improve the integration of mental health care into primary health care, so that services are delivered down to the lowest level of treatment and care;
- to intensify efforts and concerns for children and the elderly who are mentally ill; these require community-based facilities for living in a sheltered but private environment;
- to strengthen users' organizations;
- to increase efforts at public information to overcome prejudice and the stigmatization of mental disorder and disability and to enhance public recognition and discussion about the problems;
- to provide medical treatment and social services as an integrated entity in a flexible and continuous manner through multidisciplinary teams.

An outline of the German situation should also reflect reunification. In East Germany, the reform of the mental health care system started after unification in 1990 and though considerable improvement has been achieved, reaching the same standard as in the West will take more time.

GREECE

Community-based psychiatry and other services

The situation with respect to psychiatric services in Greece changed considerably during the period 1981–1996. In 1981, there was only one psychiatric unit (with 16 beds) in a general hospital and six mental health centres. By 1996, there were 30 units in general hospitals (321 beds) and 24 mental health centres. In addition, there were another ten psychiatric units without inpatient facilities in general hospitals, offering outpatient and consultation-liaison services. These developments have substantially changed the pattern of provision of psychiatric services in Greece. One-third of the total number of psychiatric admissions per year is now taking place in general hospitals and the vast majority of psychiatric outpatients are seen in the mental health centres and the psychiatric units in general hospitals.

A further 15 Mental Health Centres (MHCs) have been built, but their opening is dependent on the national financial situation; it is hoped that funding for this will be available through the 3rd European Union (EU) Framework Programme. The EU, through the “Psychoargos” programme, has already approved the development of 45 hostels, 20 sheltered workshops for occupational rehabilitation, and five sheltered boarding houses (accommodating patients with a higher degree of dependency than the hostel accommodation). The process of renting suitable accommodation and hiring personnel is in progress. A second phase for the development of rehabilitation facilities, which includes 50 hostels, 20 workshops, and ten sheltered houses, is currently under negotiation.

There have been considerable delays in the development and staffing of MHCs throughout the country, with the result that there are only 24 functioning MHCs, when the estimated requirement is at least 80. This is a result of the restricted financial situation which arises from the effort to join the EMU. The same financial situation also has an effect on the further development and staffing of psychiatric units in general hospitals. Athens Psychiatric Hospital (Dafni) was severely affected by an earthquake in September 1999: 85% of the buildings have been judged as requiring demolition. This is imposing considerable hardship on the patients and immense pressure on all the mental health units of the Attica region in their effort to accommodate the needs that surfaced as a result of this natural disaster.

In addition to the above, there are extensive health programmes targeted at the use of narcotic drugs. A programme for depression is in the initial stages, with particular emphasis on the elderly. All other mental health promotion takes place at the local level, with whatever resources are available.

National mental health plans

A ten-year national plan for Mental Health was submitted for financial assistance to the EU in 1997 (Psychoargos), part of which has already been approved and is now in progress. The following are the main points of this plan.

1. The continuation of deinstitutionalization and destigmatization. It is estimated that 60% of patients now residing in psychiatric hospitals can be moved to community sheltered accommodation. The Greek policy for deinstitutionalization is included in the ten year plan for mental health, and confirmed by the recent Mental Health legislation and the Psychoargos programme.
2. Sectorization of the psychiatric services throughout the country.

3. Continuation of the development of primary health care units and psychiatric units in general hospitals.
4. Continuation and intensification of the development of rehabilitation facilities.
5. Establishment and development of Patient Cooperatives in order to promote the social, economic, and occupational reintegration into society of patients with severe psychiatric problems.
6. Establishment of detailed guarantees and procedures for the protection of patients' rights.
7. During the period 2000–2006, there will be special emphasis on the areas of child psychiatry, psychogeriatrics, and the reform of psychiatric hospitals.

Intersectoral cooperation

There is very close cooperation between the Ministry of Health and the Ministry of Labour and Social Security concerning management and support for the National Mental Health Plan. In addition, the Ministry of Health is given first option on public buildings which have been designated for disposal by the Ministry of Finance. If they are considered suitable for use as mental health units, ownership is transferred to the Ministry of Health without charge. Three such buildings have already been transferred, with 15 more transfers pending. The Ministry of Health is also working closely with the Ministry of Internal Affairs and Public Administration to achieve approval of new posts within the health sector in general and mental health in particular. This involves exemption from the ban which has been imposed on public appointments, due to the financial restrictions that are part of the strategic planning for participation in the European Monetary Union.

There is however, very variable cooperation at the local level between mental health units and County Authorities. For example, some counties facilitate the establishment of sheltered accommodation in the community, while others strongly oppose it, as they feel that property prices will fall due to the presence of psychiatric patients. Encouraging developments are expected as a result of the 1999 Mental Health Act, which anticipates the establishment by local authorities of mental health units that will participate in the sectorization of mental health services.

Mental health legislation

The new Mental Health Act (Law 2716/99) is based on and informed by the Mental Health plan, described above. All the essential points are included in the Act. In particular, the sectorization of mental health services is elaborated in considerable detail.

Morbidity and mortality figures

Epidemiological studies in the community have shown that 14–16% of the general population in Greece suffers from a psychiatric disorder (point-prevalence) – a figure which is similar to that obtained in other western populations. The prevalence of regular alcohol drinking is quite high in the general population (54% for males and 18.5% for females). About 5% of the population uses illicit drugs, with hashish the most common. The WHO study *Mental illness in general health care* showed a one-month prevalence of psychiatric disorder of 22% (generalized anxiety disorder 14.9%, depression 6.4%, neurasthenia 4.6%, harmful use of alcohol 3.5%).

In the population over 15 years of age, the suicide rate is 4.22 per 100 000, although it should be remembered that there is under-reporting due to religious practices and restrictions. Men represent 83% of the total, with the over-75 age group being particularly vulnerable.

Multidisciplinary teamwork

All mental health centres operate using multidisciplinary teamwork. However, there are gaps in this approach as far as the psychiatric units in general hospitals and the psychiatric hospitals are concerned, with relatively few staff other than psychiatrists and psychiatric nurses. The recent Act requires a multidisciplinary approach in the new rehabilitation units.

Matters of greatest concern

The attitude of the mass media continues to consist of negative and sensationalist presentation of matters concerning psychiatric patients. This is despite repeated efforts to change this situation by organizing specific educational events including both mental health professionals and “enlightened” journalists. The main issue behind this is not so much ignorance, but rather viewer ratings and circulation figures.

The change in composition of the population is leading to increases in vulnerable groups, specifically the aged, unemployed, and immigrants. Significant factors here include the changes occurring in the traditional family support network and massive immigration due to the geographical position of the country.

Areas of progress

The progress of deinstitutionalization, in its various forms, and the dramatic improvement in the Leros Psychiatric Hospital, as documented by the EU.

The passing of the Mental Health Act (Law 2716/99), which constitutes a comprehensive policy document for the further development of psychiatric services in Greece, including its particular emphasis on the sectorization of mental health services and the priority it gives to primary health care and community-based psychiatry.

The development of a variety of educational programmes for mental health professionals, including a national multidisciplinary training programme, which has recently been completed.

HUNGARY

The mental health indicators for Hungary are generally unfavourable. Traditionally, the Hungarian population tends to describe itself as inclined to depression, despair, and self-destruction. The same self-image is generally reflected by the mass media.

The suicide rate has always been in the high range since statistics have existed, but it increased rapidly after the Second World War to become one of the highest in the world in the early 1980s. However, during the last ten years, a spectacular decrease of one-third has brought Hungary back into rates of suicide comparable with those of other European countries although this positive trend seems to have slowed down in the last two years.

Per capita alcohol consumption has increased up to approximately ten litres per annum and the death rate caused by liver cirrhosis continues to rise (to date, around 80/100 000). An increase in drug abuse has been registered by different data sources with about 1% of the population having a drug abuse problem.

According to a recent epidemiological study, the lifetime prevalence of major depression is 15.1% in the population aged between 18 and 65 years. (One-month prevalence: 2.6%). The prevalence of affective and anxiety disorders was found to be 15% in a general practice patient population.

Psychiatric services

There is an insurance-based state- or municipally-owned psychiatric service system, with a very small private sector providing outpatient care. A reduction in the number of hospital beds from 13 to 9.5 per 10 000 inhabitants took place during the 1990s. There is however, a shortage of half-way institutions and inpatient facilities for long-stay patients.

There is a system of psychiatric outpatient services (with about one per 70/100 000 inhabitants) staffed by psychiatrists, clinical psychologists, social workers, psychiatric nurses, etc. Some of these also provide community-based activities. The Psychiatric Clinic of the Semmelweis University in Budapest has developed model services during the last ten years, including a community psychiatry programme in collaboration with an international sponsor. However, the process of deinstitutionalization is still at an early stage of development. Though the need for multidisciplinary teamwork seems to be generally acknowledged, the health system is medically dominated, and non-medical professionals play a secondary role.

Collaboration between government departments on mental health issues is not strong and the nongovernmental organizations are relatively weak, as well as lacking experience in collaborating with governmental agencies.

Mental health legislation

A new Health Act, voted by the Parliament in 1998, came into effect in 1999. There is no special law on mental health, but this Act contains a chapter on mental disorders and their treatment, including hospitalization and compulsory measures. The legislation on mental health issues, with the protection of the human rights of mental patients, conforms to European norms.

The State Public Health Office does not give prominence to psychiatric interests. A National Institute of Health Protection was established under the Ministry of Health and Social

Welfare, with some programmes relevant to mental health (such as one against smoking). A National Mental Hygiene Bureau with 12 regional offices was set up in 1995 but has now been merged with the above-mentioned Institute, forming an Institute of Health Promotion. In this process, however, the mental aspects of health promotion (including budgeting, staffing, etc.) have had to be defended.

Some national mental health programmes have been elaborated during the last five years, with some parts of them being realized and others reframed. A new version of the National Mental Health Programme is in preparation, taking into account the shift in the concept of health (see the Ottawa and Jakarta Declarations), and the priorities of the World Health Organization. A National Programme against Drug Abuse has also recently been elaborated. Hungary's primary mental health problem continues to be alcohol-related disorders, but despite the social, economic, and human burden, it is overshadowed by drug abuse in the public's mind.

Concerns and progress

Although the development of Hungarian society stagnated after the Second World War with the imposition of an enforced alien political and cultural system, there has recently been an unambiguous increase in living standards and a development of social integration. There has also been an expansion of education for an ever-increasing part of the young generations who are now accessing higher education and university. Health and related issues are coming to the foreground among the values generally accepted by the majority of the population and there seems to be an increasing tolerance of mental disorders in the population.

ICELAND

The mental health services are funded by government taxation. Inpatient treatment is free, but patients pay a modest fee for outpatient treatment. Specialist consultations are subsidized by the Department of Health and Social Security. As well as inpatient services, facilities include outpatient clinics, day hospitals and centres, rehabilitation wards and centres, rehabilitation workshops, and sheltered accommodation.

In recent years, the number of psychiatric beds has been reduced substantially and alternative forms of treatment such as day- and outpatient services and community care have been emphasized. Subsequently, many long-stay patients have been provided with accommodation in the community. Attendance at outpatient departments has grown significantly and in spite of the substantial reduction in hospital beds, the number of admissions has not decreased. More people are being admitted to day units and the length of stay in hospitals is markedly shorter than before.

The role of primary health care in the treatment of psychiatric disorders is an important one. A substantial proportion of people with depression and other psychiatric disorders of lesser severity are treated by general practitioners. Nevertheless, the integration of this aspect of psychiatric care with primary health care has still not developed fully and further coordination with social services is also needed.

The local authorities and nongovernmental organizations (NGOs) also provide valuable psychiatric services. In addition to residential support and other community services, NGOs have important roles in non-hospital care, as well as promoting mental health and the prevention of psychiatric illnesses.

The Icelandic Department of Health and Social Security has drawn up a plan for a health policy extending to the year 2005. This plan emphasizes long-term objectives in health. Among the main objectives is the reduction in prevalence of psychiatric disorders by 10%, suicides by 25%, and an annual extension of psychiatric services to 2% of children and adolescents, from birth up to eighteen years of age.

The main means of reaching these objectives are:

- the recording of psychiatric disorders will be comparable to the recording of other diseases;
- improved education, information, and specialist training of professional staff;
- providing more public information about psychiatric disorders;
- access to the psychiatric health services is to be facilitated;
- school activities and specialist psychiatric health services will be coordinated.

There is considerable intersectoral cooperation at government level, among the Ministries of Health, Social Affairs, and Education as well as local authorities. NGOs organizations and local authorities are gradually developing psychiatric care and other support services in the community, although this development has still not been achieved fully. Community-based services need to be strengthened and psychiatric care requires further integration with primary health care and social services. The role of NGOs is of growing importance, for example in providing residential care, treatment facilities for substance abusers, and as promoters of patients' rights.

There is no separate mental health legislation in Iceland. The necessary legislation for involuntary hospital admission is included under the law on legal capacity. This ensures, among other things, the rights of patients to an appeal and an independent medical review.

The psychiatric services have been deinstitutionalized over the last three decades and almost all psychiatric beds are now within general hospitals. Psychiatric care is primarily delivered by multidisciplinary teams of professionals. In recent years, there has been a considerable increase in the numbers of psychiatrists, psychologists, and social workers, but there continues to be a shortage of psychiatric nursing personnel.

One of the main aims of the Icelandic National Mental Health Plan is to reduce substantially the prevalence of psychiatric disorders and in particular to reduce the rates of suicide by 25%. Premature deaths, accidents, and self-inflicted injuries are serious public health problems.

Substance abuse is a growing problem and stressful lifestyles, along with changes in the role of the family and social environment, may be making vulnerable individuals – in particular younger people – less able to cope with stresses and thus likely to experience feelings of hopelessness. There are some indications that stress has increased in the workplace, particularly among younger women, and depression is also more frequent among women.

It is regarded as important to promote mental health and to increase the awareness among the public of the significance of preserving this aspect of life. NGOs, the Surgeon General of Health, and others with the help of the media, have promoted awareness in the public of mental health through publications and other activities. Last but not least, systematic and ongoing action needs to be taken against stigma and meaningful steps taken to reduce social exclusion of the mentally ill.

Issues of progress and concern

Psychiatric hospital services have been developed within general hospitals, providing easy access for patients. Specialized psychiatric services for children and adolescents need to be developed further, in view of the importance of early assessment, intervention, and treatment as well as a need for a coordinated effort by the health, social, and educational systems.

An emphasis has been placed on day- and outpatient services, but integration with primary health care and social services is still not fully developed.

Information for the public and education and training of professionals has brought better understanding of mental health and psychiatric disorders. However, stigma and social exclusion remain a serious barrier to the achievement of equality, human rights issues, effective treatment, and rehabilitation.

IRELAND

The Minister for Health and Children and his Department are responsible for the overall planning and for the professional and financial regulation of the health care system. Eight regional health boards are responsible for the planning and provision of services at the local level.

Within the Department of Health, there is an administrative unit dedicated to mental health services and an Inspectorate of Mental Health Services. The Health Research Board publishes an annual report on *Activities of Irish Psychiatric Hospitals and Units*, which provides statistical data on all admissions, discharges, and deaths in the inpatient psychiatric services.

The role of the Inspector of Mental Hospitals, who is currently attached to the Department, is of key importance in relation to the improvement of standards. The Inspector is required under the Mental Treatment Act 1945 to visit each public psychiatric hospital once a year and present a report on his inspection to the Minister. Very significant improvements have taken place in psychiatric hospitals in recent years as a result of the Inspector's reports. The Inspectorate has contributed greatly to quality assurance in psychiatric hospitals and to the care of the long-term mentally ill. In 1998, the Inspector published *Guidelines on Good Practice and Quality Assurance in Mental Health* for circulation to all providers of mental health services.

Organization

The eight regional health boards were established under the Health Act 1970 and charged with responsibility for the delivery of health services. They assumed the functions formerly carried out by local authorities which, under the Mental Treatment Act 1945, had responsibility for mental health services. A majority of the members of each health board are public political representatives.

Populations in the health board areas range from 200 000 in the Midland area to over 1 200 000 in the Eastern, which is responsible for Greater Dublin. (This has now been divided into three administrative areas).

Within each health board, mental health services are organized in catchment areas, of which there are 44 in total. Thus, each health board has from two to 11 catchment areas, whose populations range from 40 000 to over 250 000. Catchment areas are in turn divided into sectors. Sectors have a population of 20 000 to 50 000. Each sector has a mental health team, led by a consultant psychiatrist. A Clinical Director – who is a consultant psychiatrist – is responsible for the organization of mental health services in each catchment area.

Psychiatric beds are available for every catchment area in either psychiatric hospitals or in acute admission units attached to general hospitals. In 1998, approximately one-third of all admissions were to the 17 acute admission units in general hospitals. A further 15 acute psychiatric units are currently in the planning process. Catchment areas are generally self-contained with respect to community-based services such as day hospitals, day centres, rehabilitation workshops, and community residences. Outpatient care is delivered from mental health centres.

Traditionally, referrals by general practitioners to the mental health services have been lower in Ireland than in other countries. Patients have traditionally had direct access to acute

admission units or psychiatric hospitals. The sectorization of psychiatry and its greater integration with other health care, together with developments in under- and postgraduate training of general practitioners, should lead to an increased participation by these doctors in mental health care in the future.

In the psychiatric service, long-term patients are maintained in separate wards from acute patients and there are separate psycho-geriatric wards. Increasingly, there is no gender separation on wards.

Child and adolescent psychiatry operates from Child and Family Centres as a separate service from adult psychiatry; it seldom uses beds and is, in the main, not hospital-based. In recent years, significant resources have been made available for this purpose. Every health board region now has a child psychiatric service and the aim is to provide a service in each catchment area. A number of inpatient facilities for children and adolescents under 16 are planned.

Attention has been given in recent years to the development of specialist hospital and community services for the care of the elderly mentally ill and infirm. All health board regions now have such a service in their area.

Treatment for alcohol and drug abuse is mainly on an outpatient basis, although alcohol-related problems accounted for approximately 19% of all admissions to psychiatric hospitals and units in 1999.

Mental health policy and legislation

In 1981, a Study Group was established to draw up guidelines on the future development of the psychiatric services. Its report, *Planning for the Future*, was published in 1984 and has been adopted as policy towards the mental health services by successive governments. In line with its recommendations, the objectives are:

- to provide a comprehensive psychiatric service to meet the individual needs of people in their communities as far as possible;
- to integrate psychiatric services with general hospital, general practitioner, community care, and voluntary services;
- to improve the standards of care in psychiatric hospitals, pending the transfer of services to alternative locations in general hospitals and in the community;
- to replace the Mental Treatment Act 1945 with legislation which gives greater recognition to the rights of detained patients and provides a legislative framework for a modern mental health service.

Planning for the Future recommended a shift from the psychiatric hospital as the focal point of the psychiatric service. It proposed a service which would be comprehensive, community-orientated, sectorized, and integrated, and whose components should include: prevention and early identification, assessment, diagnostic, and treatment services, inpatient care, day care, outpatient care, community-based residences, rehabilitation and training.

Legislation

The Mental Treatment Act 1945, as amended by subsequent Acts, provides the legislative basis for the mental health services in Ireland. This was an enlightened piece of legislation for its time, but it was designed for a psychiatric service which was centred exclusively on the psychiatric hospital. A new Mental Health Bill provides a more modern legal framework

for the involuntary admission and detention of mentally disordered patients to psychiatric hospitals and psychiatric units of general hospitals.

This new Bill significantly improves the law in relation to mentally disordered persons involuntarily admitted for psychiatric care and treatment. It provides for the establishment of an independent body, the Mental Health Commission, to ensure that the interests of persons with mental disorder are protected, and to oversee the process of independent review of involuntary admission to psychiatric centres by Mental Health Tribunals. Each decision to admit a person involuntarily for psychiatric care and treatment will be reviewed automatically by an independent tribunal, consisting of a lawyer, a consultant psychiatrist and a layperson, operating under the auspices of the proposed Mental Health Commission. The review will be completed within 28 days of a person's involuntary admission. A decision of a tribunal to extend a period of involuntary admission beyond an initial term of 28 days may be appealed against through the courts.

The Bill also includes provision regarding consent to treatment by detained persons and arrangements for the registration and regulation of all centres of detention of psychiatric patients by the new Mental Health Commission.

Recent developments

Community-based facilities

Since the publication of the report – *Planning for the Future* – in 1984, there has been continued growth of community-based facilities, alongside the provision of acute psychiatric units attached to or associated with general hospitals, to replace services previously provided in large psychiatric hospitals throughout the country.

With improvements in treatment programmes, it is no longer necessary for many patients to be hospitalized. Indeed, it is clear that the numbers hospitalized for serious psychiatric illness has declined greatly in recent years. Patients are increasingly being cared for in settings other than inpatient care. Progress is ongoing with the setting up of new mental health centres, day hospitals, and other day facilities. At the same time, additional community-based residential accommodation has also been made available, with the number of community residences in 1999 standing at 392 and providing 2873 places. Alongside these developments, support and advice is offered to the carers of persons suffering from mental illness through services such as domiciliary visits and respite care.

The increase in community-based care requires cooperation and good communication between the many different agencies involved in providing medical care, training and rehabilitation, day care, and accommodation. Much of the success and effectiveness of the policy of successive governments to deliver mental health services in a more acceptable manner to communities has been and will continue to be dependent on the active involvement of voluntary organizations such as Schizophrenia Ireland, which offers support to both people with schizophrenia and their carers and relatives. Funding has been made available to support groups and organizations such as Schizophrenia Ireland, the Mental Health Association, GROW and AWARE to heighten awareness and develop services which include carers' support groups. This partnership approach has also extended to the provision of extensive rehabilitation programmes including "Back to Work" programmes for people suffering from mental illness. It is intended to continue to develop this cooperation and to provide a comprehensive range of services to both patients and their families.

Suicide and suicide prevention

Ireland has adopted a coordinated national suicide prevention strategy. This was introduced in 1999, following a detailed examination of the incidence of suicide and attempted suicide. The key components include:

- measures aimed at high-risk groups such as young males in the 15 to 24 years age-group and older people;
- provision of information and training on suicide prevention to relevant professionals and organizations;
- improvement of services for those at risk of suicide or who attempt suicide, as well as examining ways of making the mental health services more accessible to those at risk;
- development of research and suicide prevention programmes.

This strategy has seen close cooperation between the Ministries of Health, Education, Justice, and Environment, complemented by cooperation with the nongovernmental sector. This approach has realized a range of concrete actions and measures to ensure implementation of the suicide prevention strategy.

ISRAEL

The State of Israel, with currently about 6 million inhabitants, was established in 1948, though psychiatric care predates independence. Shortly afterwards, an office at the Ministry of Health was entrusted with the responsibility of developing and coordinating the mental health services for the total population. Currently, the specialized system comprises 22 psychiatric hospitals, 12 psychiatric units in general hospitals, seven private institutions, and a psychiatric ward in a prison. In addition, there are slightly over 60 clinics that provide outpatient care and several dozen rehabilitation facilities. At this stage, most of the psychiatric care in the public sector is free and patients' rights are embodied in special legislation.

The Division of Mental Health Services of the Ministry of Health is supported by two intersectoral advisory boards – one on mental health care and one responsible for psychosocial rehabilitation. Both boards include representatives from users of services and their families. It is noteworthy that the Division includes a special unit responsible for substance abuse that coordinates activities with the National Council against Drug Use.

Since 1950, the Division cumulatively records all psychiatric admissions to inpatient facilities. More recently, the database has included information on most outpatient services. The ratio of psychiatric beds is 1.04 per 1000 of the total population (1998). The rate of inpatient admission has been steady for a number of years, at 0.7 per 1000.

The office of each of the six regional psychiatrists in the country plans and coordinates mental health care activities in that area and is responsible for determining involuntary admissions.

Intersectoral cooperation has been facilitated by the social welfare orientation of the country. Primarily, the Ministry of Health coordinates with the Ministry of Labour and Welfare, the National Insurance Institute, the judicial system, and others. This cooperation operates at both the central and local level; in general, it operates smoothly.

The national mental health policy is guided by community principles and great efforts are being made to expand the network of community-based clinics and rehabilitation facilities. However, it is the inpatient system and the power exerted by the medical superintendents within the system that prevail in regard to budgetary allocations. As of late, the Division has devised a programme of deinstitutionalization that will include 1000 inpatients, which will take full advantage of a recently approved “basket of rehabilitation services”. During the year 1998, 4435 out of the total number of 7339 inpatients had stayed for 12 months or longer – a decrease of 9% compared with the previous year. The rehabilitation facilities include sheltered housing, hostels, vocational rehabilitation units, sheltered workshops, and social clubs. During 1999, there were 1296 residents in sheltered housing, with extra support (376) or without, and 1109 persons resident in hostels, 848 with extra support. These services are being actively expanded. Other areas of community psychiatry (such as the rehabilitation of deviant youth, care for rape victims) are covered by other ministries than health or by NGOs, which may or may not have governmental financial support.

The Division of Mental Health has a curative/rehabilitative emphasis, but several promotional activities are in the planning stage such as the reduction of corporal punishment of children and disaster preparedness. Other ministries have also developed promotional activities, such as the Ministry of Education promoting healthy life skills.

KAZAKHSTAN

Psychiatric services in the Republic of Kazakhstan are provided by 15 psychiatric hospitals, ten psychiatric departments in general hospitals and 20 centres for preventive psychiatry. All in all, 11 305 beds are available for patients with mental disorders. In the central regional hospitals, there are 155 psychiatric outpatient clinics, 35 psychiatric outpatient clinics in polyclinics, and 72 psychiatric emergency clinics. There are also 16 day hospitals, with places for 894 patients and 13 workshops for treatment and social rehabilitation for 1386 patients. There are 830 psychiatrists working in these psychiatric facilities, together with 1300 neurologists, psychologists, and social workers, and 3000 nurses and paramedical personnel. Sixty doctors work in the social protection (preventive) field.

To become a psychiatrist, medical students have to attend courses in medical psychology and psychiatry, as well as continuing their general education and working as a medical intern. Paramedical personnel attend courses at medical colleges.

At both national and local level, there are various combinations of inpatient and outpatient psychiatric services (both state and private), as well as services for the prevention of psychopathology. The education of highly qualified personnel should be achieved over the course of time.

LATVIA

Human rights are the cornerstone on which the psychiatry of this next century will be built. After Latvia regained its independence, the liberalization of psychiatry followed, with deinstitutionalization, decentralization, destigmatization, and humanization. The cardinal change has been in the attitude to patients' rights and they are now free to choose their doctor, have the right to complain about their treatment and about the behaviour of personnel, and they can challenge hospital admission.

Each psychiatric facility in Latvia has been given autonomy as part of the process of decentralization and in the process of deinstitutionalization; the number of beds has decreased from 2.2 to 1.6 per 1000 inhabitants in the region of Riga. Parallel with this decrease in inpatient beds, outpatient care has expanded, as well as support for the patients' personal lives outside hospital.

The decrease in inpatient beds has not meant that whole departments and hospitals were closed instantly, nor were the number of hospital personnel reduced dramatically. Compared with other European countries, Latvia has 2–4 times fewer specialists working in psychiatry. This is true of psychiatrists, social workers, occupational therapists, psychologists, and psychotherapists. Many require additional training or refresher courses in one or more aspects of the subject and much help has been received in this field from the medical colleges of Denmark, Norway and Sweden and in recent years, from Germany and Holland.

Latvia has had high rates of suicide (33–35 per 100 000 inhabitants) in recent years as well as high levels of depression. A programme directed at this problem and incorporating psychotherapeutic support groups has been organized in collaboration with the Soros Foundation. In addition, the World Bank is supporting a project on mental health promotion, including preventive activities.

Education of relatives and patients has taken place within psychotherapeutic support groups established by the psychiatric institutions. TV, radio, and the press have also been involved in providing education for the public on mental health matters through interviews, discussions, and articles about outpatient care, long-term treatment, and the prevention of exacerbations and relapses.

National mental health plans

As an emerging independent democracy, Latvia is currently undergoing a wide range of political, economic, and social reforms. However, a review of the mental health system in Latvia reveals significant ongoing problems. By international standards, the current system is both underfunded and overly reliant on institutional beds. The system remains centred on large underfunded mental hospitals and nursing homes, which nevertheless consume most of the available mental health budget, leaving community care with little. Latvia does have, however, a community-based system of 29 psychiatrists working in 27 districts.

There is a low level of integration of the mental health system into broader health care and frontline family doctors and general practitioners are still reluctant to provide care to the mentally ill. Latvia however, does have a community of well-trained mental health professionals who are committed to the welfare of people with mental illness and since independence, many have received training in psychotherapy and other techniques which were not used before.

Within the policy context approved by the Minister, the leadership of the reform process will be taken by the Mental Health Care Centre of Latvia, which has been established as a central point for coordination and planning and for further organization. Reforming the mental health system in Latvia is a complex process, which is about to enter a new phase and moving forward with mental health reform will require political will, leadership, and a concerted effort. A plan has been prepared which represents a comprehensive set of ideas, values, and concrete strategies for change. As a document for reform, it sets the overall direction and provides a timetable for implementation. The Centre will develop and staff a Steering Committee, which will include senior Ministry representatives, staff from various regions, members of the mental health disciplines, as well as family and consumer representatives. Successful change is possible and should return Latvia to its rightful place as a leader of health care provision in Europe.

The national level still has an important role to play in the provision of highly specialized services. The population base of Latvia is such that in certain cases, only one programme will be needed for the nation. In the case of forensic services, for example, inpatient care requires only one specially equipped and staffed unit. This type of unit is very expensive and a single one would be able to serve all the patients needing this type of care. It has been recommended that the Mental Health Care Centre of Latvia take responsibility for planning and coordinating these specialist services. The Centre may provide them directly, or contract the work to regional psychiatric hospitals.

Multidisciplinary teamwork

The trend, still in its infancy, in psychiatric institutions in Latvia is now towards the establishment of multidisciplinary teamwork, with the team consisting of a nurse, nursing assistant, psychologist, psychiatrist, rehabilitation specialist, and social worker.

The occupational therapists help the patient develop and improve their functioning, gradually increasing the complexity of exercises. The psychologists work with patients using behavioural methods, art therapy and elements of psychological training. In group work, patients acquire the knowledge to deal with communication problems and conflict situations. Rehabilitation specialists lead work in which the patient acquires skills such as drawing, painting, pottery, and flower arranging.

The multidisciplinary teamwork is patient-orientated, helping the clients back into society more quickly and helping them to become normally functioning members. The teams have thus far been established in the following hospitals in Latvia: Riga forensic hospital, Jurmala crisis and neuroses hospital, and Vecpiebalga rehabilitation hospital.

Projects

- A project has been set up on “Creating positive insight and attitudes in society towards depression as a mental illness”. In 12 towns in Latvia, professionals and general practitioners are being instructed in the clinical signs and symptoms of depression, and in the treatment and rehabilitation requirements of depressive patients. The project also includes activities for the public, such as lectures, booklets, and other information. This is supported by the Soros Foundation.
- The Soros Foundation has also supported a project on “Improvement of services dealing with suicide: statistical data, analyses of suicides, organizing support therapy groups, training of professionals and volunteers in working on the crisis support hotline”.

- A project has been set up for “Promotion of destigmatization and changes in attitude toward mental disorder and mental health, especially among young people”.
- A booklet for relatives of mental patients – “Advice on patients’ rights” has been published with the cooperation of the Centre for Latvian Human Rights and Ethnic Studies.
- A national support group network for people with mental disorders and their relatives is being developed.
- Cooperation is occurring between specialists in psychiatry, cardiology, oncology, and infectious diseases in the HIV/AIDS sphere.
- Cooperation is taking place with primary health care doctors in the field of suicide prevention. An objective is to decrease the incidence of suicide by one third, paying special attention to population groups who show relatively high rates.

LITHUANIA

During recent years, much has been achieved in the Republic of Lithuania in the development of mental health services. The joint efforts of professionals, nongovernmental organizations (NGOs), politicians, mass media, and the general public has led to a new level of awareness about the burden of mental disorders on society and effective ways for their prevention. One of the most painful discoveries which stimulated the development of the field was the fact that Lithuania appeared several years ago to have the highest rate of suicide in Europe.

Intersectoral cooperation

Though there have been several attempts to raise the issue of intersectoral cooperation in mental health as being important, this is a most difficult task. One of the new bodies for such cooperation in the field of general health is a National Health Board, which was established by the Lithuanian Parliament in 1997. There are two representatives of mental health among its 15 members. In April 1999, the Board held a special meeting on mental health and issued strong recommendations for the government, ministries, and municipalities to facilitate intersectoral cooperation in this field. However, the response from the ministries responsible for social welfare, education, transport, labour, and finance remains rather vague.

The other way to attempt to strengthen intersectoral cooperation was to establish a Joint Mental Health Commission within the Government. Though the President of Lithuania and the Chairman of Parliament supported this idea, it was met with resistance by other politicians, to some extent by the general public and even by the mass media. Finally however, at the end of 1999, Parliament agreed that the Mental Health Commission should be established, although, at present, there is an ongoing debate about which governmental and non-governmental bodies should send representatives to this committee.

Community-based psychiatry

Under the Mental Health Act, approved by the Seimas (Lithuanian Parliament) in 1995, each municipality has to establish a mental health centre, responsible for the outpatient mental health care of its population. In 1997, the process of development of this network of mental health facilities started. Currently, there are 50 centres throughout the country, and it is estimated that there should be about 100 in the near future. The centres are funded by the national health insurance system, which allocates a certain amount of money for each inhabitant for primary mental health. After active lobbying, the amount of money allocated per inhabitant for municipal mental health rose from US \$0.7 in 1997 to US \$2.8 in 1999. This means that a team of professionals (including adult psychiatrist, child and adolescent psychiatrist, psychiatrist specialized in drug and alcohol abuse, clinical psychologist, social workers, nurses) can be employed. The increasing number of municipal mental health centres are effectively cooperating with local social services, schools, and other services.

National mental health plan

In 1998, the Seimas adopted a national health programme for the years 1998–2000. One of its components is “Mental Health and Suicide”. In 1999, the National Programme for Prevention of Mental Disorders was approved, which has the following main goals:

1. to stabilize the morbidity from mental disorders by the year 2010;
2. to reduce the rate of suicide to 25 per 100 000 by the year 2010;

3. to develop an effective system of rehabilitation and reintegration into society of persons with mental disabilities;
4. to develop a network of municipal mental health centres;
5. to train adult psychiatrists, child and adolescent psychiatrists, psychotherapists, psychologists, social workers, and mental health nurses;
6. to develop programmes for the treatment of the main mental disorders; to improve the level of equipment of mental health facilities;
7. to develop a system of monitoring suicides and mental disorders generally, according to European standards;
8. to develop a system of crisis intervention services and of intersectoral cooperation in the field of mental health by the year 2005;
9. to train professionals representing other medical and nonmedical specialities in the field of mental health;
10. to involve nongovernmental organizations in the network of community-based services.

There are also other goals (18 in total).

Morbidity and mortality figures

According to national statistical data, the prevalence of mental disorders is increasing. However, this impression might also be the effect of better access to mental health services. In 1990, there were 145 688 persons diagnosed with mental disorder (3.9 per 1000 population). In 1997, the corresponding number was 155 490 (4.2 per 1000). The incidence of mental diseases was 130 per 100 000 in 1995, and 132 per 100 000 in 1997. The number of persons with alcoholic psychoses also increased dramatically, rising from 12.3 in 1990 to 36.2 in 1995 and 45.6 per 100 000 population in 1997.

The suicide rate increased from 26.9 per 100 000 in 1990 to 46.8 per 100 000 in 1995 in all age-groups over 15 years. An extremely high increase was observed for men, rising from 47.9 in 1990 to 87.5 per 100 000 in 1994. During the last few years, suicide rates have gradually declined.

Deinstitutionalization

Most people with chronic mental illnesses are resident in centralized psychiatric institutions. The process of deinstitutionalization has started with persons affected by mental retardation. This process was initiated by Viltis, a voluntary organization of parents with mentally retarded family members and was supported by both national and local authorities. There are many new schools and day care centres which are attended by both moderately and severely mentally retarded children and young adults who would have been institutionalized in the former system. Since 1998–1999, there has been an increasing number of projects (supported by the Soros Foundation, state budget programmes, and other sources), directed towards community-based services for mentally ill people. However, one of the obstacles to more rapid deinstitutionalization is the high level of stigma surrounding mental illness.

Multidisciplinary teamwork

There are an increasing number of clinical and training programmes which emphasize multidisciplinary teamwork as a basis for effective practice. The new system of municipal mental health centres is based on the philosophy of such teamwork, but one of the problems is that the psychiatrists do not always accept other mental health professionals as equal partners.

During recent years, many new prevention programmes have been launched, both nationally and regionally. They deal with prevention of suicide, juvenile delinquency, child abuse, violence, and drug and alcohol abuse. In 1999, the State Health Fund was established to support prevention programmes in the field of health. A new concern is how to develop a system of evaluation of the effectiveness of these programmes.

Areas of greatest concern:

1. The reform is taking place from the top, without scientific analysis of mental health needs and without monitoring changes
2. Psychosocial rehabilitation and social psychiatry remain under-funded, and there is still no alternative to large segregated institutions for chronically mentally ill people
3. No consensus has been achieved on the national strategy for prevention of suicides.

Areas of greatest progress:

1. There is a growing number of NGOs in the field of mental health.
2. There is growing awareness among politicians and the general public that public mental health is an extremely important issue and that it is a much broader concept than clinical psychiatry.
3. There are new initiatives (such as “consensus” projects) which facilitate cooperation between different participants in the mental health field (governmental structures, NGOs, universities, mass media, different professional groups, biologically vs. psychologically orientated psychiatrists, etc).

LUXEMBOURG

The Grand-Duchy of Luxembourg with its 430 000 inhabitants is the smallest member state of the European Union. The proportion of foreigners amounts to 35% of the resident population. Except for the capital, Luxembourg-City, the country has a mostly rural character. Traffic links and public transport are both good so that almost every place in the country can be reached within a maximum of one hour by car or public transport. Luxembourg's standard of living is one of the highest in Europe and the unemployment rate (3.1%) is very low.

At the end of the 1980s, the authorities became conscious that there was an urgent need to modernize health care. The Ministry of Health appointed the Central Institute for Mental Health of Mannheim (Germany) to examine the situation in Luxembourg and recommend alternative models of psychiatric care. Information about the current state of psychiatric care was obtained by research using documents, interviews, and a questionnaire distributed among all facilities and services participating in psychiatric care from April to October 1991.

The research resulted in the publication in 1993 of a report, *Mental Health Care in Luxembourg, Current State and Recommendations for Future Development*. The recommendations in this document referred to results of international research and evaluation studies on psychiatric care, as well as to reliably reported experience in different European countries. Having full regard to the needs of psychiatric patients, this part of the study was submitted to a group of WHO experts, who gave an international dimension to the work. This helped the local decision-makers to propose optimal solutions, regardless of the pressure from local interest groups. These proposals were designed in collaboration with the national health authorities to serve as guidelines for the future development of psychiatric care in Luxembourg. Following this, the Minister of Health nominated a large representative panel of concerned professionals, institutions, and NGOs, to discuss the implementation of the recommendations. After discussions that were often difficult but always constructive, in six different subgroups over nearly one year, the panel agreed on a final document. This described the principles, guidelines, and priorities, as well as proposing a timetable for the implementation of the recommendations, depending on the available financial resources.

To be able to counteract either open or veiled animosity towards the approach of psychiatric community care, it was necessary to know the factors influencing public opinion. Therefore, a study financed by the Ministry of Health determined the population's attitude towards the country's mental health care. Only then was the final document published and explained to the whole population by press conferences and a media campaign under the title: *What kind of psychiatric care for the year 2000?* Another view on illness was published as, *Together let's overcome taboos*. This was a success, and the reform process received general acceptance and support.

During the 1990s, steady progress was made and to date, seven different information, consultation, and day-centres offer various aspects of community mental health care. More than 100 sheltered living places are available in small units in the main areas. These units have from one to six places each, the total representing one per 4000 inhabitants. Around 100 sheltered work places are available, including a new workshop opened in 2000. During the 1990s, the staff working in community psychiatric care increased tenfold. The estimated needs to be reached in 2004 are 0.3 sheltered living places per 1000 population and 0.25 sheltered work places per 1000 population.

Parallel to these developments, there was increasing deinstitutionalization. The large, single psychiatric hospital established under a law of 1975, with a capacity of 1200 beds, was under state control up to 1999. However, a new law of 1999 made it a more liberal entity, but even before this, numbers of beds had been reduced to 860 in 1990, 475 in 1995, and 360 by the end of 1999. A target of 180 inpatients by 2006 has been set, through the creation of psychiatric units in four general regional hospitals. A limit of a total of 360 beds is then to be maintained for the whole country. However, because of a political change, after elections in 1999, the organization of treatment places in hospitals has been postponed for one year.

The suicide rate for 1997 was 22 per 100 000 population. Of the various categories of mentally ill people, only suicides are registered by age. Cases of heroin addiction are recorded as five per 1000 inhabitants.

Thanks to a good epidemiological system, prevention activities at intersectoral and multidisciplinary levels have achieved some helpful results. The Health Promotion Services of the Ministry of Health have programmes to prevent drug dependence, alcoholism, and suicide.

Different ministries (Family, Social Security, Youth, Education) in collaboration between themselves and the local authorities, have developed a support network for both young people and adults suffering from, or in danger of, developing mental health problems. It is possible to find consultation and follow-up in schools or other areas of society, free of charge and easy to access. If not directly provided by a state agency, this service depends on NGOs but is controlled and financed by public authorities. This service exists alongside the more conventional health services, which function through health insurance.

NETHERLANDS

Every year, five billion guilders are spent on mental health care in Holland – 3.5 billion on inpatient or residential care and 1.5 billion on semi-residential and outpatient care. In any one year, around 5% of the people in the Netherlands are treated, counselled, or cared for by the mental health care sector; 45 000 professionals work in that sector (full-time equivalents), a relatively small number being in private practice. The majority work in general or specialist psychiatric hospitals, psychiatric departments of general hospitals, regional institutions for sheltered living, regional institutes for outpatient mental health care, or in collaborative arrangements between these institutions.

Matters of concern

Dutch mental health care is facing three major challenges:

- Epidemiological research and the statistics on trends in the use of care services point towards a steep rise in demand, particularly for outpatient care. The mental health care sector must respond to this appropriately.
- The nature of the demand for care is changing: many people with chronic psychiatric problems want to be given the opportunity to remain part of the community. This means the further transformation of residential care into outpatient care.
- The mental health care sector has to establish a much more explicit presence with regard to a number of social problems. Examples include incapacity for work as a result of mental problems, the problems surrounding the “neglected” and “degenerate”, as well as the mental health problems of prisons, abuse, loneliness, and poor living conditions.

Progress

To enable the mental health care sector to tackle these challenges, the Dutch Government is working with the sector, to turn it into an efficient, effective, and open-care operation. The government has developed a policy (National Mental Health Plan) to create a mental health care sector that has the following characteristics:

- The care provided is demand-driven, tailored to the care needs of the individual client and his or her specific social or cultural characteristics. It comes about through consultation with the client, is easily accessible, and consists of both medical and psychiatric treatment and social assistance.
- The provision of care is organized effectively in accordance with a clear profile at three levels from “light and general” to “heavy and specialized”:
 - (a) Disorders that can be treated in the short term and by general means are dealt with in the locally organized first echelon of mental health care by the general practitioner, the health care psychologist, and the social worker.
 - (b) Disorders that are beyond the capacities of the first echelon are referred to the regionally organized specialist mental health care centres, which are preferably located in or near the general hospital. These regional centres offer a complete range of facilities (prevention, diagnosis, crisis care, outpatient and short-term inpatient treatment, resocialization, and sheltered accommodation).
 - (c) Lastly, super-specialist help is provided at the supra-regional/national level in the university hospitals and in a number of designated mental health care institutions.

- There is a logically configured professional structure in which each professional group has a clear profile of activity.
- The mental health care providers use methods, laid out in protocols, that have been scientifically validated and are based on clients' experiences. There is a clear structure for prioritizing and coordinating research, and for the dissemination of scientific knowledge.
- The activities of the mental health care providers are transparent in the organization of the provision of care, so that both those providing the funding and the clients are in a position to form a judgement about the effectiveness and quality of the care service.
- The social services work closely with the specialist mental health care sector.

Intersectoral cooperation

As a result of the moves towards care in the community and the changing wishes of patients, the mental health care sector, the other care sectors, social organizations, and local authorities are increasingly becoming involved with and reliant on one another in the areas of housing, jobs, education, and participation. The mental health care sector itself cannot provide an integrated service in all areas of life – nor should it attempt to do so.

Former psychiatric patients and addicts can call upon a wide range of social provision: the regular care sector, social pensions, sheltered accommodation facilities, crisis centres, specialist women's refuges, service centres, etc. The local authorities in which these centres are located receive specific funding from central government for these facilities. These local authorities are asked to compile a regional policy plan setting out the way in which they and other players arrive at a coherent system of support in the shape of prevention, board and lodging, and care for the vulnerable groups that need support in the region. The social services work closely with the specialist mental health care sector. This cooperation is encouraged at the national level.

Community-based psychiatry and deinstitutionalization

The further development of community-based psychiatry is one of the great challenges for Dutch mental health care. The nature of the demand for care is changing and many people with chronic psychiatric problems want to be given the opportunity to remain in the community. Therefore, mental health care institutions are less likely to admit patients and they are cutting the length of admissions. For the mental health sector, this means the further transformation of residential care into outpatient care, without this leading to the impoverishment of the lives of psychiatric patients or to high burdens on families, neighbourhoods, the police, or the legal system.

As a result of these developments, the burden of the care required by clients who are admitted is increasing. This can be seen from, among other things, an increase in the number of compulsory admissions.

National mental health plan

In 1999, the Dutch government issued an integral policy document on mental health care. This document is available in English; it describes the ideal mental health care sector and how to reach (or to come close to) that ideal. Its principles include: demand-driven care which is effective and transparent; deinstitutionalization; further development of the locally organized first echelon of mental health care; a logically configured professional structure; use of methods that have been scientifically validated; and coherent and integrated services

for patients in which mental health care providers work closely with other care sectors, social sectors and local authorities.

Mental health legislation

The specialist mental health care sector, like the care for the handicapped and (in part) the nursing and care sector, is managed on the basis of three related pieces of legislation: The Exceptional Medical Expenses Act (entitlements/accreditation); *The Hospital Provision Act* (planning and building); and The Health Care Charges Act (charges).

During the past few years, several Acts have come into being to strengthen the position of clients in health care, such as: the Medical Treatment Contract Act, which stipulates that a care plan must be drawn up with the consent of the patient; the Client's Right of Complaint Act; the individual Health Care Professional Act, which regulates the duties and responsibilities of care providers; and the Psychiatric Hospitals Act, which protects patients' rights in cases of committal and compulsory treatment

The Psychiatric Hospitals Act has recently been evaluated. Input from patients and family organizations has helped to identify a number of problem areas relating to the limited options for the compulsory treatment of patients who have no insight into their illness, as well as patients' need for more opportunities for autonomy by means of self-binding undertakings. It has become evident however, that there is also a need for compulsory outpatient treatment. It is planned therefore, that the Psychiatric Hospitals Act will be changed in the coming years.

Morbidity figures

In the Netherlands, 41% of all people between 18–65 have suffered from a mental disorder once or several times. For 23%, this has been in the past year. Major mental health problems are alcohol-related problems, major depressive disorders and anxiety disorders.

Lifetime prevalence of mental disorders (as percentage of adults):

Depression	19%
Anxiety disorders	19%
Alcohol use or dependence	17%
Drug use or drug dependence	3.0%
Eating disorders	0.7%
Schizophrenia	0.4%

Mental health promotion

Prevention, early detection and identification, and public mental health policy (including management of addiction) are important preconditions for containing the growing demand for care. According to the Dutch government, the mental health sector has to adopt a much more specific stance in this area. The government has set up a broadly-based committee to advise on an active public mental health policy which will report at the end of the year 2001.

NORWAY

Norway shares borders with Sweden, Finland and the Russia Federation, and has a very long coastline with deep fjords. Its 4.4 million inhabitants share a total land area of 386 958 square kilometres (14 persons per sq km). Large parts of the country cannot be cultivated or permanently inhabited because of mountains and glaciers. It has been a matter of national policy to maintain a decentralized settlement pattern in the country. This is an important fact to remember if one is going to understand the Norwegian Government's policy on decentralized health services for the public. 16% of the population however, lives in and around Oslo.

Norway is a modern democracy where the welfare of the individual has been regarded as a responsibility of the society as a whole. Thus the health and social services in Norway are closely attached to the welfare state. Norway has traditionally endorsed the principle of equal rights to satisfactory health services. The overall goal is therefore to secure for everyone a good and equal opportunity for medical treatment and other health and nursing services, regardless of place of residence, income, gender or social background. Current health priorities are concerned with improving and further developing primary health care services, mental health services, cancer treatment and services for the elderly.

The mental health situation

Mental health is one of the most crucial health issues in our society. Mental health problems undermine wellbeing and cause severe suffering at personal, family and society levels. They are a leading cause of disability leading to heavy costs for society. During the last decade, there has therefore been an increasing focus in Norway on issues concerning mental illness and care. There has been a growing political awareness and an increasing political will and commitment with regard to the need for improving mental health services. This has led to the development of national health policies and action plans.

The national mental health programme

A White Paper dealing with mental health issues was published in 1996/1997. In 1998 the Norwegian Parliament decided to launch a national mental health reform programme for the period 1999 to 2006. This sets out a nationwide strategy for the development and improvement of the health and social services and for the treatment given to patients who suffer from mental disorders.

The Norwegian Mental Health Programme is comprehensive, covering all the different settings and links in the service. It refers (amongst other things) to primary health care, specialized health services, the educational system, social services, employment, etc. This major reform in the field of mental health has required extensive grants and subsidies to the public health sector from the Government, which has set aside a total of 24 billion Norwegian crowns to achieve this goal. The eventual aim is to have community-based psychiatry with local outpatient psychiatric clinics in close contact with primary health care and with psychiatric hospitals. These hospitals have differentiated wards (acute, long-term, psychogeriatric, etc).

The mental health programme aims at improving the availability, quality and organization of mental health services and treatment at all levels of the service. One way of achieving this is to be more focused on certain issues, such as:

- Promoting deinstitutionalization, with greater emphasis on community-based psychiatry, where the treatment is given closer to the patient's normal environment and primary health services. Around the country, district psychiatric centres are being established (community-based out-patient clinics). This community psychiatry model represents a form of all-round psychiatric practice and consists of a network of services, which offer continuing treatment, accommodation, occupation and social support which together helps those with mental illness keep or achieve an acceptable and suitable social role.
- Developing smoother collaboration and cooperation between primary health care and specialized health services.
- Stimulating educational programmes about mental illness in primary care, directed at GPs/family doctors.
- Improving collaboration between different specialized health services and medical disciplines.
- Producing and disseminating relevant and up-dated (evidence-based) literature and publications concerning diagnosis and treatment regarding major psychiatric disorders. During the year 2000, the Norwegian National Board of Health published four guidelines dealing with anxiety disorders, mood disorders, eating disorders and schizophrenia.
- Producing strategies that aim at improving the organization and effectiveness of services given to patients.
- Improving training and increasing the number of mental health professionals – recruiting them to decentralized areas.
- Developing specific mental health programmes and projects that will be evaluated and eventually implemented to address major disorders, such as suicide, eating disorders, schizophrenia, as well as especially vulnerable groups, including the mentally handicapped with severe psychiatric symptoms, children and adolescents, refugees and traumatized groups.
- Promoting multidisciplinary teamwork. Mental health is a complex phenomenon which is determined by multiple social, environmental, biological and psychological factors demanding a broad and multidisciplinary approach.
- Stimulating counties and municipalities in developing mental health plans made according to the needs of community and population.

Health legislation

In July 1999 the Norwegian Parliament passed four new acts concerning different aspects of health: the Specialized Health Services Act; the Mental Health Act; the Patients' Rights Act; and the Health Personnel Act. These new health acts with their additional regulations came into force on 1 January 2001. The four acts interact and complement each other; hence they may be regarded as an overall health act "package". Psychiatry, as a specialized health service, is regulated together with other specialized medical disciplines in the Specialized Health Services Act. However, the part of psychiatry that deals with compulsory treatment is regulated in the Mental Health Act.

Matters of concern

One of the main intentions of the ongoing mental health reform and the new health act package is to enhance and promote coordination and cooperation between specialized health services and primary health and social services. The objective is to prevent incoherent and inconsistent services being given to patients with long-term needs, in addition to improving the quality of the services. This is one of the main goals for the Norwegian Government and the national health authorities over the next few years.

POLAND

Over 920 000 people (over 2% of the whole population) are treated annually in psychiatric outpatient facilities (including substance abuse facilities). Over 160 000 patients are hospitalized in a year.

The numbers of those admitted to hospital on account of a psychosis was 63 per 100 000 population. Over the years 1990–1996, the numbers with non-psychotic disorders in outpatient care increased by 45% (from 275 per 100 000 population in 1990 to 395 in 1998), whilst those with alcohol-related disorders increased by 25% (from 90 to 115 per 100 000 population) and with drug-related disorders by 100% (3.5 to 7.6). While the number of those with non-psychotic disorders in inpatient care did not change in the years 1990–1996, the numbers of new cases of alcohol- and drug-related disorders rose (by 42 and 117%, respectively). The estimated level of alcohol consumption increased in the 1990s by about 40–50%, but was declining again towards the end of that decade. The actual number of people in the country with alcohol dependence is estimated to range between 700 000 and one million. The number of those dependent on drugs in 1996–1998 was estimated to be between 25 000 and 45 000.

There is a relatively low suicide rate in Poland – 14.2 per 100 000 population in the years 1994–1996, but there has been an alarming 50% increase in the number of suicides committed by children and adolescents in the 9–19 age-range. Suicides among teenagers, however, constitute less than 10% of all suicides and they do not affect overall trends.

Mental health legislation

The following legal acts regulate mental health issues:

- The Mental Health Act adopted with amendments by the Polish Parliament in 1994. It provides legal protection to persons with mental disorder and defines legal principles concerning the relations between patients and staff.
- The Act on Upbringing in Sobriety and Counteracting Alcoholism of 1982.
- The Act on Counteracting Drug Abuse of 1997.
- The Act on Social Assistance of 1990, with subsequent changes.
- The Act on Vocational and Social Rehabilitation and Employment of the Disabled of 1997.

Medical faculties exist in 11 universities in Poland. After six years of medical studies and 18 months' internship, trainee specialists have a five-year programme with an additional two years for child and adolescent psychiatry. In 1998, there were 2480 psychiatrists, equivalent to 0.064 per thousand general population. There are also 1483 psychologists working in the psychiatric services, mainly engaged in psychotherapy or psychosocial and rehabilitation programmes. In 1998, 7326 registered nurses were employed in psychiatric inpatient services. The number of psychiatric beds in 1998 was 30 455, with 155 189 admissions during the year. Of all psychiatric beds, 80% were still in mental hospitals; people addicted to alcohol account for 30% of patients in psychiatric wards and hospitals.

Intersectoral cooperation

For decades, mental health problems had been dealt with by psychiatric care services only, but recently, other sectors have become involved. According to the first National Programme of Mental Health, three types of facilities should provide care to persons with mental disorders. These are primary care facilities and other non-psychiatric services; psychiatric and alcohol or drug treatment services; and a network of nursing homes controlled by the Ministry of Labour and Social Policy.

About 2000 clinical psychologists, 450 social workers (only a few with a university degree), and almost 800 therapists are working in psychiatric units.

According to the Mental Health Act of 1994, the Minister of Health and Social Welfare is responsible for the organization of responsibilities for the whole psychiatric care system, but the question of mental health is considered an intersectoral one, and many ministries are collaborating in the organization of the various services needed by those with mental health problems. According to the Mental Health Act, the local authorities should establish and operate mental health care facilities, as well as organise services and nursing homes to provide for the specific needs of mentally disordered persons. Coordinating teams have been created at the level of the county, consisting of representatives of those services providing health care to the mentally disordered. The team acts also as an advisory body in matters of social policy concerning mental health issues and the needs of psychiatric care (including the allocation of financial resources).

A voluntary Coalition for Mental Health was set up in 1993 as a national organization including many self-help and related associations and groups.

Deinstitutionalization

Deinstitutionalization of the psychiatric care system is needed if mentally disordered people are to obtain comprehensive, accessible health care and other forms of help, which are necessary to their living in the community. The process of transformation of psychiatric care started in the mid 1970s, but was rather slow and inconsistent. Average total bed occupancy fell from 39 000 in 1970 to 25 000 in 1996. The counselling system, which is the strong point of Polish psychiatric care, emerged some years before the dismantling of large psychiatric hospitals began. Until 1995, the number of beds in the psychiatric wards of general hospitals increased moderately, at the expense of beds in large psychiatric institutions.

The main forms of psychiatric care and delivery of alcohol or drug abuse treatment are outpatient clinics and various forms of intermediate care – day hospitals, mobile community teams, crisis intervention centres and rehabilitation facilities. In 1998, there were 603 outpatient mental health clinics, 419 outpatient alcohol treatment facilities and 34 outpatient clinics for those dependent on drugs.

For intermediate care, in 1998 there were 112 day centres (56 in 1985 and 100 in 1995), with a total of 2464 places. This form of care was provided to 8691 patients. The number of day clinics is expected to increase to 430 by the year 2005. Though the network of outpatient clinics is quite well developed, only 71 per cent had a full-time psychiatrist and were open every day.

Community-based psychiatry

The first community-based teams were set up in the 1970s, but the lack of financial resources for training professionals was the main reason for the slow progress in this field. The situation changed rapidly in 1995, when psychiatrists from Holland offered technical assistance to Polish community-based psychiatry. Mobile community teams were first organized in six centres and are now functioning in 19 centres. In 1999, they provided treatment to 2262 patients (i.e. to 17% more than in 1997). Teams work mostly in large cities, but recently more attention has been focused on the population in the countryside. It is expected that 141 mobile community teams will have been established by the year 2005.

Alcoholism

A special network of both inpatient and outpatient facilities was created to deal with the social problem of alcoholism, which has many serious medical consequences. In 1997, there were 425 of these outpatient clinics. The Alcoholics Anonymous movement is also very active throughout the country. There are also about 33 specialist outpatient clinics for treating drug addiction.

National mental health programme

The national mental health plans were defined in the National Mental Health Programme of 1992, which was revised in 1999 and is expected to be adopted by the Polish government in the very near future. The main goal of the programme is to provide the mentally disordered with comprehensive, accessible health care and other forms of help necessary to their living in the community. It implies a need for deinstitutionalization.

To attain this goal, the following activities are planned.

- The main form of psychiatric care will be outpatient facilities, with greater involvement of general practitioners, social services, case managers, and multidisciplinary therapeutic teams.
- Intermediate care facilities are to be developed in the local communities, including day hospitals, mobile community teams, emergency services, rehabilitation facilities and sheltered housing.
- Hospital care is to be provided mostly in psychiatric wards of general hospitals. Large psychiatric hospitals are to be dismantled or transformed for some other purpose.
- The number of psychiatric beds is to decline by about 20%, i.e. to the level of 0.53 per thousand population by the year 2005. The number of beds per hospital is to be reduced to no more than 350.
- Communal coordinating teams should be created at the level of county areas, consisting of representatives of services providing health care to the mentally disordered. The team should also serve as an advisory body in matters of social policy concerning mental health issues and the needs of psychiatric care (including allotment of financial resources).
- The quality of care in psychiatric facilities will be improved by introducing a system of quality monitoring. In addition, a programme of postgraduate training for general practitioners is now under development and an internship in psychiatry for medical school graduates was introduced from the beginning of 2000.

The following activities for mental health promotion are also being planned, depending on the availability of resources:

- to develop in the community the knowledge and skills needed for an individual's growth and self-actualization, successful coping with stress and environmental demands, and gaining better mental health;
- to shape mental health-promoting behaviour and lifestyles, including prevention of alcohol and other psychoactive substance abuse;
- to include the issues of mental health promotion and prevention of mental disorders in school curricula;
- to develop and implement programmes aimed at the prevention of mental disorders in high-risk groups, such as the disabled, unemployed, the homeless or those with a pathological family background;
- to organize various forms of service delivery in crisis situations (crisis intervention centres, emergency telephone services, consultation units, self-help groups) to prevent suicidal behaviour or forms of emotional crisis related to the negative effects of economic change, such as unemployment, early retirement, agricultural reorganization;
- to implement programmes of cooperation within the local communities on mental disorders, mental health promotion, and prevention of substance abuse.

The three greatest priorities of the national mental health programme are:

- deinstitutionalization and improvement of the quality of care;
- development of community-based psychiatry;
- mental health promotion.

In 1999, considerable changes were introduced both in the structure of local government and in the financing of the public health care system. These are likely to have far-reaching effects, and at present, it does not seem that their effect on mental health services will be entirely positive.

PORTUGAL

In 1996, the Portuguese government approved a National Plan for Mental Health. The main objectives of this Plan were:

- elaboration of new mental health legislation;
- development of the national network of local mental health services;
- gradual replacement of psychiatric hospitals by community-based services and by psychiatric departments in general hospitals;
- development of psychosocial rehabilitation.

In 1998, a new Mental Health Law was ratified. This law has three parts concerned with:

- the rights of people with mental health problems;
- the organization of mental health services;
- the compulsory treatment of psychiatric patients.

At the same time, other legislation regarding the collaboration of the health sector with social services and NGOs in the development of psychosocial rehabilitation programmes was also approved. More recently, the National Council of Mental Health was created, and similar Regional Councils are expected to be created in the near future. According to the new legislation, “Local Mental Health Services” are the basis of specialized mental health care. Each of these services is responsible for a population of about 250 000 people. It must include multi-disciplinary teams working in the community (collaborating with primary care), rehabilitation facilities (day centres, residential units, etc.), inpatient units in general hospitals, and a team for child psychiatry.

The planning of local services depends now on Regional Health Administrations, which have a Mental Health Coordinating Group. In the last three years, important advances have taken place in the development of local services, which have been replacing psychiatric hospitals. In connection with the reorganization of psychiatric hospitals, some work is being done in the area of rehabilitation and deinstitutionalization of long-term patients, as well as in the reallocation of resources to community services.

Child psychiatry services were concentrated in the three largest cities, but now units are being created at the local level. In some cases, the integration is with paediatric departments.

A national mental health information system had been implemented at the end of the 1980s. During the past year, this system has been reorganized and integrated with the general health information system.

After the new legislation was approved, several psychosocial rehabilitation projects (vocational training, employment support, day centres, and residential support) were initiated, through cooperation between health services, social services, and NGOs. These projects are the best example in Portugal of intersectoral cooperation at the national and regional levels. Other examples are the collaboration of the health and justice sectors (mental health care in prisons, compulsory treatment of psychiatric patients) and the collaboration of health and education services (alcohol and drug abuse prevention projects).

Up until now, there have been no reliable data on psychiatric morbidity in Portugal. For this reason, the Ministry of Health has promoted a large survey in the region of Lisbon (which will be replicated in the other regions of the country).

The number of beds in psychiatric hospitals has been decreasing in a significant way in the last ten years: in some hospitals, there has been a decrease of more than 40%. However, the continuation of this process demands careful planning, as well as the resources needed to develop rehabilitation programmes and create several types of residential facilities in the community.

Prevention and health promotion activities have been significant in Portugal up to now, except in the fields of alcohol and drug addiction. However, some activities of this kind have been promoted, mainly by the Portuguese Mental Health Association and other NGOs. These include actions aiming at the enhancement of the value of mental health and programmes of suicide prevention.

Currently, the main matters of concern are: stigmatization of the mentally ill, lack of motivation of professionals to work in community settings and difficulties in funding and managing deinstitutionalization programmes.

The main progress of recent years can be seen in the following areas: creation of new mental health legislation; development of the cooperation between the health sector, social services, and NGOs in psychosocial rehabilitation projects; and the growing participation of users and relatives in the discussion of mental health problems.

REPUBLIC of MOLDOVA

Moldova has a population of 4.3 million people. It borders on both Romania and Ukraine, and covers 33.7 thousand sq. km. The population density is 128 per square kilometre. The ethnic composition of the population is: 64.5% Moldavians; 13.8% Ukrainians; 13% Russians; and 8.7% others including Bulgarians, Jews, Germans.

The proportion of gross national product devoted to health is 3%. Both outpatient and inpatient treatment of mentally ill patients is free. Mental health services are financed from both government and local authority budgets. In Moldova there are five psychiatric hospitals, and four psychiatric departments within municipal and central district hospitals, providing 3985 psychiatric beds, which amounts to 0.93 beds per 1000 people. The provision of psychiatrists is 0.6 per 10 000 people. Two psycho-neurological clinics and three departments within general clinics provide outpatient psychiatric care. The number of repeat admissions to psychiatric facilities has decreased and mortality amongst inpatients has also decreased over recent years. The number of places in day hospitals is increasing.

Urgent psychiatric help is provided by five emergency psychiatric teams as well as at the centres for medical care in districts. First-line help is given in villages and districts, at feldsher (medical assistant) and midwives' posts in rural medical outpatient sectors, or in psychiatric units in district polyclinics. The average number of people living in a given sector is 50 000. At this peripheral level, the aims are to provide: identification of individuals with psychiatric disturbance; emergency psychiatric attention (urgent admission or control of disturbed behaviour by outpatient treatment); mechanisms for onward referral where necessary, with improvement of documentation for this.

The next level of help is provided through outpatient consultation in towns by psychiatrists or psycho-neurologists. These provide high-quality help in psycho-neurological dispensary polyclinics or psychiatric hospitals. Planned measures for providing psychiatric help at this level include more flexible forms of care, such as partial hospitalization, depending on the needs of particular patients.

In 1998, a programme to improve the psychiatric services was adopted giving emphasis to the rights and interests of persons suffering from mental disorders and codifying the criteria applied in compulsory admission. In that same year, the law, *Concerning psychiatric assistance and guarantees of the citizen's rights* was adopted.

Since the beginning of 1999, the project: *Developing humane mental health care in Moldova through professional training for psychiatric nurses and doctors in multidisciplinary teamwork* has been in the process of implementation, supported by the Geneva Initiative in Psychiatry.

The suicide rate in the last five years has been 25 per 100 000 population, with most occurring among persons aged 40–59. For those aged 60–64, the rate decreases a little, but it increases again among those aged 65–70. There is little difference between urban and rural populations. Married people commit suicide less often than the unmarried, widowed, and divorced.

During the last ten years, the number of psychiatric patients who have been recognized as disabled has increased. The main reason for this increase is the limited range of opportunities to employ them, because of the lack of special workshops and the insufficient number of work places in them. Another reason is the increased mechanization of agriculture. In the last five years, the number of inpatient admissions, including cases of schizophrenia, has fallen by 3.8%, due to the socioeconomic crisis in the country. The prevalence of mental retardation has remained at the same level during the last five years and the number recorded with non-psychotic disorders decreased.

ROMANIA

Mental health care

Mental health care in Romania is concentrated in the psychiatric hospitals and wards although the number of psychiatric beds is not high (76.1 beds per 100 000 habitants). The total number of beds is 16 895, with 13 374 in mental hospitals, 3521 in general hospitals, 605 in other settings. Psychiatric beds represent 11% of all hospital beds in Romania. There are 861 adult psychiatrists and 240 child psychiatrists.

Some of the care outside the hospitals is provided by “Mental Health Laboratories”, which are organized on an autonomous basis or within polyclinics. These should be centres for community care, but in reality, they are not, with probably only 10% of these “laboratories” having an activity approaching this. Many consist simply of a psychiatrist, with no therapeutic team, providing basic outpatient care. Some therapeutic units do have nurses (who do not have a specific training) and psychologists working with the psychiatrists. Social workers are a rarity, however, and the number of nurses and psychologists is insufficient. A few units have work therapists, but these are insufficiently qualified.

The lack of funds and any financial priority at the national level has resulted in very little being done towards the improvement of psychiatry. While some hospitals do offer care according to international standards, many units fall below the minimal acceptable level. In particular the high-security hospitals offer care conditions that are below standard, most of them being “asylums” with few having proper rehabilitation facilities. Many of the hospitals are overcrowded and some of them are also oversized (800–1200 beds). Overall there is a lack of patient activity, high admission and re-admission rates and treatment almost exclusively based on pharmacotherapy.

The uneven territorial distribution of services causes problems. Some of the hospitals are overcrowded because of the absence of community units, such as halfway houses or other post-treatment units, which are meant to ease the passage from hospital care to the patient’s independent existence in the community. Within the country as a whole, however, the bed utilization for psychiatry is below the country average, leading to the false idea that the mental health services do not need more resources.

Ideology of the care process

Mental health is not officially considered a priority matter of public health. There is a tendency (frequently undeclared) to stigmatize psychiatric patients and unfortunately the mass media sustain this.

The principles of community psychiatry (which include putting the patient as the therapist’s partner) are only put into practice in isolated cases. Paternalism is prevalent; but it must be admitted that in the last 5–6 years, there has been increasing acceptance and respect for both the patient’s rights and psychiatric ethics. The international documents that set out patient’s rights have not yet been officially included in any normative documents in Romania.

The following are a list of shortcomings which need to be addressed:

- lack of up-to-date comprehensive studies on morbidity or studies evaluating population needs within a definite area or with certain risk factors;
- lack of (or only a rudimentary level of) multidisciplinary teams for outpatients, due to the reduced number (or even the absence) of persons and/or necessary positions (psychologists, social workers, vocational therapists, legal advisors);

- the development of social protection and non-medical ways of helping some categories of mentally ill patients and some populations with a high risk for mental illness;
- there are insufficient day centres and counselling services (of various types);
- there is a lack of effective coordination of the care services at the national level;
- postgraduate specialist training is still based on an excessively biological and reductionism model, which seems to promote pharmacotherapy as the only really effective and credible therapeutic approach. Continuing education is inadequate;
- the liaison psychiatry, forensic psychiatry, community psychiatry and psychotherapy are not officially recognized;
- the general practitioners and other specialists lack basic psychiatric knowledge and have little capacity to provide psychiatric help or make referrals to psychiatrists.

Mental health needs

Priorities should include:

- The elaboration and implementation of a **Mental Health Law**. [In December 1999, a Project of the Law concerning the promotion of mental health and the protection of rights of the persons suffering of mental disorders was elaborated by a work group consisting of representatives of the Romanian Psychiatric Association and Romanian League for Mental Health, with consultant help from WHO Geneva and WHO Romania.]
- This Law stipulates the elaboration of the **National Plan of Mental Health** which will include the necessary elements for the planning and implementation of the mental health reform in Romania.
- The National Plan of Mental Health will be based on an analysis of a **mental health assessment** (morbidity and mortality figures) in Romania and will include items such as, prevention, deinstitutionalization, community care, multidisciplinary teamwork, training and intersectoral cooperation.

Mental health promotion

In Romania, it can be said that mental health services are hospital centred; there is unsatisfactory communication between inpatient and outpatient services; there is no coordination between primary care and mental health services; and there is no regular programme to train primary care professionals in mental health. In addition, there are few activities for mental health promotion and people are not educated about mental health issues, hold strong negative prejudices against persons with mental disorders and avoid using mental health services.

Romania does not have yet an official mental health policy. A national mental health programme has been formulated, but is still largely ineffective. The budget for mental health is around US\$ 450 000 (only 3% of the total budget for health). The Romanian League for Mental Health, the first and until now the strongest organization involved in mental health promotion, has developed a long term programme for changing attitudes and carrying out successful projects that could become models of practice.

Equity and human rights

Although many mental health professionals still have a paternalistic attitude toward the persons with mental disorders, they generally observe the rights of these persons. More information and training on this topic is needed, however, especially for psychiatric nurses.

The main problem is that beyond the circle of mental health professionals these rights are largely ignored or denied. Up to now there has been no official policy or campaign to challenge the strong prejudices against persons with mental health problems. The existence of a favourable opinion among Romanian psychiatrists regarding the necessity for mental health reform however, should be noted.

A group constituted by some active members of the Romanian League for Mental Health and of the Romanian Psychiatric Association has elaborated a project entitled “The Law Regarding the Promotion of Mental Health and Protection of the Persons Affected by Mental Disorders”. This project was forwarded to the Ministry of Health in December 1999.

Mental health audit

A mental health audit took place in Romania recently, organized by the WHO Regional Office for Europe together with the Romanian Ministry of Health, WHO Liaison Office for Romania and Romanian League for Mental Health. The audit was an exceptional event and has led to the formulation of further objectives. An analysis of their work has led to the following proposals being made

- Elaboration of a National Plan for Mental Health, with short-, medium- and long-term objectives.
- Promoting a law concerning the promotion of mental health and the protection of the persons with mental disorders, aligned with European legislation and in conformity with the Resolution 46/119 from December 1991 of the General Assembly of the United Nations (a project has already been deposited at the Parliament).
- Emphasizing the need for a nationally coordinated epidemiological research plan for gathering reliable data on psychiatric morbidity;
- Identifying new ways of collaboration between Ministry of Health and NGOs (most of the progress in promoting mental health has been made by the activity of the NGOs, seldom supported by governmental action).
- Promoting and supporting local initiatives in prevention and therapy, adapted to specific needs of the population.
- Community support for the persons with mental disorder and for their families.

These objectives cannot be realized unless a national structure for mental health is established. This structure (which could be a National Institute for Mental Health) would collaborate closely with the Ministry of Health for the coordination of the mental health policy.

RUSSIAN FEDERATION

Current resources of psychiatric services

The Russian Ministry of Health has 278 mental hospitals, with 183 474 beds; 164 psycho-neurological outpatient clinics (dispensaries), including day-hospitals as separate wards with 13 705 places; and 2010 psycho-neurological consulting rooms in rural areas. There are around 16 600 psychiatrists. There are also 124 600 beds in 442 hostels under the authority of Ministry of Social Protection. (The Russian Federation has a population of 148 million people).

Current situation

During the last decade, it has become clear that improving the mental health of the population is a complex medical-social problem; its successful solution requires the joint efforts of different specialists and departments requiring a high level of cooperation. At governmental level this cooperation is implemented in several ways:

An increasing number of catastrophes, natural disasters, international conflicts, terrorist incidents, and military conflicts have led to a sharp growth in stress-related mental disorders. These have required the continuous joint efforts of medical and psychiatric services of the Ministry of Public Health and departments of the Ministry of Emergency Situations. Various programmes for the examination, support, and treatment of affected persons and for the assessment of the consequences of trauma, have been implemented. Along with this, the number of nongovernmental and non-commercial organizations rendering charitable medical and social-psychological care to sufferers has been growing. Unfortunately, at the local level, the network of these services is insufficiently developed, which frequently leads to the decomposition of those affected after their discharge from care.

In connection with a sharp growth in the level of socially dangerous actions of the mentally ill, the recorded number of which doubled during the period 1991–1996, the necessity of close contact between public health services and the Ministry of Internal Affairs became clear. Though joint activity of these two departments was legally consolidated by special government documents, in practice the collaboration is inadequate, both at the federal and local levels.

The special social support provided by public health bodies and religious organizations has grown considerably. The corresponding programmes were worked out and approved by the Ministry of Public Health and the Moscow Patriarchy of the Russian Orthodox Church, as well as by local public health bodies. In this respect, hospices and new hospital churches have been working successfully. The amount of care provided by organizations of consumers themselves, acting mainly at regional levels, has also increased (in approximately 20 regions). Collaboration between public health, social security, and public education bodies, however, requires more support than is given now, both at state and local level.

A federal programme for the improvement of psychiatric care was adopted in 1995, but has only been implemented at the national level to the extent of 2%, and only a few regional psychiatric services (Krasnodar, Tver) have been implementing the main items.

Most details of the Law on Psychiatric Care, adopted in 1992, work successfully both at federal and regional levels. This law regulates the interaction of the public health and internal affairs structures and their control over the working of the law; however, social provision and a guaranteed level of care have not been implemented sufficiently. In 1999, many new

additions and changes were made to the existing Law and presented to the Government for further consideration and adoption in the Parliament.

Reflecting the process of deinstitutionalization, there are now 1.22 psychiatric beds per 1000 population, representing a decrease over recent years. In 1998, the number of unoccupied psychiatric beds reached 19 000. There was also a move in the last decade towards more intensive multidisciplinary teamwork in Russian psychiatry. This tendency was especially displayed by the joint work of psychiatrists, psychologists, psychotherapists, general practitioners, social workers, workers of the public education bodies, representatives of religious organizations, consumers of care, and their relatives.

With regard to community psychiatry, there have been several developments. First of all, there has been more intensive implementation of psychiatric care in general practice. Secondly, there has been more active attention by psychiatrists and psychologists to the care of stress-related psychiatric disorders and in connection with natural disasters, an ecological form of psychiatry has been actively developed in recent years.

The three most serious problems are:

- the instability of government and power structures, with a permanent state of economic crisis in the country;
- insufficient access by the population to information on the disturbing problems of psychiatry and a misunderstanding of the importance for the state and society of problems related to the mental health of the population;
- insufficiently rapid implementation in practice of the modern trends in clinical and social psychiatry.

There is now more open discussion of psychiatric problems in the country. This contrasts with previous years, when psychiatric topics were closed. This new situation has contributed to the active development of public movements and public forms of care in psychiatry.

The introduction of legal and ethical standards in psychiatry (the Law on Psychiatric Care and Ethical Code of Psychiatrists) have radically changed the status of patients, workers in the psychiatric services and the system of care in general.

There is an improvement in clinical and social psychiatry in the Russian Federation, which has brought more patients into care and made that care more effective.

SAN MARINO

The Republic of San Marino is the oldest and smallest in the world. The national language is Italian. Two Captains-Regent are the supreme representatives of the State and they preside over the Great and General Council, one of the six bodies of the political administration, which exercises comprehensive legal jurisdiction and administrative power. The Republic is located 22 km from Rimini, between the Italian regions of Emilia-Romagna and Marche. The area is politically divided into nine districts. These show few major differences. The population (1998) consisted of 26 474 inhabitants, with almost equal numbers of males and females. The population density is 361.4 inhabitants per sq km, whereas in Italy it is about 190.

The population's age-structure is typical of economically and socially advanced countries, but in the last 30 years, the socio-demographic structure has changed considerably. During the last 20 years, the previous emigration flow was inverted (306 entered, while 94 emigrated in 1986) and at present, the population is roughly stable.

A developing process of the economy and industrialization – started in the later 1960s – has influenced the economic structure in a radical way. The percentage of the population working in agriculture decreased from around 40% in 1947 to 3% in 1986 and remains low, whilst industrial, commercial and tourism activities have expanded enormously. The number of people employed in the public sector has increased in recent years.

Social and health care services

In 1956, following the example of Great Britain and the countries of Northern Europe, the National Health Care Service (ISS) was established in San Marino. This includes all social and health care services: medical care, hospitals, drugs, old-age pensions, disability pensions, etc. All inhabitants have free access to medical services. Primary health services are provided by the 15 general practitioners (1 GP per 1494 inhabitants). These doctors are distributed between three Medical Centres where each patient has a follow-up record. The records are continually updated. There is also a hospital with about 200 beds (approximately 10 beds per 1000 inhabitants).

In 1969, the Neuro-Psychiatric Service (SNP) was created and in 1977 became part of the Social Services. The SNP or mental health service is made up of psychiatrists, psychologists, neurologists, social workers, nurses, electro-physiology technicians and a secretary. Since there is no psychiatric department in the hospital, psychiatric admissions go to departments of general medicine or, when necessary, to an Italian psychiatric clinic. In 1980, a section dealing with alcohol-related problems and drug abuse was created within the SNP, since alcohol abuse constitutes one of the main fields of engagement for the mental health service.

Suicide

The rate of suicide is lower than that registered in many other European countries and is almost the same as that in the neighbouring Emilia-Romagna region of Italy (11 per 100 000 population).

Community-based psychiatry and multidisciplinary teamwork

The mental health service is the only agency dealing with mental health. It is a multidisciplinary service, and is based on the teamwork of psychiatrists, psychologists, social workers and nurses. Organizing work in multidisciplinary groups is the usual practice, and its

importance is fully recognized by all mental health staff. Health and social care services are offered both at its facilities and in the patients' homes, schools, and places of work.

Mental health legislation

A mixed commission, made up of judges and psychiatrists, is now working to adapt the present legislation on mental health to new needs of both the citizens and the services. In particular, the aim is to reconcile the demands for individual freedom, privacy and liberty of choice with the need to prevent harm and enable interventions in the care of mental disorder.

Deinstitutionalization

As in Italy, the process of deinstitutionalization started at the beginning of the 1980s, and is not presently producing any particular problems in San Marino.

In 1998, a social study was initiated, focusing on psychological uneasiness, especially in adolescents. This aims to collect and analyse data coming both from agencies such as GPs, and schools, as well as directly from the community (bars, discos, places of work).

The following matters are of concern in San Marino but there has been progress in both of them:

- stigmatization and social prejudice towards those with mental illness;
- the relationship between the mental health service and other structures, including collaboration between the mental health service, schools, and the political and judicial systems.

SLOVAKIA

Recent trends in health care

It is difficult to provide a picture of the current status of mental health care in Slovakia without first describing the transformation undergone by the entire health care system, along with that undergone by society as a whole.

The transformation from a “socialist” to a more liberal society began in 1989, and has involved numerous changes. The former system was in many ways simpler and less demanding for individuals whose position was relatively stable. The collective principles of the system also meant substantially reduced individual responsibility. Health was considered to be a natural state, and since medical care was free, the value placed on it by society was low. Correspondingly, an individual’s responsibility to maintain his/her health was also very low. Health care workers were among the lowest paid in the country. As representatives of the intellectual class, doctors (along with teachers and judges) had a relatively low position in society. Since general practitioners were reduced to dispatching their patients to specialists, their feeling of responsibility was also low. Nevertheless the health care system as a whole was not really open to criticism. Health care was provided on a regional basis, with basic care for everyone and minimal freedom of choice for patients. This led to corruption on a grand scale.

When more freedom arrived, this meant more responsibilities for individuals, which many found difficult to accept. The new phenomenon of unemployment emerged (currently at 17%). Uncertainties regarding the limits of freedom and the necessity of obeying the law led to the growth of crime, more organized crime, and even greater corruption than before. Initial hopes for positive change were replaced by hopelessness, since the understanding that change is possible only through one’s own actions was only slowly growing. Social anxiety increased, which may be one of the most important reasons for a sharp increase in the numbers of patients visiting psychiatrists as well as of psychiatric inpatients.

Efforts to transform the health care system began with the change in the political system. The governmental budget system was replaced by an insurance system requiring compulsory payments by both employees and employers. The government paid insurance only for those without jobs. Primary care was virtually completely privatized, as general practitioners entered into contracts with insurance companies. Direct cash payments by patients remained rare, as salaries for most of the population were still very low. The possibility of free choice of a doctor was basically academic, as 50% of the population lived in rural areas with a single general practitioner in the neighbourhood. No true transformation of the entire system was achieved, because general practitioners still worked as referrers to specialists, and there was no competition among health care providers. The restructuring of hospitals, including the closure of unnecessary ones, failed to occur.

Cash flowed to insurance companies which has led to a situation in which all decisive power sits in their hands. Slovakia’s negative economic situation has resulted in growing debts and failure at every level of the system. Employers and the government failed to pay insurance companies, who failed to pay providers (such as private doctors, hospitals, and pharmacies). As a result, hospitals were unable to pay for drugs, power, or food, with a hospital’s debts sometimes reaching as high as its annual budget. A change in the thinking of doctors could not be achieved, as their main goal became survival. Pay was better in the outpatient system, but the salaries of its staff were still very low. The extent of corruption and illegal money in the system has become even greater than before. Providers are receiving less money, the

quality of services is reduced, and a “crisis regime” has been introduced. This has meant admissions of only acute patients to hospital wards, a reduced spectrum of laboratory investigations, and less money for drugs until further major changes of some kind are made. This state of affairs has had a directly negative influence on both staff and quality of work, contributing to an atmosphere of insecurity and resignation. Feelings of frustration lead to symptoms of burn-out, while feelings of responsibility are further decreased.

The mental health services

The position of psychiatry in the health care system was never good and psychiatric patients were always discriminated against, in comparison to the physically ill. In the past, psychiatric institutions had been placed in unsuitable buildings, such as old castles, located far from large towns or regional centres. Although psychiatrists have tried to improve the situation in recent years, the attitude of health care organizers towards psychiatry has not changed and proposed plans for financing care are again discriminating against the speciality, such that it is uncertain if even the basic level of care can be maintained.

Before the changes in 1989, psychiatry was mostly biologically orientated. Two-thirds of psychiatric beds were in mental hospitals (mostly unsuitable for this purpose) and the rest in general hospitals. Outpatient care was inadequate, with large regional differences. The current national position is that for the present population of 5.4 million, there are 546 psychiatrists and 4834 psychiatric beds situated in five large long-stay mental hospitals and 25 psychiatric departments in general hospitals. There are also 15 psychiatric day care centres.

The reform of mental health care in Slovakia was planned in 1990–1991 and was then accepted by the Ministry of Health Care. It served as a basis for the mental health programme which was approved by the Ministry in 1997. The reform is based on the regional (or catchment area) principle, with units of 100 000 to 150 000 inhabitants, in which all the required services should function. The emphasis was placed on the balance of inpatient and outpatient care, including restructuring the profile of beds (closing beds in mental hospitals and opening new wards in general hospitals). The development of new outpatient services and forms of care such as day centres, rehabilitation facilities, sheltered workshops, and sheltered housing were also included. Non-regional facilities were to be used only for special forms of treatment (addiction, children, forensic units, etc.).

The current emphasis on outpatient care is evident when the three day centres existing in the whole country ten years ago are compared with the 15 operating today. The number of outpatient psychiatrists has also increased from 188 in 1990 to 223 in 1998, the number of psychiatric wards in general hospitals from 20 to 25 (1451 beds to 1594), while the number of beds in mental hospitals has decreased by 250 to 3270, making a total ratio of 0.9 beds per 1000 inhabitants. Further changes are planned in which some of the hospitals are expected to be closed and replaced by wards in general hospitals and new day centres. The reforms however, are not moving forward with sufficient speed because of recent economic difficulties.

The shortage of money for health care, together with unsuccessful efforts to transform the entire health care system, have led to the isolation of sectors which ought to be cooperating on mental health care. For example, health authorities try to shift responsibility for any “social” activities to the social sector. Local authorities have few resources and until now have been involved only marginally in any kind of health care. The system of catchment areas still exists and outpatient psychiatrists have responsibilities for certain areas, but patients still have the freedom to choose a psychiatrist from a different region.

As the result of the health insurance policy for health care, no social workers are presently operating in outpatient facilities. Also, since psychiatric nurses work only within doctors' examination offices, no community work exists. Most psychiatrists work on a private basis, and are not paid by patients but by insurance. Since psychiatry (outpatient as well as inpatient) is the worst paid among all medical branches, psychiatrists usually employ only one nurse, mainly for administrative work. Clinical psychologists, who also used to be members of the team, work independently (also on a private basis) and cooperation with others is often lacking. There are no mental health centres and no liaison committees in regions, as was planned in the initial reform. However, some day centres also function as mental health centres, but with a limited number of functions.

Mental health legislation

There are no special mental health laws in Slovakia. Care is based on constitutional principles, and the general health care laws have a special section which deals with psychiatry, mainly with involuntary admissions. The courts have to decide on individual cases and sometimes a wrong interpretation of the law prevents admission of a seriously ill person for treatment. The treatment of psychotic patients who refuse treatment and any kind of care also became an important issue. Although the situation is improving, an incorrect interpretation of the law, combined with a fear of violating individual civil rights, has caused much longer delays than before between the beginning of an illness and the first visit of a psychiatrist.

The Bratislava model

Bratislava, the biggest city in Slovakia, has five sectors, and an attempt is being made to set up integrated mental health care in one of them. The catchment area has over 120 000 inhabitants. The general hospital has a psychiatric inpatient department with 58 beds, serving all adult patients including the elderly. A day centre with 30 places is part of the department, but it is located nearly five km away, on the other side of the area served. Patients dependent on drugs or alcohol are treated in a special centre for the whole city, which is located near the hospital. The day centre serves young acute psychotics, chronic psychotic patients and those with neurotic, depressive, and personality disorders. Movement of both patients and staff take place between the inpatient and day patient facilities, in order to provide continuity. The day centre's programme is based on therapeutic community principles, trying to create a family atmosphere of acceptance and principles of individual case management are also being applied. There is a broad spectrum of therapeutic, social and occupational activities available, as well as social support. In recent years, psycho-education, mainly for schizophrenic patients and their family members, has become an integral part of the therapy. Work with family members takes place and a self-help group for family members, led initially by a professional, is an additional activity. There are 30 full-time patients at the day centre and another 20–45 visit the centre for only a few hours or days each week. So far, the system described in Bratislava is unique in Slovakia in its complexity and in the broad range of services that are available for patients.

Other developments

Sheltered accommodation is not yet available, but a law to provide this was accepted by Parliament, although the economic situation and the lack of any accommodation represent a difficult problem to overcome. The provision of sheltered work poses problems because psychiatric patients cannot work in sheltered conditions if they are receiving disability pensions. It is hoped that a new law will change this situation.

Independent organizations of patients and of family members are being encouraged throughout Slovakia and national coordination of these groups is being established. Efforts are also being made to reduce the stigma associated with mental illness. Some mental health facilities are organizing public visits during open days and attempts are being made to change the way the media describe mental illness. In 1999, an educational programme about psychiatry was started for a group of journalists from leading media, but otherwise few activities for the promotion of mental health have been implemented.

Mental health care has become one of three priorities of national health care policy and so there is hope that the situation will change for the better. Unfortunately, the hope that was present in the early years after reform of the political system has been replaced by disappointment and hopelessness; corruption and dissatisfaction with the political parties appear to be even more serious than before. Yet in spite of all the difficulties, political freedom – with all its consequences – is a positive and important factor.

Matters of concern

- The poor state of financing of mental health care.
- Inadequate education and training of all professionals in the field.
- Stigmatization of the mentally ill in society.
- Illicit drugs have recently become a serious problem. New drugs such as heroin have emerged on the scene and spread quickly, affecting mainly the young population.

Signs of progress

- Wide acceptance of the reform by professionals and also by administrators (at least on paper).
- Implementation of some reforms (restructuring of mental hospitals, new day centres, and examples of community mental health approaches).
- The increased interest of young physicians in psychiatry.

It has been accepted that standard psychiatric care should be decentralized to the regions, made generally accessible, and diversified so it can care for the whole spectrum of patients with mental disorders within all age-categories. Patients should not have to travel more than 25 km to get to a psychiatric facility and the journey should not take more than one hour when travelling by public transport. However, the present state of mental health care in the Slovak Republic must be considered insufficient and even backward, not only in comparison to the rest of the developed world, but also compared to physical health care in the country.

SLOVENIA

Slovenia has been an independent country in its own right since 1991. There are about 150 qualified psychiatrists in the country. Training lasts three years and takes place in all six psychiatric hospitals, although one of the three years must be spent at the University Psychiatric Hospital. Compulsory courses in psychopathology and psychotherapy are included, but the training programme is likely to be modified to conform to European standards. In addition to the University Psychiatric Hospital which also serves as a national tertiary referral centre, there are five regional psychiatric hospitals, but none are in the south of the country. All have wards for general psychiatry, psycho-geriatrics, and the treatment of alcohol dependency. The University Hospital also has wards for adolescent psychiatry, drug dependence and psychotherapy. There is a child psychiatry ward in the University Children's Hospital. Psychiatric services receive approximately one third of national hospital funds.

Factors which are clearly damaging to mental health in the country, are unemployment, high use of alcohol, aging of the population, and a high level of stigmatization of persons with mental disorders, which prevents many from seeking suitable help in time. Alcohol consumption is one of the highest in Europe and deaths due to liver disease are more than double the average European rate.

Though a national programme of mental health has not yet been adopted, it is the responsibility of the Council for Health – a government advisory body which includes experts from the fields of both health and social security. National programmes have, however, been adopted for preventing suicide and dependence on alcohol and drugs.

The Involuntary Commitment Act provides for the admission of patients without their consent, which is the most frequently discussed question in relation to mental health policies in the country. Two laws to regulate specific deficiencies in this field, until now determined by laws which have already become invalid, are under parliamentary discussion. The new legislation will also introduce the right to advocacy, though other important mental health issues remain unregulated.

In Ljubljana (the capital), a rehabilitation service has been created within the framework of the psychiatric service, which is intended to provide better coordination with outside collaborators and introduce rehabilitation principles into treatment. The psychiatric rehabilitation service should enable suitable referral of patients and coordination among the so far poorly linked non-governmental and social services, as well as GP services. The University Psychiatric Hospital in Ljubljana also gives professional and material support to non-governmental organizations that provide outpatient community care for its patients.

Though community psychiatry has not been planned as an independent form of work, community social services are quickly spreading within the framework of non-governmental organizations, some of which cooperate closely with psychiatric hospitals in the Ljubljana region. User organizations and associations of interested experts have been founded. The largest is the National Association for Mental Health (ŠENT) which, together with the psychiatric profession, is involved in prevention programmes, mainly tackling stigma.

Suicide rates

The suicide rate in the population aged 0–64 has been around 26 per 100 000 in recent years. The rate is three times higher than average for men in the aged around 50, among retired people and among the unemployed. In Slovenia, people who commit suicide very often have no psychiatric diagnosis, but amongst those who have received a diagnosis, dependence on alcohol and psychotic disturbance are the most common. Of those people who commit suicide, 20.9% have already attempted this previously. The prevalence of alcohol-related psychiatric disorders appears to be the best predictor of regional suicide rates.

Deinstitutionalization

Deinstitutionalization has not taken place significantly in Slovenia, despite the strong influence of neighbouring Italy, though the number of psychiatric beds has been reduced to 0.8 per 1000 of the population. There is a substantial amount of non-clinical accommodation for people with mental disorder. Two specialized social institutions each provide about 200 beds for patients with chronic psychiatric disorders. Similarly, eight local homes for older people have departments with psychiatric beds.

The average length of hospitalization is between 45 and 60 days. However, adequate complementary services in the community have not been developed in parallel with the reduction of hospital beds and shortening of hospitalization. As a result, there has been a build-up of persons with mental disturbance out of hospital, who present a major social and family burden. In recent years, various community support systems have been set up by nongovernmental organizations, which could improve the situation although they do not yet have properly arranged sources of finance.

Multidisciplinary and multisectoral cooperation

As in other countries, multidisciplinary teamwork is normal in psychiatry, since psychiatrists, nurses, occupational therapists, clinical psychologists, and social workers cooperate in working groups, normally led by a doctor. Links however, with external collaborators are often not effective enough and rehabilitation programmes for patients on release from hospital are more the exception than the rule. The Ministry of Health is distinct from the Ministry of Labour, Family and Social Affairs, which makes it more difficult to form policies and divide resources within the areas in which mental health belongs. Cooperation between the ministries has been encouraged since 1995, but there is as yet no coordination in the planning of mental health services in the community. At a local level, psychiatric units and outpatient clinics, financed by healthcare funds, are linked with social and non-governmental institutions through social workers employed in the psychiatric facilities. However, obsolete educational programmes, mainly at the College of Social Work, hinder the full inclusion of this group of professionals in working groups, because it teaches an anti-psychiatric approach. Postgraduate training programmes are being developed for professionals who do community work with persons suffering from mental disturbances. Courses on depression for general practitioners and on eating disorders are also provided. Preventive education programmes for recognising suicidal tendencies take place constantly. The Institute for Health Protection organises numerous preventive programmes against smoking, other addictions, and infection with AIDS. Health programmes are also organized at schools and kindergarten.

The network of organizations and services outside psychiatry, which could support preventive activities (mainly early recognition and treatment of mental disorders) is weak. The economic pressures of poverty and unemployment are growing, and with them the

amount of violence, both against the self and others. There is less social security than before, and the exclusion of various individual members of society is increasing.

Matters of concern

There is a need to extend and supplement training/education programmes, in order to broaden the anti-stigma movement so that it embraces not just experts, but families and the general public.

There is also a need to establish standards for work in nongovernmental and other services which deal with mental health, in order to ensure high quality, comprehensiveness, and accessibility of care for people with mental disorders.

A priority task is to create and extend the network of services for mental health, which with multidisciplinary teamwork should enable support and more immediate help to be given for people with mental difficulties.

SPAIN

Background

Two events mark a turning point in the recent history of psychiatric care in Spain: the passing of the General Law on Health (*Ley General de Sanidad*, LGS, 1986) and the Commission for Psychiatric Reform (1987). The General Law on Health includes a specific chapter dedicated to mental health, which is not the case for any other aspect of public health. It brings the care of psychiatric disorders to a level of equality with other diseases.

The Commission for Psychiatric Reform lays out the need to replace the old model of care, centred on psychiatric hospitals, by comprehensive outpatient and community-based care. It recommends the replacement of psychiatric hospitals by inpatient units in general hospitals for severe cases, the creation of outpatient mental health units and the introduction of intermediate and rehabilitation mechanisms. Previously, psychiatric care had been mainly in the hands of local authorities and religious orders, owners of the old psychiatric hospitals and to a lesser extent, university hospitals with psychiatric departments. In the last years of the 1970s, the first psychiatric units in general hospitals were opened, although sometimes with minimal facilities, limited only to liaison consultation with other specialities.

In Spain the right to health care is guaranteed by the already mentioned General Law on Health. This law recognizes health as a right and, as a consequence, the health system is entirely financed by general taxes and includes a large range of services without the need for patients to pay for any services. Spanish health care is extremely decentralized, with its management in the hands of each Autonomous Community. Of the 17 such communities in Spain, seven already carry out this function and it is foreseen that the remaining ten will do so in a short time. A relatively small proportion of the population have additional health insurance of one form or another, allowing them more freedom of choice for their health care. The provision of health care is mainly carried out through public institutions. Doctors are usually salaried and in the last few years, incentives linked to performance have been introduced, but have as yet, relative little effect on the total salary.

Present situation

In the 1980s and the first half of the 1990s, psychiatry departments were established in almost all public general hospitals with more than 200 beds. This led to the transformation of the psychiatric hospitals and community mental health units were created. These were initially conceived to support primary care since in this same period, a new model of primary care was introduced which included early detection and early treatment of psychiatric disorders.

Psychiatric care is financed alongside the rest of health care and there are therefore no specific budgets for this speciality. In the model in force until 2001, the Autonomous Communities receive from the Central Government, a budget for health care calculated according to per capita criteria, with small corrections. Hospitals are financed through a budget, calculated according to the volume and complexity of the foreseen activities, although some financing per capita have begun to be introduced, a model reserved until now only for primary health.

The inclusion of psychiatry within speciality training (including a period of residence) has led to a substantial change in the profile of psychiatrists, who now have a solid medical training. This has resulted in more medicalized psychiatry and more recently to the promotion of the community model of care. Training in psychology is also now accredited

through a similar standardized programme. Specialization in mental health is one of the few recognized in nursing, although it is not obligatory to have this to be able to work in psychiatric units.

Matters of concern

This very positive picture however, needs to be balanced by certain problems that exist. With such a decentralized model, there is a need for tight regulatory control, which should be under the Ministry of Health. This has hardly been developed and, for example, there is no National Plan for Mental Health. The only exception is a National Plan on Drugs, which sets out a framework of actions to deal with drug abuse and although the lead agency is the Department of the Interior, it has an interdepartmental character. None the less, even this Plan on Drugs leaves a large discretionary margin to the Autonomous Communities in the provision of health care to drug abusers.

Each Autonomous Community does have its own Mental Health Plan, which are similar in some respects, but do involve some marked differences with regards to the organization and funding of resources for psychiatric care. A recent example concerns the care of those with eating disorders. Some Autonomous Communities manage them in special units whilst others do so in the general psychiatric care system.

A further problem is the insufficient development of intermediate systems for rehabilitation and reinsertion of patients into the community. Although in recent years, more psychiatric day hospitals have been established in the public health system, there is still no adequate system for reducing long term hospitalization.

In 1999, changes in the Penal Code created new problems, because it was decided that mentally ill offenders should keep their right to be treated within the National Health Care system. Consequently prison services and hospitals were closed, which has led to pressure for the treatment of mentally ill offenders in general psychiatric services, which find it difficult to manage. Some special units for these patients are now being opened.

Psychopharmacological drugs, including the new narcoleptics and anti-depressants, are subsidized by the social security system. They are provided free for pensioners and many of the drugs (above all the expensive ones) require only a reduced contribution from the working population, who in the worst cases have to contribute 40% of the cost. This lack of restriction on the prescription of new drugs within the social security system was responsible for olanzapine, risperdal and sertraline, in that order, being the most prescribed drugs (measured in expense) in Spain in the year 2000.

Mental illness is recognized as cause of disability, giving those affected the right to receive a disability allowance from the social security system. The care of severe psychiatric illness is covered by all private insurance companies, although they lay down maximum limits to the length of psychiatric hospitalization. Many outpatient consultations with mental health professionals are still being paid for by patients themselves, without later reimbursement by private health insurance companies.

SWEDEN

Following a White Paper prepared by the Swedish Psychiatry Commission, highlighting deficiencies in psychiatric care, the Board of Health and Welfare was given the task of carrying out a national survey on the content and quality of this care. The Board was to focus on specialized psychiatry, mainly the care given by the county councils and municipalities. The survey did not include services for the mentally disordered provided outside specialized psychiatry, such as primary medical care and the social services and this limitation of the assignment caused problems. The Board of Health and Welfare has however, attempted to examine specialized psychiatry in the context of all the help which the mentally disordered require.

The current state of psychiatry

The social position of the mentally ill in Sweden is unsatisfactory. Admittedly, considerable improvements have been made from the strongly prejudiced attitudes of previous years, but a lack of tolerance towards those affected by mental disorder has severe consequences for them. There is little public pressure for more resources to be allocated and there can be delays in getting treatment. Discrimination also forms a serious obstacle to rehabilitation.

Differing schools of psychiatry, with splintering of groups and territorial disputes, have contributed to the image of a discipline which has not yet become mature, but psychiatry has increasingly been able to put this phase behind it. Knowledge about mental disorder has increased, diagnosis has been improved, and it has been increasingly possible to create evidence-based, effective treatment.

The number of inpatient psychiatric beds in Sweden has been reduced, and replaced by outpatient management focused on treating the patients in their home environment. In many respects, this is a positive development, but unfortunately specialized psychiatry still often takes place without enough collaboration and support from colleagues in other sectors. Although antagonisms between the sectors have been bridged over to a large extent, the lack of a common body of knowledge, both within psychiatry and in the collaboration between psychiatry and its colleagues (mainly the social services) is still a problem.

Despite these positive developments, many mentally disordered people still have difficulty in getting their needs for care met. The fundamental pieces of legislation for psychiatric health and sickness are the Health and Illness Act (HSL), the Compulsory Psychiatric Care Act (LPT), and the Forensic Psychiatric Care Act (LRV). Guidance is also provided by the 1991 United Nations Resolution, supported by Sweden, concerning the principles for the protection of the mentally ill. The demands which these put on health care are not being entirely met.

The lack of knowledge in psychiatry is one obstruction to successful treatment, but other obstructions include the views of society at large on psychiatry and the mentally ill, insufficient access to care, as well as lack of continuity and collaboration which causes gaps in the total care of the patient. The deficiencies also include the difficulties that patients, relatives, and other interested persons have in influencing to any reasonable extent, the care that is given.

The regional differences in Sweden, in resources for care, methods of care and the use of care, are far greater than would be justified by differences in the rates of disorder. Such differences can be explained to some extent by variations in geographical and social

conditions, but may also be a consequence of the fact that care has developed in different ways.

Currently in Sweden there is a lack of specialist psychiatrists and also an insufficient variety of treatment options. Inpatient care is still carried out to a large extent in unsuitable general hospital wards, which means that for some patients, their experience of care is unnecessarily burdensome, intrusive and frightening.

To deal with these and other deficiencies in Swedish psychiatry, the Board of Health and Welfare examined the following issues:

Better status for patients and their relatives

Attitudes to human rights and how these should be respected for mentally ill people, and in particular the rights to integrity and of self-determination need to be brought more into focus in psychiatry. The use of and extent of compulsory institutional care should always be carefully monitored.

Increased user influence, through well-informed and participating patients and relatives, is an important development. The influence of both patients and relatives needs to be enhanced through active participation in planning and implementation of care. Patient and relative committees at county level are one way to enhance the standing of users. These could also be centres for new and comprehensive efforts to make mental disorder and its treatment known to the general public. They could also contribute to mentally disordered people being treated with the same respect and consideration as is given to other people with severe illnesses.

Individual care plans, drafted in consultation with the patients and their relatives where possible, are one way to clarify the goals of the care provided. Care plans should be integrated with the planning of other colleagues, to encompass the patient's entire life situation.

Efforts to develop personnel competence in care

Continuous further education and guidance should be ensured for those at all levels in mental health work. The transformation from inpatient to outpatient care, demands massive training efforts for all personnel.

The lack of specialists in psychiatry, which has existed for many years, requires intensive recruitment efforts.

Leadership training should be offered to all categories of personnel in psychiatry, recognising that good leadership is more a question of individual ability than of membership of a particular profession.

Better collaboration and coordination

Better collaboration is needed with other disciplines and sectors, based on a common outlook, language and goals for treatment.

Improved psychiatric care in the primary health care system, both for the common disorders as well as for those with chronic mental illness is also needed. This requires training and consultation from mental health professionals. In the same way, social services personnel should receive guidance from staff with psychiatric training.

Special attention to collaboration is needed for certain groups of people, namely forensic patients on parole, mentally disturbed drug abusers and persons liable to commit suicide. Procedures for collaboration should be established between the National Probation and Prison Board and those in charge of hospital care to facilitate the provision of psychiatric care for mentally disturbed offenders.

The sub-speciality of psycho-geriatrics needs to develop collaboration with medical services organized by the municipalities, so that treatable illness is diagnosed and dealt with.

Collaboration between schools, social services, and child and adolescent psychiatry must be developed to deal with young psychiatric patients in the early stages of their illnesses.

An enhanced psychiatric care organization

The goal should be that only psychiatric care with documented efficacy should be offered.

The effects of care should also be followed-up and evaluated and psychiatric case registers should be introduced in Sweden comparable to those available for many somatic illnesses. Improved documentation should lead to the better evaluation of treatment.

The highest priority for the allocation of resources must be given to patients at risk of developing severe mental disorders and those subject to compulsory psychiatric care. Society has a particular responsibility for care associated with loss of freedom and other compulsion.

THE FORMER YUGOSLAV REPUBLIC of MACEDONIA

During the 1990s, the former Yugoslav Republic of Macedonia acted as an important stabilizing factor in the Balkan region and a model for other countries. Establishing an independent society, passing through a difficult time of social transition, coping with tensions in the surrounding Balkans, as well as providing shelter to refugees and a foothold for international intervention have put a great deal of strain on the former Yugoslav Republic of Macedonia. The socioeconomic state of the country has progressively deteriorated (in 1996, the rate of unemployment was 39.8% of the labour force).

Faced with such factors as unemployment and poverty, stressful life in a post-traumatic society, growing tensions between ethnic groups, increasing homelessness and rising substance abuse of various forms, there has been a weakening of family and social networks and support systems in the region. This creates great concern for the consequences on mental health and finding solutions is impossible without help from the international community, including WHO.

The psychological consequences can be widely seen, especially among those directly affected by the enormous number of refugees who came into the country, even if many have returned to their homes. Host families, local health and social services, the local communities and society in general have all been involved in this crisis.

Since the beginning of the war in Kosovo, mental health activities in the former Yugoslav Republic of Macedonia have been carried out by the Ministry of Health and the Ministry of Labour and Social Policy, supported by many international organizations and in cooperation with local authorities and NGOs. Especially in the western parts of the country, most affected by the great influx of refugees, this cooperation required an immediate response and the mobilization of mental health professionals dealing with different target groups of the vulnerable population. Since the country however, had traditional hospital-based mental health services, which was not efficient and largely depended on a centralized organization, they were not able to meet the extensive needs. These services were unsatisfactory from the medical, psychological, human, outcome, efficiency, or economic points of view. The lack of outpatient services, prevention, rehabilitation, family involvement and social support, alternatives to mental hospitals, and other services enabling people with mental illness to live and cope in the community, all point to the urgency of decentralization and the implementation of community mental health care in the former Yugoslav Republic of Macedonia. This will require first-line services provided by multidisciplinary teams, alternatives to mental hospitals such as day centres, sheltered accommodation, work centres, social clubs, as well as peer support and self-help opportunities.

National mental health plan

Initial investigation of the mental health care system and an assessment of the needs to improve it were undertaken in 1994 by WHO. This was followed by the organization of a one-year postgraduate course “Psychosocial and Traumatic Stress – Understanding, Prevention, Treatment” in 1997–1998 with 40 participants from all over the country, mainly psychiatrists and psychologists. During 1999, in cooperation with the Ministry of Health, a meeting of more than 100 participants took place to discuss ways of providing psychosocial support. The need to improve community mental health in order to meet the mental health needs of the population, both native and refugees, was agreed. As a result, a Letter of Intent concerning the improvement of the mental health services in the former Yugoslav Republic of Macedonia and the creation of community mental health services was signed between the National Coordinator for Mental Health (Professor Aleksievski), and the WHO Humanitarian

Assistance Office in the former Yugoslav Republic of Macedonia. A National Mental Health Plan to guide this transformation, according to the Letter of Intent, was prepared together with international experts, during the year 2000, to be implemented in 2001.

Mental health legislation

Mental health legislation, which still has not been worked out as a separate law, has to be prepared to strengthen the human rights of people with mental illnesses, especially long-term illnesses. Currently, some of the legislative regulation is incorporated in the Law for Health Protection, and some is under criminal law, but very little relates to the protection of the human rights of people with mental disorders and compulsory hospitalization.

Deinstitutionalization

Centralized hospital-based provision dominates mental health care in the country. During the 10-year period 1987–1997, the number of psychiatric beds in large psychiatric hospitals has decreased from 1630 to 1410. The occupancy of the psychiatric hospitals has ranged from 91.1% in 1987 to 99.6 in 1997. The average duration of treatment in these hospitals has increased from 156.2 days to 225.8 days over the same period, pointing to a lack of rehabilitation services. On the other hand, the number of psychiatric beds in general hospitals did not change much, although their occupancy decreased from 84.5% in 1987 to 70.7% in 1997, evidence that decentralization in psychiatry in the former Yugoslav Republic of Macedonia has hardly started.

Multidisciplinary teams

The teams in mental health services in the former Yugoslav Republic of Macedonia mainly consist of psychiatrists, psychologists, nurses, and social workers although psychiatrists are much more numerous than psychologists and social workers. According to the Letter of Intent, multidisciplinary teams must be set up as the first-line service in each Health Care District, which will require a training programme for community mental health activities.

Mental health promotion

There is little mental health promotion taking place, but some effort has been put into prevention of substance abuse, child abuse, and domestic violence, mostly by NGOs, as well as programmes in schools, with the cooperation of NGOs and the Ministry of Education. There are however, no organized public campaigns promoting specific aspects of mental health.

UKRAINE

The provision of psychiatric care in Ukraine, including its planning and financing at the national level, are under the Department of Disease Treatment and Prevention of the Ministry of Public Health. Within the Department, there is a psychiatric working group, consisting of the most senior specialists: chief psychiatrist, chief child psychiatrist, chief psychotherapist, and chief forensic psychiatrist. Currently, the most important task for this working group is to develop a "Conception of Mental Health Care in Ukraine". Throughout the country, there are similar working groups in the regional Departments of Public Health, consisting of the leading specialists in the field of mental health within each region.

In addition, there is a problem-solving commission within the Ministry of Public Health, whose main goal is to plan further scientific studies in the field of psychiatry. At present, priority is given to the following objectives of studies and research:

- adaptation of ICD-10 to Ukrainian settings;
- studies of risk factors leading to mental disorders in children and teenagers and the development of methods for overcoming these disorders;
- improvement of theory and practice in prevention and treatment, including psychotherapy;
- studies of psychosomatic disorders;
- the improvement of methods of treatment for addictive disorders.

A new Law on Psychiatric Care was adopted in February 2000 which has been confirmed by the President of Ukraine. The Draft Law was developed by a working group of the Ukrainian Psychiatric Association in 1997. This was the first time in the history of the independent Ukrainian State that consideration was given by the supreme legislative body to a law drafted by a nongovernmental professional organization.

Official statistics in Ukraine show that the annual incidence of mental disorders in 1999 was 3.1 and 2.4 per 1000 of the urban and rural population respectively. The annual incidence of mental disorders among children is 6.7 per 1000. Disability as a result of mental disorders is 4.7 per 1000 of the population.

There are 87 psychiatric hospitals in Ukraine, with 49 469 beds. Only 435 of these are in general hospitals. Currently, there is a movement to decrease the number of inpatient beds in hospitals, but the need for psychiatric beds in Ukraine is difficult to assess. The number of psychiatrists in the country is 4325.

The use of multidisciplinary teamwork is fairly new for Ukrainian psychiatry. The Ukrainian Psychiatric Association is developing and implementing a series of projects which introduce leading world experience into Ukrainian psychiatry and in particular, interactions between state psychiatric services, nongovernmental professional organizations and organizations of relatives and users, has been an important positive experience. As a result of these projects, the use of multidisciplinary teamwork and case management has been introduced into the practice of some facilities in Ukraine. Training of psychiatric nurses has been developed in Kiev, organized in association with the Kiev Medical Academy of postgraduate education and the psychiatric services of the city. Training of social workers has also begun in Kiev and this is quite a new profession within Ukrainian psychiatry.

Certainly, in the field of mental health in Ukraine there are currently many problems, including insufficient material and technical equipment, insufficient financing and an absence of the new generation of antipsychotic drugs. However, positive changes have occurred. Rectors, nurses, state organizations, and nongovernmental organizations of relatives and users of psychiatric services all show great commitment to this progress continuing.

UNITED KINGDOM

Within the United Kingdom and Northern Ireland, Scotland is a separate jurisdiction, which also organizes its own health care independently. This report describes the situation in England and Wales.

Despite the fact that mental illness is very common, public knowledge of it is generally poor. Depression will affect nearly half of all women and a quarter of all men in the United Kingdom before the age of 70. One study of depression showed that the costs were as high as for chronic heart disease: around 80 million working days may be lost due to mental ill health, at a cost of around £3.7 billion. Mental health problems which are not identified and treated in children can lead to under-achievement and social exclusion. There is evidence of an increase in poor mental health in children and young people over the last three decades, particularly among those who are socially disadvantaged.

The first comprehensive national survey on mental illness was published in 1995. It showed that one in six adults aged 16–64 had suffered from some type of mental health problem in the week prior to being interviewed. The most common of these were “neurotic” conditions like anxiety and depression, whereas a very small proportion of the population (less than one per cent) had a psychotic illness such as schizophrenia.

Other important risk factors for mental illness in the United Kingdom, include stress, loss of social support, and social isolation, as well as a variety of social and economic pressures. For example:

- Anxiety and depression are much more common in separated, widowed, or divorced people.
- Children who are cared for away from their family home have much higher rates of mental health problems.
- Rates of depression are highest amongst those who are unemployed, while people living in urban settings are one and a half times more at risk than those in rural areas.
- As many as 60 % of those in night shelters or are homeless, have a mental disorder.
- Rates of mental disorder are also very high amongst the prison population.
- Depression appears to be increasing in frequency, particularly amongst young people.

National mental health plans

The Mental Health National Service Framework was published in September 1999; it focuses on the mental health of working-age adults. The Framework applies to both health and social services, and includes health promotion, assessment and diagnosis, treatment, rehabilitation and care, including support to carers, and also encompasses both primary and specialist care and the roles of other relevant agencies. It sets out a number of standards on the discrimination and social exclusion associated with mental health problems, primary care and access to services, services for people with severe mental illness, individuals who care for people with mental health problems and finally, the reduction of suicides. The Framework is being implemented by local teams operating within the various regions, assisted by a National Implementation Team.

Mental health legislation

In July 1998, the Government announced their intention to carry out a “root and branch” review of the Mental Health Act (1983). An expert committee was asked to consider how powers of compulsory care and treatment might be extended to the community and the Government has now published its own proposals. These focus on helping patients whilst also managing risk in a way that strikes the right balance between public safety and the rights of individuals. One of the key changes proposed, is the extension of compulsory powers to the community. The 1983 Mental Health Act was exclusively concerned with detention in hospital, but services for people with mental disorder are increasingly being provided in the community. The new proposals will for the first time enable compulsory treatment to take place in the community.

Morbidity

The Survey of Psychiatric Morbidity showed that:

- About one in seven adults aged 16–64 living in private households had some sort of neurotic problem in the week prior to interview, with women far more likely to suffer a neurotic health problem than men. The four most common neurotic symptoms were fatigue (27%), sleep problems (25%), irritability (22%), and worry (20%). The most prevalent neurotic disorder in the week prior to interview was mixed anxiety and depressive disorder (71/1000) followed by generalized anxiety disorder (30/1000).
- Non-organic psychosis had a prevalence of four per 1000 population in the past year.
- The overall rate of alcohol and drug dependence was 47 per 1000 and 22 per 1000 (both in the last year). Men were three times more likely than women to have alcohol dependence, and were twice as likely to be drug-dependent. Alcohol and drug dependence were most prevalent among young adults, particularly young men aged 16 to 24.

Suicide

The overall rate of suicide in England is falling, although there are still over 4000 deaths from suicide each year. A study of suicide in England and Wales between 1982 and 1997 indicated a fall in the total number of deaths by suicide and undetermined deaths of over 12%. However, this hides the fact that some groups of the population remain at higher risk. These include men, particularly young men, people with a history of self-harm and severe mental illness, unemployed people, people who have suffered bereavement and loss, people detained in prison, those from certain occupational groups including doctors, and young women from the Indian sub-continent.

A national Confidential Inquiry into Suicide and Homicide by People with Mental Illness found that 26% of those who committed suicide had been in contact with specialist mental health services in the year before death. In addition to mental illness, 50% also had another problem, usually substance misuse, personality disorder, or both. At the time of their suicide, 13% were inpatients and 28% had been discharged from hospital within the previous three months. Less than half were fully compliant with psychiatric treatment. However, in the majority of suicides by people with mental illness, staff had perceived the risk to be low.

Deinstitutionalization

Whilst the shift away from institutionalized care for mentally ill people is not a new policy, it has caused concern amongst the public. It was recognized that there was a need to ensure that when considering future closing plans, a full range of alternative services would be available. An Independent Reference Group (IRG), was established in 1997 to help restore public

credibility in mental health services through a new inclusive approach to policy development. The Group was particularly asked to look at the way that mental health services, including community support, would be provided for the patients from 34 long-stay hospitals, which were due to close before 2001.

Multidisciplinary teamwork

The Care Programme Approach (CPA) was introduced in 1991 as one of the cornerstones of the Government's mental health policy. In collaboration with local social services departments, Mental Health Service units are required to initiate explicit, individually tailored care programmes for all inpatients about to be discharged from mental hospitals and for all new patients accepted by the specialist psychiatric services.

The CPA involves a systematic assessment of health and social care needs, a care plan agreed between the relevant professional staff and the patient and regular review of the patient's progress. Most important however is the allocation of a key professional worker who has the responsibility for coordinating care, keeping in touch with the patient, ensuring that the care plan is delivered and calling for reviews of the plan when required.

Review and changes

The essential elements of CPA have received wide support and are congruent with sound health and social care practice. The aim has been both to retain good practice and make improvements where necessary. However, a number of key changes are being introduced to ensure that care coordination is strengthened and that there is a proper focus on the needs of service users. At present there are two systems of care coordination for adults of working age, one used by health authorities and one by social services. In the future, there will be only one system, and this will be the CPA. The new policy will enable mental health service users to gain access to resources from both agencies.

Other changes are also proposed but overall, the priority task is seen as creating and extending the network of services for mental health which, with multidisciplinary teamwork, should enable support and immediate help to be provided for people with psychiatric difficulties.

Annex I

LIST OF COUNTERPARTS FOR THE MENTAL HEALTH PROGRAMME OF WHO REGIONAL OFFICE FOR EUROPE as at November 2001

Albania

Dr Petrit Vasili, Deputy Minister of Health, Ministry of Health, Tirana

Andorra

Dr Joan Obiols Llandrich, Director, Centre de Salut Mental, Hospital Na Sa de Meritxell
Escaldes-Engordany

Armenia

Dr Samvel Torosyan, Chief Psychiatrist, c/o Ministry of Health, Yerevan

Austria

Professor Heinz Katschnig, Ludwig-Boltzmann Institute for Social Psychiatry, Vienna

Azerbaijan

Professor Agabey Sultanov, Chief Specialist, c/o Ministry of Health, Baku

Belgium

Professor F.C.J. Baro, WHO collaborating centre for health and psychosocial and
psychobiological factors, Brussels

Bosnia and Herzegovina

Dr Milomir Djerić, Psychiatrist, Health Center Sokolac, c/o Ministry of Health, Republika
Srpsk, Banja Luka

Dr Abdulah Kucukalic, c/o Federal Ministry of Health, Sarajevo

Belarus

Professor Pavel Rynkov, Chief Psychiatrist, Ministry of Health of the Republic of Belarus,
Minsk

Bulgaria

Dr Toma Tomov, Head, Department of Psychiatry, Alexandrovska Hospital, Sofia Medical
Academy, Sofia

Croatia

Dr Neven Henigsberg, Psychiatrist, 'Vrapce' Psychiatric Hospital, Zagreb

Czech Republic

Professor Cyril Höschl, Director, Prague Psychiatric Centre, Prague

Denmark

Dr Marianne Jespersen, Consultant, National Board of Health, Copenhagen

Estonia

Dr Andres Lehtmets, Wismari Hospital, Tallinn

Finland

Professor Vappu Taipale, Director General, National Research and Development Centre for Welfare and Health-STAKES, Helsinki

France

To be nominated

Georgia

Professor George B. Naneishvili, M. Asatiani Research Institute of Psychiatry, Tbilisi

Germany

Dr Christiane Redel, Federal Ministry of Health, Bonn

Greece

Dr Athanassios Constantopoulos, Consultant Psychiatrist and Director, Mental Health Centre, Regional General Hospital of Athens, Attica

Hungary

Professor Laszlo Tringer, SOTE Psychiatric Clinic, Semmelweis Medical School, Budapest

Iceland

Dr Hannes Petursson, Professor of Psychiatry, Department of Psychiatry, University Hospital, Reykjavik

Ireland

Ms Bairbre Nic Aongusa, Mental Health Services, Department of Health and Children, Dublin

Israel

Dr Alexander Grinshpoon, Acting Director, Mental Health Services, Ministry of Health, Jerusalem

Italy

Dr Fabrizio Oleari, Director General, Department of Prevention, Ministry of Health, Rome

Dr Teresa Di Fiandra, Senior Psychologist Officer, Prevention Directorate, Ministry of Health, Rome

Kazakhstan

Dr Aigul Tastanova, Chief Specialist, Agency of the Republic of Kazakhstan for Health Affairs, Astana

Kyrgyzstan

Professor Valeri Solojenkin, Head of Chair of Psychiatry, Drug, Abuse and Clinical Psychology, Medical Academy, Bishkek

Latvia

Professor Raisa Andrezina, President, Latvian Psychiatric Association, Riga

Lithuania

Professor Dainius Puras, Director, Clinic of Social Pediatrics and Child, Psychiatry, Vilnius University, Vilnius

Malta

Dr Ray G. Xerri, Director, Policy & Planning, Department of Health, Floriana

Monaco

Dr Anne Negre-Brugnetti, Adjoint Administratif, Direction de l'Action Sanitaire et Sociale, Monaco

Netherlands

Mr Alexander Bersee, Head, Division of Mental Health, Ministry of Health, Welfare and Sport, The Hague

Norway

Dr John Glad, Medical Adviser, Department of Psychiatry, Norwegian Board of Health, Oslo

Poland

Professor Stanislaw Puzynski, Director, Institute of Psychiatry and Neurology, Warsaw

Portugal

Dr Maria João Heitor dos Santos, Direcção Geral da Saude, Lisbon

Republic of Moldova

Dr Mihai Hotineanu, Chief Psychiatrist, Ministry of Health, Chisinau

Romania

Dr Bogdana Tudorache, Psychiatrist, Romanian League for Mental Health, Bucharest

Russian Federation

Dr V.S. Yastrebov, Chief, Mental Health Support Systems, Research Centre, Mental Health Scientific Centre, Moscow

San Marino

Dr Sebastiano Bastianelli, Neuropsychiatric Services, The State Hospital, Cailungo

Slovakia

Dr Peter Breier, Head, Department of Psychiatry, General Hospital Ruzinov, Bratislava

Slovenia

Dr Andrej Marusic, Institute of Public Health of Republic of Slovenia, Ljubljana

Spain

Professor Juan Lopez-Ibor, Head, Servicio de Psiquiatria, Hospital Clinico "San Carlos", Madrid

Sweden

Dr Helena Silfverhielm, Medical Adviser, National Board of Health and Welfare, Stockholm

Switzerland

Dr Herbert Heise, Deputy Director, Universitäre Psychiatrische Dienste (UPD), Berne

The former Yugoslav Republic of Macedonia

Professor Vitomir Micev, President, Macedonian Medical Association, Skopje

Turkmenistan

Mr Rovshan Melekhanov, Chief Specialist, Department of Treatment and Prevention, Ministry of Health and Medical Industry, Ashgabat

Ukraine

Professor Valery N. Kuznetsov, Chair of Psychiatry, Medical Academy of Postgraduate Training, Kiev

United Kingdom

Dr Richard Berry, Mental Health Promotion Manager, Mental Health Services Branch, Department of Health, Leeds

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