FIFTH MEETING OF THE EUROPEAN NATIONAL COUNTERPARTS FOR THE WHO EUROPEAN MENTAL HEALTH PROGRAMME

Report on a WHO meeting

Bucharest, Romania
4–6 April 2002
ABSTRACT

The mental health programme of the Regional Office has 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 often work in the ministry or are the most senior government mental health professionals. The network meets twice yearly in a different location and, at each meeting, the host country is invited to start by presenting its mental health situation.

In April 2002 the network met for the first time in a central and eastern European country, Romania. Counterparts from 30 countries were present, together with temporary advisers and invited speakers, representatives of the Romanian Ministry of Health and Family, and representatives of various nongovernmental organizations active in the field of mental health. The counterparts discussed the Romanian mental health situation and gave feedback to the representatives of the Romanian Government. They also presented the mental health situation in their own countries and discussed in working groups as well as in plenary sessions topics such as deinstitutionalization, community care development, legislation, reform of psychiatric structures, destigmatization and compulsory care.

Keywords

MENTAL HEALTH SERVICES – organization and administration
MENTAL DISORDERS
EVALUATION STUDIES
HEALTH LEGISLATION
HEALTH POLICY
EUROPE
ROMANIA
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Thursday, 4 April 2002

Official Opening

Dr Daniela Bartos, Minister of Health and Family, Romania

Dr Bartos welcomed the participants and expressed the honour of the Ministry of Health and Family to host such an important meeting. She stated that mental health is an important component of health and essential to assure the quality of life. For Romania, the important social changes after 1989, as well as the exposure to several forms of violence, unemployment, deterioration of economic and living conditions represented threatening factors for the population’s mental health.

She tackled the issue of high costs of therapeutic measures and the social costs added to these. The health government programme starts from the assumption that health is a collective social good, accessible to everyone. From this perspective, Romanian MoH has a new strategy in mental health. This will have in view that the persons with mental disorders should be treated within a complete respect of human being, according to the provisions of the UN resolution 46/119.

Starting from the assumption that there is no health without mental health, she also emphasized the importance of an intersectorial approach in the promotion of mental health. Health education classes, including mental health promotion and prophylactic activities, were introduced in the school curricula in Romania since 1999, on the basis of a common Order between the Ministry of Health and Family and the Ministry of Education and Research.

Emphasis was made also on the creation of the Mental Health Centre, coordinated by MoH within a project financed by the World Bank. The aim of the project is to prevent some psychiatric disorders by an early intervention in crisis situation and to offer modern day mental health care. It is a pilot project and there is the intention to extend it.

She also mentioned a few issues of concern, which are currently in the attention of MoH:

- development of activities concerning mental health education;
- improving the access of the mentally ill to general health services in order to early detect the disease;
- improving the quality of medical services given to mentally ill.

Dr Bartos considered hospital reform as the most difficult part of the health reform. As for the recommendation of international experts to reduce the number of beds in hospitals, she emphasized it is a difficult objective to attain, because of mentality-related obstacles.

In conclusion, Dr Bartos expressed her hope that this meeting should be a valuable exchange of experience and a way to a new and successful approach to mental health.

Dr Wolfgang Rutz, Regional Adviser for Mental Health, WHO Regional Office for Europe

Dr Rutz thanked Ms. Bartos for her speech, which confirms the involvement of the Romanian Ministry of Health and Family in mental health field. He also thanked the Romanian hosts for
their kind hospitality and welcomed the participants.

Romania is an accessing country to EU and NATO, a state of transition that has been passing through dramatic changes. As indicators, he mentioned the excessive mortality and premature death, the dramatic increase of male mortality as well as the stress related complex of morbidity.

He continued by saying that Romania has to change focus from institutions to community mental health based services. He reminded about the WHO assessment from August-September 2000, which identified mental health as a priority area of intervention, and about the WHO meeting on mental health organized in Bucharest in June 1999.

He reiterated the need of a focal point within the Ministry of Health, as well as the need of a national mental health law.

De-hospitalization is an ongoing process in Romania and the allocation of 3-4 % of the health expenditure does not correspond to the real burden of mental health troubles. As for human resources, Dr. Rutz mentioned that in Europe there is a considerable number of doctors, nurses, beds in institutions, but few social workers and psychologists, which is the problem in Romania too.

He continued by expressing his satisfaction as to the high intellectual capacity in the country, of which the best use should be made.

He concluded on the need to step to concrete action and reiterated that experts from the whole Europe were invited to give advice, feedback and share their experience with the Romanian colleagues. The situation in Romania is a bridge between East and West European countries.

**Romania – state of art and panorama of problems**

**Psychiatric issues and problems in Romania**

**Professor Tudor Udrisoiu, vice president of the Psychiatry and Mental Health Commission of the Ministry of Health and Family**

Professor Udrisoiu started by saying that mental health is far away from being a national priority in Romania. Among the obstacles to this achievement, there are mentality, general lack of interest for basic patients rights and their life quality, lack of transparency, lack of intersectorial co-operation, poor resources and financing.

He briefly mentioned the main aspects of the reform of health services.

**The Health Insurance House (HIH)** has had its own development as major objective, but minor interest for patient health care. It keeps the historical criteria in allocating the money, neglecting the efficiency and quality of the medical act. There is an excessive bureaucracy and an inappropriate mixing of contractual and budget relationship with health suppliers.
The College of Physicians has been transformed into an annex of the HIH. It is more interested in the financing of the medical facilities, than in the functioning and problems of doctors. It does not intervene in the organization and quality control of expertise activities.

The Ministry of Health has been practically eliminated from the elaboration and control of health policies (because of the new legislation). It has had an ambiguous relationship with the professional associations and with the local institutions. There are still barriers in communication, despite the improvement achieved last year.

Some of the current problems are: insufficient number of trained personnel (nurses); lack of adequate protection in the “high security hospitals” (forensic hospitals); stigmatization firstly of the psychiatric care, and then of the disease; reduced financing for psychiatry (276 000 lei/day in psychiatry compared to 842 000 lei in neurology).

Priority issues should be: extension of contractual work relations in every medical institution; transparency and responsibility; mental health law; national and regional coordination of psychiatric care; development of extramural facilities, both medical and non-medical; respect of patients’ rights; administration of all compulsory admission and force facilities by the Ministry of Justice; coherent actions for de-stigmatization.

Health care system in Romania

Dr Victor Olsavszky, WHO Liaison Officer

The introduction of the Health Insurance Fund marked the shifting from a centralized health care system (Semashko type) to an insurance based system (Bismark model).

Until 1997, the main source of funding was general revenues, mainly through the state budget. After 1997, the health insurance law made insurance memberships mandatory and linked it to employment. The contribution rate is of 7% from employers and 7% from employees and is raised by the District Health Insurance Funds (DHIF). They are responsible for reimbursement of local providers (individual – physicians - or institutional- hospitals or outpatient centres). They are financing mainly curative services on a contractual basis.

Hospitals receive global budgets that are set 70% on a historical basis and 30% on performance criteria. Maintenance and overhead costs are also the responsibility of DHIF. Major capital investments remain the responsibility of MoH. Since September 2001 a DRG pilot project is being implemented in 25 hospitals.

The National Health Insurance Fund negotiates the framework contract with the Romanian College of Physicians which has important responsibilities regarding all areas of concerns for physicians (who should be registered in order to practice, the content of benefits package, the type of reimbursement, which drugs are compensated, etc.).

The mandatory health insurance scheme covers theoretically the whole population. Children, the handicapped, war veterans and dependents have free access. Contributions for soldiers and prisoners are covered by the Ministries of Defense and Justice. However, there are vulnerable groups that cannot benefit from this (mainly because of lack of papers, lack of information, illiteracy). There is a MoH initiative for community nurses to do a part of this job.
WHO Mental Health Assessment in Romania

Dr Bogdana Tudorache, Romanian mental health counterpart, president of the Romanian League for Mental Health

Dr Tudorache warmly welcomed the participants and expressed her hope that this meeting would help Romanians to deal more efficiently with the mental health reform in their country. She insisted on thanking the Minister of Health and Family for immediately accepting to organize this meeting in Bucharest and also thanked the young and efficient staff of the Romanian League for Mental Health (RLMH) and the WHO Liaison Office in Romania for their support in the organization of this event.

She stressed that the programme of the meeting was structured according to the recommendations of the mental health assessment carried out in Romania 28 August-1 September 2000 by the WHO European Task Force for Mental Health Assessments.

The main actions in which WHO has been involved in Romania were:

1. The WHO workshop “Mental Health in Romania”, Bucharest, 8-9 June, 1999 organized by the Romanian MoH, the WHO Department for Mental Health (within the programme Nations for Mental Health), WHO Regional Office for Europe and the Romanian League for Mental Health; the main topics discussed were the need to elaborate a National Plan for Mental Health and to create an adequate legal framework, including a mental health law.

2. The audit for the evaluation of the Romanian potential regarding investments for health and its promotion, June 1999, conducted on the request of the Romanian Parliament by a panel of experts of the WHO Regional Office for Europe; the first recommendation stipulates the necessity “to take the decision that mental health is a priority, as a response to the serious impact on mental health which was affected by the long period of Romanian social-economic transition, as well as on the potential gain regarding the personal, social and economic well-being”.

3. The WHO mental health assessment, 28 August-1 September, carried out at the invitation of the MoH and in close collaboration with the RLMH and the WHO Liaison Office in Romania.

The experts met several ministers, officials, presidents of associations, mental professionals in health area, users of mental health services, journalists and visited several institutions: Ministry of Health, Ministry of Labor and Social Protection, Ministry of Education, Ministry of Justice, Ministry of Defense, Ministry of Foreign Affairs, National Tourism Authority, External Policy Commission and Health Commission of the Romanian Parliament, NGOs actively involved in the mental health field. Also, visits in three districts (including three major psychiatric hospitals) – Socola in Iasi, Poiana Mare in Dolj and Sibiu psychiatric hospital - have been made.

The final recommendations of the assessment were:

- Mental health should be made a national priority issue, since there is no health without mental health and developmental delay can be found in comparison with somatic health services.

- A National Mental Health Plan should be established, ratified and mandated. It should outline principles, policies and a plan of action.

- A focal point on mental health should be designated within the Ministry of Health, as well as
a national coordinating body in order to facilitate and ensure intersectorial co-ordination at the regional and local level.

- The creation of an Interministerial Committee for Mental Health is considered pivotal.
- A permanent advisory board should be established including significant professional associations, NGOs and family and users representatives.
- Monitoring and evaluation strategies on mental health should be improved, considering examples of good practice for national psychiatric care development, training, data collection and analysis.
- Development of community psychiatric care and appropriate social and welfare support must be a priority; this includes the involvement of general practitioners, primary health care workers and family doctors.
- The increasing need of mental health services requires the establishment of multidisciplinary teams including nurses, psychologists, social workers, ergotherapists. Adequate curricula for all mental health professionals should be developed in accordance with European standards. Training in psychotherapy should be encouraged.
- The activities on mental health promotion, including the elimination of stigma and discrimination must be increased.
- The law concerning the protection of persons with mental health disorders and mental health policy must be adopted and should be in line with the Council of Europe and with the United Nations provisions regarding the respect of civil and human rights.

Dr Tudorache concluded that such a programme would be never developed without the substantial support of MoH, of the Government and of the Parliament. She expressed her hope that the active participation at this meeting would help to find practical solutions at the issues that would be discussed.

**The law concerning the promotion of mental health and the protection of persons with mental disorders**

**Professor Dan Prelipceanu, Romanian League for Mental Health**

Professor Prelipceanu emphasized the imperative need of a mental health law in Romania in the spirit of the UN resolution 46/119 concerning “the principles for the protection of the persons with mental disorders and for improvement of mental services”.

He mentioned the legislative gap of the Romanian mental health system:

- mental health professionals lack legislative tools to intervene for the legal protection of mentally ill patients and of their families;
- compulsory admissions are regulated by a decree (and not by a law) issued during the communist era; it regulates “commitment of dangerous psychiatric patients”;
- the quality of mental health services is decided by bureaucrats and has no connection with guaranteed legal standards;
- police and fire departments, public guardian services, social services take advantage of the legislative gap and don’t intervene to protect the person who has a public inadequate behavior or the neighboring persons;
uninformed journalists incline to transform simple clinical situations that require admission in a psychiatric facility into sensational stories.

The project of the *Law for Mental Health Promotion and Protection of Persons with Mental Disorders* has been elaborated by the Task Force of the RLMH, in collaboration with WHO and European Council experts.

Main points of the project:

- the objectives of the law project include financial issues, mental health promotion policies and quality standards of care;
- the project respects the 22 recommendations of the UN General Assembly Resolution 46/119 as well as the 10 UN principles regarding the mental health legislation;
- the project is structured in eight chapters: general provisions and glossary of terms related to legislative issues; promotion and protection of mental health and prevention of mental illness; mental health assessment – diagnostic procedure; mental health care system; admission to a mental health care facility; penalties; financing; final and transitory provisions.

The law project has been revised by the Legislative Commission of the Deputy Chamber of the Romanian Parliament and is waiting to be endorsed by the Senate.

**The strategy for mental health of the Ministry of Health and Family of Romania**

**Dr Radu Teodorescu, vice president of the Romanian League for Mental Health**

Dr Teodorescu explained that the strategy has been elaborated by a group of experts according to the WHO assessment recommendations and was finally approved and adopted by the MoH. The aim of the strategy is to decrease the morbidity related to psychiatric conditions and to improve the mental health care.

The overall objectives are to reinforce the mental health concept within the system of values of the Romanian society, to reduce the risk and vulnerability factors for the mental illness, to reform the mental health care system.

**Prevention module (primary prophylaxis)** takes into consideration three types of prevention:

1. *General prevention* (target population – whole population – e.g. mental hygiene programmes, stress management, crisis management, conflict management programmes)
2. *Selective prevention* (target population – groups exposed to a significant higher risk than the average population – e.g. programmes for children in institutions, programmes for children and teenagers with heredo-colateral antecedents for alcohol addiction).
3. *Focussed prevention* (target population: high-risk groups- e.g. programmes for children with heredo-colateral antecedents of affective pathology, schizophrenia, programmes for elderly).

MoH considers as a priority the actions that concern the children and adolescents’ mental health. In this context the immediate objectives are:

- promotion of a broader conception on the protection of mental health that should include both the child and his family (at least the mother);
bullet setting up prenatal counselling centres;
bullet prevention of the delay of the psychomotor development by introducing the regular screening for early diagnosis and intervention;
bullet stronger mental health protection for the primary school pupils obtained through a continuous training for the medical staff in schools;
bullet a better education for health (healthy lifestyle, fight against drug addiction, alcoholism, suicide, and violence);
bullet diversification of medical-educational interventions in schools and outside schools for covering the special needs of some high vulnerability categories among children and adolescents (different forms of disability, social maladjustment and delinquency).

System of care module (secondary and tertiary prophylaxis)
MoH considers that the reform of the mental health system should respect the following world-wide validated principles: territoriality; multidisciplinary therapeutic team; continuity of care; specialization; community orientation.

The structure of the system of care should be: mental health centre; psychiatric hospital; psychiatric ward from the general hospital; ambulatory service; crisis intervention centre; specialized networks -addictions, geronto-psychiatry.

The mental health centre has to become the fundamental unit of mental health, allowing a better monitoring of treatment, rehabilitation programmes and an optimal cost-efficiency balance. Other important functions of the mental health centre are screening for the identification of risk factors, of concrete needs on a specific area, and implementation of selective and focused programmes.

Legislative module
MoH aims to develop: a mental health law; other legislative initiatives concerning the psychoactive substance regime (including alcoholic drinks), the dissemination of violence behavior in the media, the juridical status of mentally ill offenders.

The law project concerning the promotion of mental health and the protection of persons with mental disorders is in the process of being endorsed by the Parliament. Afterwards, MoH will be involved in the implementation process, both among mental health professionals (through regional workshops with the support of the specialists who contributed to the elaboration of the law) and among the general population (through mass-media campaigns).

Resources module
Financial resources - MoH will continue to fund the Mental Health Prophylaxis Programme and will encourage the identification of extra budgetary financial resources (WB, PHARE).

Human resources - MOH will elaborate and implement: training programmes at all levels (medical students, psychiatrists, psychologists, nurses, social assistants, etc.); specialization programmes for family doctors; mechanisms of attracting other specialists to the mental health area (psychologists, sociologists, lawyers, clergy representatives, civil servants, etc).
The development of the community psychiatric care and an adequate social assistance should be a priority.

**Connection with other systems**

**Connection with the general medical system:**
- development of liaison psychiatry (psychiatric wards in the general hospital);
- fight against the exclusion of the psychiatric patient within the somatic medical community; development of an alliance strategy with the family medical care;
- connection with the academic community and the scientific research;
- introduction of the mental health issue in the syllabus of the faculties of medicine, psychology, sociology, etc;
- setting up a mental health department within the Institute of Public Health and a Mental Health Research Institute in co-operation with the Academy of Medical Sciences.

**Connection with the media:** information and awareness programmes for young journalists; press monitoring programmes, targeting stigmatization tendencies towards mental illness and users.

**Connection with the associative system (NGOs).**

To implement this strategy, the MoH will continue to cooperate with the main NGOs in the area (Romania League for Mental Health, Romanian Psychiatric Association). The implementation of the strategy urges the elaboration of a National Mental Health Plan, with short-term, medium and long-term objectives and monitoring of the achievements and responsibilities.

**Current approaches and perspectives in the area of child psychiatry**

**Dr. Alina Mandroiu, counsellor, Department of Social and Family Assistance, Romanian MoHF**

Dr Mândroiu explained that the approach of psychiatric aspects depends on the socio-economic changes Romania has been going through during the last decade, i.e. gradual decrease of the life standard, increase of the general mortality and social diseases (TB, syphilis, malnutrition), noticeable increase of psychiatric troubles mainly with young people.

From this perspective, MoHF, through its new organizational structure, had enlarged its activities from a social and family perspective. Child psychiatry is directly involved in promoting a harmonious development of the child, contributing to his integration in family, school and community. This is why the mental health status of young people depends on the early intervention for the child well-being.

Significant changes occurred at the level of cultural values especially among children and young people. This led to increased juvenile delinquency, school abandonment, children on the street, drug dependency.

The national health programmes elaborated by MoHF in order to meet the above mentioned needs are the following:
- Programme of Fight and Prevention of Drug Abuse and Substance Dependence;
• Programme for Child and Family Health Care;
• partnership with the Ministry of Education and Research for health education in schools;
• partnership with other ministries, governmental or non-governmental organizations for fight against juvenile delinquency and school and/or family abandonment.

Dr Mândroiu underlined that Romanian Government has recently started a large process of reform on children in institutions, who suffer from major development lags and neuro-psychiatric disorders. A multi-disciplinary team (specialists and researchers from the social, educational and psycho-medical field) has been created in each district to evaluate at what extend children rights are respected and to take adequate measures on this purpose. This team in co-ordinated by local authorities. Child psychiatrists are part of the team planning individualized strategy of recovery.

The recently endorsed *Law on social assistance* will create the framework for the development of social health services. The direct target of these services will be the community and therefore, psychiatry services will have to be provided both in specialized institutions (residential or nonresidential) and at home.

There is a need for a policy framework of child psychiatry in order to offer qualified services.

*Main issues to be solved*

• Psychiatric medical services need to be improved.
• High qualified services need to be recognized by the College of Physicians and reimbursed by the National Health Insurance House.
• The development of psychiatric nursing in Romania is strongly needed.
• The National Screening Programme for Early Diagnose of Mental Diseases among children needs to be improved.
• The mental health law will provide specific responsibilities for child and adolescent psychiatry.

*Good practice examples*

Chairpersons: Dr John Henderson, Dr Victor Olsavszky

**Community psychiatry in Romania**

**Dr Radu Teodorescu, vice president of the Romanian League for Mental Health**

Romanian League for Mental Health started its activity in 1993 and offered the first shelter homes for chronic psychiatry patients.

There are several positive initiatives in the community psychiatry area:

• ESTUAR, social integration centre for adults, which started as a programme of the RLMH;
the open-minded department of psychiatry in Timisoara which took part at the WHO programme “Nations for Mental Health” and developed a series of programmes of prevention of the abandonment of mentally ill persons and of training of professionals;

• the programmes in Brasov, initiated in 1994 offering shelter homes with foreign support;

• the first Centre of Mental Health, to provide services for chronically psychotic patients.

Dr Teodorescu also mentioned that before 1989 psychotherapy was forbidden in Romania and was ideologically linked.

He concluded by expressing his hope that The Mental Health Centre will help to work in multidisciplinary teams and will provide case management.

Discussions

Dr John Henderson pointed out that it was useful to remember that the reform programmes in Romania started ever since ’80s, with Professor Branzei’s initiative in Iasi, as a pilot study. Reform is a continuous process and there are always further steps in front of us.

He also stressed that one of the outcomes of the pilot study was to create a nation-wide programme of the concept of catchment area as a distribution area of resources. He then proposed as a topic for discussion the issue of using resources to best benefit.

Liaison Psychiatry in Romania

Dr Florin Tudose, Head of the Liaison Psychiatric Department, University Hospital, Bucharest / Dr Anca Niculaita, assistant researcher

The creation of the Liaison Psychiatry Department of the Emergency University of Bucharest was a novelty in the country. The hospital includes 30 university clinics, more than 1500 beds with more than 2 500 people working in the wards and laboratories.

The Liaison Psychiatry Department was created in 1995, the team in made up of 2 psychiatrists, 2 researchers, 1 psychologist, 3 nurses and 1 data operator. The database is fully computerized, phone, pager or intranet make the connection with the clinics and, until the end of March, there were more than 18 000 consultations. The consultations are performed on the base of referrals from the physicians working in the hospital or ambulatory facilities.

The main functions of the Liaison Psychiatry Department are:

• to analyze the real pathology in a general hospital;

• to use correct diagnosis criteria (DSM IV);

• to make specific therapeutic interventions and use of psychotherapy;

• to provide an alternative, a modern model of care;

• to contribute to the decreasing of hospitalization costs;

• to prevent iathrogenozis;

• to develop a continuous collaboration with the general practitioner.
The therapeutic interventions in liaison psychiatry are specific according to: age; comorbidity; pathological circumstances; side effects of associated drug therapy; obstruction of clinician; short time inpatient; lack of therapeutic agreements with other specialists; lack of tradition; lack of psychiatric knowledge of family doctors.

As for the attitudes of non-psychiatric physicians towards liaison psychiatry, remarks were made that:

- in theory: the physician should efficiently and carefully look at the general condition of the patient and diagnose and treat him in order to increase his compliance and quality of life;
- in practice, he is inclined for very sophisticated diagnosis and tries to use the newest medication or surgical interventions, prolongs the hospital admission without taking into consideration the “quality of life”, calls on the volitional resources of the patient who is supposed to restrain from expressing his psychiatric symptoms.

Thus, in the general hospital, the resistance to psychiatric diagnosis and treatment is double:

- the patient hardly accepts that the symptoms have the origin in his mind;
- the clinician, fascinated by “the game of laboratory findings”, but confused by the inefficiency of his therapeutic approach, wants the psychiatrists to accept his diagnosis and treatment.

In order to increase the quality of medical practice and patient care, an active training programme of medical staff was initiated to encourage for a proper medical conduct in relation with the psychotic patients.

Some data from an economic perspective were presented, which proved that that the Liaison Psychiatry Department is “a good business” for the general hospital:

- US $1 invested in liaison psychiatry saves US $48 from the hospital budget
- US $326 000 represent the saving achieved by the Liaison Psychiatry Department throughout 8 months;
- staff salaries and administrative expenses were of US $12 000 for 8 months, which means that US $1 invested in Liaison Psychiatry Department = US $25 saved in the University Hospital budget.

Plans for the future: ongoing information process for non psychiatric physicians; dynamic co-operation with the family doctors; continuing research papers on psychotropic drugs in the general hospital; establishing procedures regarding the therapeutic attitude for ill patients with associated pathology; systematic studies about “specific pathology”: chronic pain, neurasthenia, anorexia/bulimia, somatoform pain; elaborating therapeutic strategy for the elderly.

**Discussions**

Dr John Henderson noted the importance of a cost-effectiveness analysis as an argument for the decision-makers. He again emphasized the importance of local initiatives for the development at the country level.
Development of psychiatric nursing in Romania

Professor Constantin Oancea/ Ms. Mihaela Hrestic

The project of a training programme in psychiatric nursing was based on a large WHO assessment carried out in 1990 which clearly emphasized the poor quality of psychiatric care in hospitals, and the importance of opening a psychiatric school at the level of mental health professionals. The same year came the proposal of opening a school for specialization in psychiatric nursing, in the context in which nurses were a simple “performer” of doctors.

The training started in 1994 in Bucharest at “Alexandru Obregia Hospital” and in 1997 it was organized at “Socola “ hospital in Iasi. The course in psychiatric nursing emphasized the necessity of changing the attitude of nurses, as a consequence of patients’ complains about the indifference of the staff.

The main objectives of the course are: a more complex role of the general nurse in the psychiatric care; a half independent, but a co-operative style of working in a multidisciplinary team; fulfillment of specific tasks of psychiatric nursing such as:

- autonomous assessment of the needs for psychiatric patients;
- development of the therapeutic nursing relationship;
- psychological and psychotherapeutic interventions (empathic listening, providing information, guiding rehabilitation tasks, participation to group therapy as co-therapist, psychiatric nursing in community and home care as case manager).

The curriculum of the course includes: general psychology; medical psychology; sociology; psychiatry; ethics and legislation; examination and exploration of the psychiatric patient; psychiatric nursing (models of care); specialized interventions; rehabilitation of psychiatric patient; general psychiatric care; health management; computer (medical informatics).

During the period 1994-2000, 137 psychiatry nurses were trained, the most successful departments being, as well as Bucharest (53): Prahova (10), Buzau (11), Brasov (11), Mures (10), Dambovita (8), etc. Significant changes were registered in health care procedures. In the district of Mures, the trained nurses became important leaders in depression groups and for rehabilitation tasks. However, no nurse from district outpatients health facilities was sent to the training.

Since 2002 the course has been under the authority of the MoH and one of the objectives for the future is to train nurses from chronic disease hospitals.

The importance of mental health nongovernmental organizations (NGOs) for the development of mental health area in Romania

Dr Victor Olsavszy pointed out that the mental health NGOs in Romania represents the most dynamic part of the system. Nevertheless, he emphasized there is a need for coordination of NGOs’ activities, common strategy, in order to avoid duplication. The NGOs should also be stimulated to be synergetic with government policy.
**Romanian Alzheimer Society**

**Dr Catalina Tudose**

The main event organized by the Romanian Alzheimer Society recently was the XI Alzheimer European Conference, held in Bucharest in June 2001.

More than 550 persons attended the conference, among which 140 foreigners as representatives of 21 Alzheimer organizations (from Europe, Israel, New Zealand, USA, Mexico), well known professionals in psychiatry, gerontopsychiatry and neurology, representatives of international media. Politicians, local authorities, students, specialists and non-specialists, family members were present too.

Dr Tudose also mentioned the quality of the conference programme, the diversity of the thematic, the optimistic atmosphere and the excellent organization, which made it an interesting and unexpected event.

Positive points of the conference: high number of Romanian and foreign participants; relatively high number of governmental and local authorities (3 ministers took the floor in the opening); favorable opinions expressed in evaluation forms.

Negative points: low attendance of mass-media; no attendance from the local authority with whom the organization had the strongest contacts and developed services (State Secretary of People with Handicap, General Mayor of Bucharest, the mayor of the 5th sector of Bucharest).

The *Memory Centre* is a successful partnership between the Romanian Alzheimer Society and the Hospital Alexandru Obregia, financed by the hospital and United Kingdom Embassy. It represents an ambulatory facility which has as main objective the early diagnose of cognitive disorders in adults and elderly people. The programme began its activity on the 20 October 2000.

Main points that characterize the *Memory Centre*:

- multidisciplinary staff: coordinator, psychiatrists, neurologist, psychologist;
- 870 initial psychiatric examinations (710 patients with cognitive disorders, 560 with dementia, 150 patients with other cognitive syndromes); 440 Alzheimer disease and 120 other dementia;
- 1410 periodical consultations; 466 psychological examinations; 330 neurological examinations.

Positive aspects of the Memory Centre:

- it has become an official department of the hospital;
- a lot of people ask for examination in early stages of dementia;
- low costs;
- favorable opinions on behalf of the patients and the families;
- good opportunities for functional links with hospital facilities and community services;
- excellent opportunities for family information and counseling.

The programme should be continued and multiplied in other big hospitals.
Negative aspects: uncertainty as to the future; the legislation and the cutting of funds made the continuation of the programme very difficult.

The Day Centre for Alzheimer Sufferers- Respite Care Programme was created in 2001 for 30 people with mild dementia within the community centre for elderly which had been set up 8 years ago. The financial support is provided by the Dutch Foundation. The results of the programme were the improvement of patients’ behaviour and the satisfaction of the families. The growing number of requests proves the great need for such services.

Positive points: low costs; services highly appreciated by the families and the patients themselves.

Negative points: great difficulties in continuing the programme; difficulty in convincing the local authorities about the importance and usefulness of such projects.

Dr Tudose concluded that the weak point of Romanian Alzheimer Society may be an inefficient and insufficient activity of lobbying for the rights and needs of the patients. She also mentioned that physicians tend to take for granted that political authorities can easily understand the importance of health issues that medical doctors generally care for (which is not true). Likewise, the voice of the clients and families is too weak.

**Estuar Foundation**

**Ms. Roxana Braga**

Ms. Roxana Braga started by saying that she would talk about people, not about medicines and papers. Coming from a marketing area, she is proud of being an engineer and of having succeeded in carrying out the difficult mission of leading the Estuar Foundation.

Estuar is a non-governmental organization set up in 1993 by the RLMH and the Scottish association Penumbra, which provides social options and alternatives for adults with mental health problems for their integration within community.

After nine years of activity, the Estuar Foundation has more than 300 people committed to its goals. In November 2001 the Foundation passed through a serious crisis, which threatened its disappearance, as the bank where they had the donors’ money collapsed. This meant an extraordinary solidarity exercise for the staff of the Foundation (45 persons) who had to manage the crisis and continue to function without money during 8 months.

She also spoke about the wide range of emotions that Estuar staff and herself experienced at this difficult moment: despair, disappointment, anger, envy, temptation of being aggressive, hope. Another point she outlined was that Estuar mission is to serve users who need their families, not only medicines. Estuar provides services of social integration: therapy groups, drama, theatre groups, free legal advice. The staff of the association includes psychologists, social workers, psychiatrists, lawyers, etc.

Some figures are relevant for the cost-efficiency and the real need of services provided by Estuar: US $6/month in Estuar is the equivalent of US $212/month in hospital.

Ms. Braga ended by presenting Estuar annual report and a few magazines edited by the users.
ALIAT Association

Dr Dan Prelipceanu

ALIAT (Alliance to Struggle against Alcoholism and Other Dependencies) is an association of mental health professionals, which was founded in 1993.

In 1999 ALIAT implemented the first primary prevention programme called IN-DEPENDENT, in partnership with the Ministry of Youth and Sport and the Ministry of Education. The programme started as a pilot project for 3 high schools in Bucharest where drug consumption was confirmed.

The structure of the programme consists of:

- a peer network (teenagers from the selected schools were trained to spread balanced information);
- an educators network (students in psychology and social assistance were trained for monthly interventions in schools);
- a counselling centre.

Since 2001 the programme has been expanded to 10 high schools under the same methodology. In April 2000, ALIAT promoted the first harm reduction programme in Romania called Minimal risk which led to the foundation of a drop-in centre for intravenous drug users, providing sterile equipment, counselling in HIV, HVB, HVC prevention and referral to other services (when needed).

The centre was created with the financial support of the Open Society Institute Romania. Since April 2000, the programme has registered 13,720 contacts and has provided 169,949 syringes collecting 55,461 used syringes. All clients are registered in the data basis under a code. In July-September 2001 a testing programme (HIV, HVB, HVC) was developed by ALIAT in partnership with UNAIDS and ARAS (Romanian Association Against AIDS) for the clients of Minimal Risk. 168 clients were tested in full confidentiality and received pre and post counseling.

50% were HVC positive and 26% HVB positive. The HIV results couldn’t be considered reliable (the samples were altered).

Minimal Risk has recently developed an outreach service for other 3 areas.

ALIAT and the Open Society Foundation Romania have been actively involved in the promotion of the new drug law, according to which the new regulations regarding the harm reduction programme became legal.

ALIAT was the founder member of the Romanian Harm Reduction Network and became partner in an international programme for mobile drug users coordinated by AMOC (Netherlands). It has also been involved in a multi-country project of the Pompidou Group (Council of Europe), preparing and editing the First Romanian Treating Guide on Addiction.

ALIAT applied for project (KAP) to the Dutch Embassy to implement a pilot project on training for a limited number of addiction specialists from Bucharest, Timisoara, Iasi and Sibiu. The
project consisted of delivering 2 courses (January and March 2002) and assessing the training needs in the field of addiction.

Plans for the future:

- ALIAT intends to promote the first Methadone Programme in Romania. Although the programme was accepted and received funds to be developer, it has not yet been put into practice because 3 main issues haven’t been clarified: the form of methadone (in Romania there is no liquid form registered and the procedures to approve it last one year); the payment; the location.

- ALIAT plans to create an infrastructure to provide training and continuous education for professionals; ALIAT in partnerships with Jellinek and other Romanian governmental institutions applied for such a programme to MATRA.

- ALIAT, in partnership with the Open Society Foundation in Romania and the European Addiction Training Institute has elaborated a project for training in harm reduction, which was applied for ACCES funds.

“Wings”- association of users

Mr. Stefan Bandol

Mr. Bandol pointed out there are two aspects of protection: one person is protected and the other one has the power. He insisted on the fact that nobody knows better than the users or the ex-users what is best for them, not in terms of medical treatment, but with regard to alternative medical services, reintegration in society.

The idea of creating an association of users and ex-users came in 1998, after having contacts with other users associations from Hungary, Poland, Slovenia. The start was difficult not only because of the complicated legislation, but also because the users themselves hesitated on the legitimacy of such an organization, when there are other NGOs which already provide alternative services.

The main objective of the association is the fight for the users rights. Other objectives are:

- introducing advocacy in psychiatric hospitals;
- creating self-support groups;
- changing the present systems of huge hospitals and passing to community care;
- protected jobs;
- eliminating the stigma.

He added that the main obstacle is mentality. To that purpose he told a short story:

On a beach, in summer, three persons are lying on beds, wearing thick clothes, with pillows under their heads, sweating. A thin boy appears on the beach, wearing only a bathing suit, sees the three persons and starts to laugh. The three ones look at him threatening, then run toward him, catch him, put a coat on him, put a cap on his head and wrap him in a blanket. Then they strike his face protectively and start smiling with satisfaction.
Mr Bandol concluded by expressing his hope that the beginning of the association would not be like this. He also addresses special thanks to Estuar Foundation represented by Ms. Roxana Braga and to the Centre STEPS represented by Dr Radu Teodorescu for their support to the association Wings.

**Romanian League for Mental Health**

**Ms. Raluca Nica**

The Romanian League for Mental Health is an inter-professional association and its mission is to be a powerful-based organization which influences government policy. The League currently covers 14 organizations acting in the mental health field.

The main difficulties usually encountered by NGOs are lack of financial support; lack of financial facilities (19% VAT, 25% taxation on profit); lack of mental health legislation; lack of organizational structure and training staff; lack of communication and information skills; donors oriented to Central Asia.

In this field women are positively discriminated, as most of employees are women.

The main areas of coverage of the Romanian League for Mental Health are:

- information and training: NGO Directory for the organizations working in mental health (1997); Mental Health Resource Centre (1997-2000); Capacity building for mental health NGOs (1998); Information and Documentation Centre (1999-2000).
- lobby and advocacy campaigns: reducing the stigma and discrimination related to schizophrenia (2000-2002);
- editorial projects (magazines): Connections; Synapses; Psychiatry Today.

**Working groups: feedback on the Romanian situation**

The participants split into four working groups to discuss their experiences and give a feedback on the Romanian situation. The groups reported their experiences as follows:

**Group 1: Reform and strategy of psychiatric structures**

Facilitators: Dr. Peter Breier (Slovakia), Dr. Radu Teodorescu (Romania),
Rapporteur: Ms. Roxana Radulescu (WHO LO Romania)

The group addressed:

- how to introduce incitements for change;
- the functioning of the financial system;
- de-hospitalization and the issue of number of beds;
education of staff.

The following issues of concern were pointed out:

- it is important to create smaller hospitals and specialized institutions (although one has to take into account that there is a culture of hospitalization in Romania);
- there is a difficulty in influencing high level decisions;
- there is a need for a higher number of staff, but also for showing good examples;
- education is important not only for nurses, but also for psychiatrists;
- the income allocated to psychiatry is usually much lower than that of other medical specialties;
- the mental health counterpart could be the person who presents ideas of change to decision makers;
- there should be awareness of the fact that the requests/suggestions for change presented to the MoH should fit the institutional regulations;
- there is a need for clarifying terminology when talking about new structures to be developed (e.g. mental health centre);
- there should be an inter-ministerial collaboration in the process of de-institutionalization; it should be a gradual process in which the logical circuit of the patients should not be neglected;
- it is important to adapt the changes according to the needs of the region.

Discussions:

What about de-institutionalization costs?
Some research indicates that de-institutionalization might be more expensive.

Emphasis was laid on the need of a glossary to clarify mental health care terminology.
The use of allocated money should be also analyzed (money might go to medicines, even if they are initially designated for community care).

Group 2: Mental health legislation

Facilitator: Dr Dan Prelipceanu (Romania), Professor Constantin Oancea (Romania), Dr Thomas Bornemann (WHO HQ)
Rapporteur: Dr Dan Prelipceanu

The group addressed:

- arguments supporting the promotion of a mental health law in Romania;
- current legislation in Romania referring to compulsory treatment and hospitalization of people with psychiatric conditions (decree 313/1980);
- the content of the legislation which wanting promotion /the content of the law which is in process of being promoted;

The following issues of concern were pointed out:
• the current legislation is not in line with the actual standards of legislation in Europe; there is a need for harmonization with EU legislation;
• project of the mental health law tackles a larger area of issues;
• structure of mental health facilities;
• improvement of procedure guaranties to preserve the patients’ civil rights;
• harmonization with the EU legislation;
• the decision making process (by the professionals or by the Court);
• there is a need to develop a strategy to convince authorities to accept new standards;
• the new mental health law could be a real engine in promoting a new standard of care.

Discussions

It was emphasized that some countries may not wish to conceive separate legislation, as in fact it may be stigmatizing itself.

Protection of human rights should mean both civil rights and human rights.

Another issue to take into account is the difference between treatability (Ministry of Health) and culpability (charge of the Ministry of Justice).

Group 3: NGOs and their role

Facilitator: Dr Catalina Tudose (Romanian Alzheimer Society)
Rapporteur: Raluca Nica (Romanian League for Mental Health)
The group addressed:
• role of the NGOs in the decision making process;
• collaboration with public authorities;
The following issues of concern were pointed out:
• The NGOs can provide a valuable contribution to the national mental health policy;
• The NGOs should be part of the mental health reform; there would not have been so much progress without them;
• the NGOs represent the voice of the civil society;
• NGOs have an important role in campaigning (stigma and discrimination campaigns); they develop the most effective local campaigns.
• there is a lack of distinction between those NGOs providing and those not providing services (either providers, or campaigners, or both);
• A National Council of Voluntary Organization in Romania should be set up and funded by the government;
• the NGOs need a focal point in the Romanian Ministry of Health and Family – see the recommendation of the assessment;
• The NGOs should be given facilities;
• There should be recognition of NGOs for their contribution in professional training.

**Discussions:**

It was emphasized that NGOs should work in synergy with public authorities to avoid duplication; there is a need of a legislation to control NGOs activities.

**Group 4: Promotion and determinants of mental health**

Facilitators: Dr Victor Olsavszky (WHO, LO Romania), Dr. Maria Joao Heitor dos Santos (Portugal)

Rapporteur: Dr Victor Olsavszky

The group addressed:

• schools- general education;
• health professionals and others;
• education for families and individuals;
• mental health promotion at workplaces;
• funds issue.

The following issues of concern were pointed out:

• there is a need of a link between schools and mental health services and promotion (HELP LINE and PURPLE line);
• local authorities should be involved in mental health promotion and helped to draft policies;
• other partners and policies should be involved;
• prevention of child abuse, prevention of alcohol and drug abuse should be included in school education, for health professionals and others;
• community based mental health promotion should be developed.
• we should start to do what does not cost.

**Discussions**

It was suggested that mental health promotion should be developed at the level of Government and power structures.

It was informed that in Finland there is an inter-ministerial level of health promotion including Ministry of Justice, Ministry of Traffic and Transportation, Ministry of Interior, Ministry of Welfare. The suggestion was that the best method in working with authorities is to ask what to do, not to tell what to do.
Friday, 5 April 2002

WHO European Mental Health activities and policies, an update

Dr Wolfgang Rutz, Regional Adviser for Mental Health, WHO Regional Office for Europe

Dr Wolfgang Rutz started the day’s activities by reiterating that the feedback given by the counterparts to the Romanian situation is very valuable and helpful to the ongoing process.

He mentioned there was no reaction from the counterparts from Iceland and Denmark and expressed his regret that some of the counterparts were not able to attend the meeting, but also his concern that the network had no counterparts in some countries as Turkey, Cyprus, Tajikistan.

He then made a review of the main mental health activities and policies in the European Region.


Chapter I – Approach

- there is a continuous interaction and a deep interdependency between mental, physical and social health;
- considerable advances have been made in the field of neuroscience and behavioral medicine;
- there should be a continuum promotion- prevention- treatment;
- mental health should be recognized as a key determinant of health and governments should assume stewardship to develop and implement policies.

Chapter II – Burden

- the disorders on which the report focuses are: depressive disorder, substance use disorders, schizophrenia, disorder of childhood and adolescence, suicide;
- during lifetime, 25% of all people develop one or more mental or behavioral disorders.
- they are universal, affecting people of all countries and societies, at all ages, as many females as males;
- they have a huge impact on individuals, families, societies;
- the burden of disease may be tangible and obvious, but also intangible and impossible to measure.

Chapter III – Solving mental health problems

- a shift in the mental health care paradigm took place focusing on de-institutionalization, new treatment, respect for human rights, partnerships with patients and families, multisectorial community engagement, community-based care, primary health care involvement;
- a holistic and multidisciplinary vision of treatment should be taken into consideration;
- the role of psychosocial rehabilitation in enabling individuals to acquire practical skills needed to reintegrate in community should be emphasized.
Chapter IV – Policy and services

- governments need to set policies that will protect and improve the mental health of the population:
  - protect people from catastrophic financial risk (minimizing out of pockets payments);
  - the healthy should subsidize the sick and the well-off should subsidize the poor;
  - forms of prepayment are preferable (via general taxation, mandatory social insurance or voluntary private insurance).

- mental health services should be based on dehospitalization, community based services, multisectorial engagement, multidisciplinary team, integration into primary health care;

- there is a wide range of strategies to promote mental health:
  - targeting determinants for ill-health;
  - screening population at risk;
  - using setting approaches;
  - raising public awareness and using mass-media;
  - using community resources to stimulate change (NGOs, family organizations);
  - involving other sectors (labor and employment, commerce, education – specific needs-, housing – no segregation-, social welfare services, criminal justice system).

Chapter V – The way forward

Ten overall recommendations.
1. provide treatment in primary care;
2. make psychotropic drugs available;
3. give care in the community;
4. educate the public;
5. involve communities, families and consumers;
6. establish national policies, programmes and legislation.
7. develop human resources;
8. link with other sectors;
9. monitor community mental health;
10. support more research.

The European situation

Atlas Report (Mental Health resources in the World 2001) shows that there are about 689 642 psychiatric beds for 841 million people in the European region (70.5%) and also a quite high number of psychiatrists in the European region compared to other regions (77 242 for 841 million people).
Main events in the European Region during 2001 - Year of Mental Health

- Athens meeting: Athens declaration, Greek commitment, South European endorsement, WEU collaboration;
- Madrid Regional Committee (RC); endorsement of Athens agreements;

Main activities:

- assessment – MNH policy;
- task force on stress and premature mortality;
- stigma and exclusion related activities;
- activities of the European Network on Suicide Prevention (comment: countries are invited to join this network);
- other collaborations and partnerships (with EU, Geneva Initiative, WPA, nurses, students);

The framework of activities is set up in: Biannual country agreement (BCAs); inter-country work; Emergency and Humanitarian Assistance (EHA) activities in South East Europe

2002 – Ongoing activities

- Council of Europe meeting in Vilnius, chaired by Lithuania;
- Joint meeting of Association of European Psychiatry (AEP), WHO and World Psychiatric Association (WPA) in Stockholm (3 May 2002);
- World Health Assembly – the Executive Board Resolutions;
- meeting for the countries of South and South Eastern Europe on Mental Health and Man-made Disasters, Stigma and Community care, Athens, 7-8 June 2002;
- XII World Congress of Psychiatry of WPA in Yokohama, 21-29 August;
- launch of the World Health Report – ministerial events;
- assessments and policy supports within BCA;
- WHO meetings in Germany on elderly and adolescents;
- various activities of networks and task forces.

Publications

- To be published in 2002: Suicide II, Suicide prevention, Mental health related morbidity and mortality, Stigma and exclusion, various editorials, articles, interviews.
WHO Global mental Health policies and activities – an update

Dr Thomas Bornemann, WHO HQ Geneva

Dr Bornemann thanked for the invitation to join the meeting and took it as a great opportunity to see what was going on in the countries.

He found the discussions of the first day them extremely important for WHO Headquarters, where concrete steps are taken towards one WHO.

He then tackled the favourable momentum to move the mental health issue forward and stressed that the crisis the world is facing is the management of long-term chronic diseases.


He added that 2001 was a tough year for WHO, but there had been many successful activities. Real work happened in the countries: Brazil’s launching of a new legislation, Nelson Mandela’s statement on mental health in Africa, President of China’s letter to Dr Brundtland, etc. WHO had produced a moving booklet, collection of drawings and stories from the Global School Contest on Mental Health – “Through children’s eyes”, the World Health Assembly had an enormous success and the World Health Report (WHR) was a springboard and a living document in itself.

The WHR focuses on the burden of disease, on a new understanding of mental disorders, on the magnitude of mental disorders, the effectiveness of treatment and intervention, the leading causes of DALYs. The clear message of the report is that there are things we can do, but we need to do them in a truly compatible way with our national realities.

Mainstream projects for the future are a campaign on epilepsy, building consulting capacity in the region and working on discrimination.

Medical vs. legal control of compulsory measures in psychiatry

Professor Heinz Katschnig, Austria

There are historical roots of mental health legislation regarding the control of misuse of professional power. Professional power of psychiatrists is considered to be larger than that of doctors in general, being reflected in actions of compulsory admission and detention in psychiatric institutions and compulsory treatment.

The misuse of this power may be personal (private mad houses in 18th century England), societal (former Soviet Union, former South Africa) and “endemic”, occasional misuse as top of an iceberg.

Mental health laws concern civil commitment law (high probability of harming one’s or other’s health), penal law (actual criminal behavior has occurred), service law (entitlement and access to treatment) and anti-discrimination law. In practice, between the special regulations in the penal law and the civil commitment law there is often only a small step between the two (through
escalation during a commitment procedure). Discrimination occurs in both instances, as indefinite detention is possible.

The areas of ethical concern in civil commitment law are: compulsory admission to mental hospital, seclusion; restraint within hospital; compulsory treatment; compulsory community control, storing and passing on information about this.

Three positions towards mental health legislation were emphasized.

**Abolitionism:**
- no special laws for mentally ill, because mental illness is a myth;
- psychiatry is regarded like any other medical discipline;
- patient and psychiatrist make a voluntary treatment contract;
- persons with mental disorders are fully subject to penal law.

**Legalism:**
- refers to the effort to control professional powers of psychiatrists by legislation providing compulsory measures.

**Medicalism:**
- there is a reaction of the medical profession against exaggerated legalism (neglect of needs, abstract concept of individual freedom);
- attention is drawn to improving services, especially emergencies and crisis intervention services;
- a tendency to push the concept “need for treatment” is registered.

Between legalism and medicalism, the question which arises is which are the types of professional controls accepted? Which steps of compulsory admission, detention, seclusion, restraint, treatments?

From the ethics of coercion perspective, two types of approaches occur: deontological (debates about rights and duties involved in a particular situation or behaviour) and empirical.

Research on coercion shows that not everyone who was legally involuntarily admitted must also have been coerced and that not everyone who was legally voluntarily admitted was not coerced. Thus, perceived coercion depends less on threats, physical force, legal status, and more on being included in the decision making, on the nature of other person’s intentions, on the absence of deceit and receiving respect. (Bennet et al 1993)

**Discussions**

Prof. Vaippu Taipale drew attention on the wider concept of coercion as of referring to child welfare, reminding that there are other areas of psychiatry where similar issues occur.

Prof. Katschnig mentioned that there are complaints that too much is done in this sense.
Involuntary treatment of mentally ill patients - Theory and practice in EU member states

Dr Hans Joachim Salize, Germany

Dr Salize presented the main results of the study Compulsory Admission and Involuntary Treatment of Mentally Ill Patients – legislation and practice in EU member states, carried out by the Central Institute of Mental Health in Mannheim.

The objective of the study was to gather and analyze information about the differences and/or similarities of legal frameworks for involuntary placement or treatment of mentally ill patients across the European Union Member States. The study did not refer to involuntary placement or treatment of mentally ill offenders.

Rules and regulations as well as the actual practice in caring for mentally ill patients on an involuntary basis differ widely. The proportion of compulsory admissions to inpatient mental health care ranges from 2.8% up to 44%.

Mental health legislation was evaluated according to:

- involuntary placement (systematic overviews are lacking); the main criteria for involuntary placement of mentally ill were threat/danger and threat/danger or need for treatment;
- decision making and psychiatric assessment (identified only in 5 countries);
- final decision on involuntary placement (belongs to non-medical authorities (60%) and to medical authorities (40%);
- Independent Council and Patient Advocate (are mandatory in 40% of the countries - e.g. Austria, Belgium, Denmark);
- maximum length of initial placement and maximum duration of short-term detention;
- compulsory outpatient treatment (it was mentioned in the laws of 4 countries: Belgium, Luxembourg, Poland, Sweden);
- involuntary placement per year – Germany has the most frequent one; although the general opinion is that the voluntary placements are increasing, the reality is rather stable.

Dr Salize pointed out that legal frameworks and practices vary remarkably across EU, that harmonizing frameworks on a EU level is hard to achieve, and it is a rather unknown mechanism how legislation influence the actual practice.

Stigma and exclusion

Professor Matthias C. Angermeyer

The stigma process consists of:

- distinguishing and labeling differences, separating “us” from them;
- associating human differences with negative stereotypes;
- loss of status and discrimination (individual discrimination or structural discrimination-refers
to dangerous criteria within civil commitment regulations);

- restricted insurance coverage;
- lack of rehabilitation programmes within the pension scheme;
- self-stigmatization.

Main anti-stigma interventions are: therapy/rehabilitation; medicalization vs. normalization; interventions in schools; working with the media; planning of mental health services; quality assurance in medicine/psychiatry; health and social policies, empowerment of the consumer and his family.

Some steps to normalization were mentioned as strategies to reduce the difference between mentally ill people and other people:

- continuum between normality and mental disorder;
- broad concept of normality vs. “mental disorder”,
- definitions “crisis” vs “illness”;
- attitude against psychiatric diagnosis, preference of psychosocial model;
- rejection of psychotropic drugs;
- calling people with mental illness “clients”, “service users”, “consumers”, “survivors”;
- alternative non psychiatric institutions/support services in the community;
- doctors wearing ordinary clothes.

The most important facets of the negative stereotype associated with mental illness are: dangerousness, unpredictability, attribution of responsibility, poor outcome, responding poorly to treatment. (Hayward and Bright, 1997).

Schizophrenia occupies the first place in ranging stereotypes of mental illness as of danger to others, followed by severe depression, panic attacks, dementia, eating disorder, alcohol addiction, and drug addiction.

According to a representative survey in Germany 2001, negative stereotypes are

- dangerousness (e.g. 36.2% agree people with schizophrenia are great threat to small children);
- unpredictability/incompetence (50.1% consider people with schizophrenia are quick to lose their self control).

Positive stereotype refers to creativity and intelligence.

In a focus group with relatives of schizophrenic patients, the most frequently mentioned direct and indirect stigmatization experiences were:

- quality of mental health care (18.2 %);
- social exclusion/withdrawal/lack of understanding (16.6%);
- contact between professionals and relatives/flow of information between professionals and patients (12.7%);
• assignment of guilt/responsibility for the illness to families and the ill (9.0 %);
• insecurity/lack of knowledge/fear among the public (7.4%);
• media portrayals (6.5%);
• ignorance, lack of information among the public, mental health professionals and official authorities, (4.6 %);
• problems with integration at work (4.4 %), etc.

As for the social distance towards the mentally ill, the highest percentage of rejection towards schizophrenia refers to child care and marriage (representative survey in the new German länder 1993). Primary and secondary stigma towards schizophrenia involves unemployment, alcoholism, obesity and homelessness, drug abuse and parkinsonoid.

Professor Angermeyer concluded by pointing out that consequences of stigmatization for people with mental illness are discrimination, self-stigmatization, isolation, unemployment, social withdrawal, non-adherence with medication, poor social adaptation, low quality of life, depression, demoralization, diminished self-esteem.

**Mental health legislation- a global perspective**

**Dr Thomas Bornemann, WHO HQ Geneva**

Dr Bornemann started by pointing out the main obstacles to formulating mental health legislation:

• power struggle between doctors and lawyers;
• tension between people in favour of mental health legislation on treatment and patients’ rights and those in favor of legislation on promotion and prevention;
• tension between the rights and responsibilities of families and those of patients;
• resistance from psychiatrists to decrease their interdependence to indicate treatments, including those on an involuntary basis;
• low priority for mental health legislation from Government, Parliament, etc.

He then emphasized the factors which facilitate the formulation of mental health legislation in relation to the above:

• formulate a mental health law from a client’s perspective and through a participative process;
• appoint a drafting Committee with representatives from people working on treatment and care and people working on promotion and prevention.
• workshops with representatives from families and patients’ organizations to analyze human rights and family roles;
• seminars on patient’s rights and medical ethics;
• empowerment of organizations of consumers, carers , etc.

Key stakeholders to invite for consultation about proposed mental health legislation should be: governmental agencies (Ministries of Health, Finance, Law, Education, Labor and Social...
Welfare); academic institutions and professional bodies; representatives or associations of families and carers; NGOs providing care, treatment and rehabilitation services; religious authorities; other special interest group.

Main barriers for mental health policies and programmes that legislation can help to overcome are:

- lack of mental health services in some areas or in the country;
- unaffordable cost of mental health care and partial coverage for psychiatric treatment; by health insurance;
- poor quality of care in mental hospital, inadequate living conditions, leading to human rights violation;
- negative impact of stigma and discrimination towards mental illness;
- denial of basic rights in civil matters, social participation, cultural expression, housing, employment of mentally ill people;
- damage made by some social conditions or cultural practices on the mental health of some population groups;
- lack of resources for mental health programs at schools and workplaces.

He pointed out ways of promoting effective protection strategies: through NGOs consumers and family organizations; by formulating mental health policy, human rights principles and quality assurance standards. Materials and tools should be disseminated through training workshops addressed to judiciary, health professionals, MoH officials, consumers and families organizations, professional associations.

Dr Bornemann mentioned in conclusion the ten basic principles formulated by WHO (1996) for a mental health care law and drew attention on the WHO Manual on Mental Health Legislation.

**Mental health legislation- clients and families**

**Dr John Henderson**

Dr Henderson spoke on behalf of users, consumers, and their families and carers, namely on behalf of the European Network of Users, ex Users and Survivors of Psychiatry.

He pointed out that these people are not happy with the terminology “mental health”, which they consider inclusive and prefer “mental illness”, “mental handicap”, “personality disorder”. He stressed that this is an issue to be thought of before starting formulating mental health legislations.

The basis of the legislation should be the UN resolution 46/119, albeit none of the countries will be able to fulfill adequately its principles. Legislation should also take into account the respect for reciprocity, confidentiality, the expectations of the client referring to the choice of placement and treatment.

From this perspective he pointed out the importance of the advocacy role as a legal potential, for what concerns the difficulty of the parents and spouses in having a part to play.
Other issues of concern in the vision of users and their families are protection against electroconvulsion therapy, the continuum of medication, but also protection in terms of housing and employment.

**Interregional group work on mental health policies and legislation**

The participants split into four working groups to address the following topics:

- need for mental health legislation;
- legislation – stigma;
- legislation reform – structure reform;
- human rights – freedom and treatment;
- forensic care – design;
- compulsory care – outpatient care;
- treatability- culpability;
- legislation-community based mental health services.

The groups reported their experiences as follows:

**Group 1**

Facilitator: Dr John Henderson (United Kingdom)
Rapporteur: Dr Toma Tomov (Bulgaria)

Andora (Dr Llandrich), Bulgaria (Dr Tomov), Croatia (Dr Henigsberg), Finland (Dr Taipale ), Georgia (Dr Naneishvili), Greece (Dr Constantopoulos), Israel (Dr Grinshpoon), Romania (Dr Teodorescu)

- Mental health legislation is needed to protect rights and safety of both patients and the public; to be adequate, a country legislation should be developed only after its mental health policy has been made clear and agreed upon by all stakeholders.

- Mental health legislation should not be restricted to the issues of involuntary treatment; it should consider the cultural institutional background of the country (in Finland, the law regulates health promotion and prevention, in Israel it refers to protected residence and employment); acceptable heritage in the practice of mental health should be codified.

- Any new legislation, when introduced, will be a challenge to the public; education on a mass scale should be seen as an inseparable part of the development of a legal frame for mental health.

- High security wards when part of general psychiatric hospitals have a propensity to excessive coercion; it can be argued that this practice is conducive to stigma; a lot of flexibility and thinking should be given in this case.

- Detainment without getting treatment was declared unethical by the Court in Strasbourg; concern has been expressed that treatments may begin to be prescribed not because helpful, but to justify detention.
Group 2

Facilitator: Professor Mathias Angermeyer (Germany)
Rapporteur: Professor Laszlo Tringer (Hungary)

Albania (Dr Como), Armenia (Dr Torosyan), Austria (Dr Krautgartner), Belarus (Dr Rynkov), Bosnia and Herzegovina (Dr Kucukalic), Hungary (Dr Tringer), Slovenia (Dr Dernovsek), Sweden (Dr Silfverhielm), Romania (Dr Prelipceanu)

The group selected mental health legislation and reforms as topics of discussion.

- Legislation and mental health care reforms should go hand in hand, although there is a more indirect relationship between them. Legislation is a longer process and belongs to the level of Government and Parliament, while reform is rather a matter of organization in the field.
- Forensic psychiatry services are found in two extreme positions (ex. Slovenia - no forensic unit at all vs. Germany - a lot of forensic units. The conclusion is there is no unique way to proceed.
- Other issues touched were: "criminality and morality", biomedical research on mentally ill patients (Bosnia and Herzegovina), training of the family doctors (Albania).

Group 3

Facilitator: Dr H.J. Salize (Germany)
Rapporteur: Dr Jacek Moskalewicz (Poland)

Former Yugoslav Republic of Macedonia (Dr Micev), Poland (Dr Moskalewicz), Portugal (Dr Heitor dos Santos), Romania (Dr Tudorache), Russian Federation (Dr Yastrebov), San Marino (Dr Bastianelli), Slovakia (Dr Breier), Swizerland (Dr Heise)

The group selected the following topics: specific mental health legislation and forensic department design. The reason of this choice: Romania is drafting its mental health legislation and Portugal is considering the question of location and design of forensic units.

Specific mental health legislation

Countries reported different experiences in the field:

- Slovakia and Switzerland have no specific legislation on mental health. Relevant questions are included in more general laws on health and welfare or in the Constitution;
- Portugal, Poland and Russian Federation adopted their new mental health laws in 1990’s;
- advantages of specific legislation: symbolic message stressing the importance of the mental health issue; obligation to initiate mental health policy; better protection of human rights, including right of appropriate treatment;
- disadvantages: likelihood of further stigmatization; risk of increased discrimination; probability/risk of not fitting the general legal framework.

Forensic department design

- Only a very small fraction of forensic patients should be treated outside general mental health services; the ideal solution would be forensic departments located separately, outside
larger psychiatric or prison settings; its security, however, should be maintained by law enforcement sector.

- Due to financial constraints, other options have to be considered, including location of forensic departments either in prisons or in psychiatric institutions.

**Conclusions**

The situations in countries are quite heterogeneous. The solutions are determined by factors that go beyond psychiatry.

**Group 4**

Facilitator: Professor Heinz Katschnig (Austria)
Rapporteur: Dr Sander van Doorn (Netherlands)

Bulgaria (Dr Varsanova), Czech Republic (Dr Höschl), Estonia (Dr Sarjas) Malta (Dr Xerri), Netherlands (Dr van Doorn), Republic of Moldova (Dr Hotineanu), Ukraine (Dr Kuznetsov), United Kingdom (Dr Berry)

The group addressed the need of specific mental health legislation and the question whether special legislation is or is not stigmatizing.

Most participants consider specific legislation is stigmatizing (except Netherlands where there is a beneficial combination of specific legislation with general health legislation).

Possible solution: including a specific part on compulsory treatment in a general health law/act which regulates/concerns all kind of diseases that need compulsory treatment (e.g. TB). There is no need to specify diseases in this part, as there is a danger of stigmatization. The rest of the general health law should cover the rest of the aspects for all the patients (the right to be informed, choose the treatment etc).

Netherlands introduced in their law system a specific act on the quality of health offered by health organizations (including mental health). There is also a general law on health care, focused on the relation patient-doctor.

Malta suggested to formulate guidelines/protocols for management in institutions in addition to a general health law. They could be drafted by a sort of "body" made up of users, doctors, families, etc.

Other topics discussed:

- is a person with alcohol or other drug addiction mentally ill? No conclusion was formulated;
- responsibility for criminal acts in relation to addiction or mental illness (interesting example from Romania: drug addiction is punished by law);
- need of a law for community care; difficult to answer;
- the problem of dual diagnosis (e.g. addicted to alcohol and depression).
**Discussions**

Dr Bornemann pointed out that there is a sort of tension concerning whether substance dependence belongs to mental illness/trouble.

**Saturday, 6 April 2002**

**Update throughout the European Region. Group work in sub-regions**

**Dr Wolfgang Rutz**

Dr Rutz invited the groups to divide according to the sub-regions and to present an update of the situation in the countries.

**East Europe sub-region**

Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine, Uzbekistan.

Steering Group member: Russian Federation; substitute: Ukraine

6 countries present: Ukraine, Armenia, Belarus, Russian Federation, Republic of Moldova, Georgia

**Armenia**

- Need of an optimization of the structure.
- Need of building clinic out-patient facilities.
- Existence of a project of a mental health law.
- Needs in socio-rehabilitation system.
- Emphasis on financial difficulties.

**Belarus**

- Ongoing project of creation of a National Research Institute.
- Discussions are present at the state level about reforming in the psychiatry area - ratifying of a new ministerial position (narcologist).
- Need of improvement of psychiatric law.
- Problems: lobbing on reforming psychiatry at governmental level; changing the financing system; integration of psychiatric care into general health system.

**Georgia**

- Important document about national health policy.
- Measures taken on de-institutionalization of mental health care services.
- Broadening the state programme of mental health care and gradual increasing of free of charge psychiatric services.
- Revising the psychiatric law.
- Creating a psychosocial aid system.
- Creating the system of mental health service of children and adolescents.
- Adequate financing of all steps of reforms.
- Improvement of the education of professionals working in the mental health area, especially nurses.
- Problems: need of epidemiological studies; no institutions of social workers; no governmental social support system for mentally ill.

**Russian Federation**

- New version of psychiatric law and commentary of it (1993).
- Ministerial Order about rebuilding and building of psychiatric facilities.
- Ministerial Order about quality assurance in mental health.
- Meeting on federal level about reforming of psychiatry care.
- Preparing a complex, multidisciplinary programme of psycho-prevention of terrorism.
- Creation of a national consumers organization with 50 regional branches.
- Development of psychiatric care into general health system.
- Problems: no implementation of the results of psychiatric researches (5 psychiatric research institutes, 50 research departments); lack of modern drugs; lack of social workers (very low wages).

**Republic of Moldova**

- Creating a Centre of Psychosocial Care.
- Acceptance of the law of psychiatric expertise.
- Further development of out-patient service.
- Free medication for mentally-ill invalids and severely ill.
- Development of psycho-social services.
- Problems: lack of adequate financing; deficit of modern psychotropic drugs; need of improvement of resources in psychiatric services.

**Ukraine**

- Endorsement of a new law on psychiatric care and sub-legislative acts.
- Ongoing preparation of a national psychiatric congress.
- Creation of new models of out-patient care services.
- Setting up new standards of psychiatric care.
• Problems: deficit of social workers in psychiatric institutions; lack of financing; need of reducing the psychiatric beds.

Discussions

Dr Yastrebov asked, on behalf of the Eastern Europe Sub-region, for WHO support in improving the connection with colleagues from the Eastern and Central Europe.

Dr Rutz thanked for the presentation of obstacles and difficulties and pointed out the need of integrated initiatives, the need of social workers and of implementing research practices. He reiterated that there is still no national mental health counterpart in Tajikistan, Turkmenistan and Kazakhstan.

South Europe sub-region

Andorra, Greece, Israel, Italy, Malta, Monaco, Portugal, San Marino, Spain, Turkey.
Steering member: Portugal; substitute: Greece.
6 countries present: Andorra, Greece, Israel, Malta, Portugal, San Marino.
Dr Heitor dos Santos presented an update of the sub-region based on the 10 overall recommendations of the WHR 2001.

1. Provision of treatment in primary care
   • Andorra: continuation of regular links with GPs.
   • Greece: will be running training courses in psychiatry for GPs.
   • Israel: translated ICD 10 for GPs.
   • Malta: is planning a training programme in depression/anxiety for GPs and nurses.
   • Portugal: DepCare/secondary prevention of major depression at PHC; continuation of regular links between some local mental health services and PHC.
   • San Marino: continuation of the links with the PHC care system.

2. Availability of psychiatric drugs
   • Andorra: complete availability; 70% co-participation.
   • Greece: complete availability for psychotic disorders; 90% available for depressive disorders.
   • Israel: 85% availability.
   • Malta: complete availability for psychotic disorders.
   • Portugal: 100% co-participation for anti-psychotic drugs and 70% for anti-depressive drugs.
   • San Marino: complete availability.

3. Care in the community
   • Greece: Daphni Hospital- 564 patients out of 1293 are in hostels and boarding houses;
     ▪ Dromokaiteio Hospital - 167 patients out of 648 are in hostels, boarding houses, etc;
Psychoargos Programme (1st phase) - operation of 55 hostels and 55 sheltered workshops, run by 32 hospitals throughout the country, housing a total of 650 patients;

- Ministerial Decree for definition of criteria for the approval and licensing of domiciliary mental health services (in accordance with art. 6, Law 2716/1999);
- total rehabilitation structures: 120 sheltered apartments, 18 boarding houses, 72 hostels, 55 sheltered workshops; 1660 patients inhoused in these facilities.

- Israel: housing 4000 people;
  - employment - workclubs, sheltered workshops, regular work with special individual support;
  - education support - Hebrew classes, computer classes.

- Malta: programme “Patients work rehabilitation scheme” - empower clients to help themselves through work schemes in the hospital and reduce stigma; after 1 year the results attained led to the development of clients’ cooperatives.

- Portugal: prevention of institutionalization of chronic mental patients (53 facilities for 752 clients); national plan of integrated continuous care (home care, 3 types of life units, transitional units); supported employment (cooperatives/social firms, “insertion enterprises”, sheltered employment); continuation of professional training programmes for people with mental illness.

4. Education of the public

- Andorra: psycho-education in child psychiatry for parents of children with ADD.

- Greece: 1st phase of anti-stigma campaign on schizophrenia.

- Israel: initiatives for child abuse ad stress.

- Portugal: health promoting school programme; promotion of mental health during the pregnancy and infancy.

- San Marino: organizing public conferences and press conferences about mental health, work in mental health services and life of people with mental health problems.

5. Involve communities, families and consumers


- Israel: organization of the congress “Rehabilitation of Mentally Ill Patients” with the participation of users and their families and others.

- Malta: creating of a patients’ work rehabilitation scheme to empower clients to help themselves through work schemes in the hospital.

- Portugal: promoting and supporting NGOs of consumers, families and volunteers.
6. Establishment of national policy, programmes and legislation:

- Andorra: special programme for drug addiction addressed to psychologists, nurses and physicians with experience in the field.
- Malta: reform initiated in 1998 is an ongoing process; management system was completed in 2001.
- San Marino: no new developments, except the preparation of a law on compulsory care.

7. Development of human resources

- Andorra: enhancing human resources for child and adolescence psychiatry (difficulties to get child psychiatrists); special programme for drug addiction (began in January 2002 with a multi disciplinary team).
- Greece: process of restructuring at Daphni hospital, which implies process of employment of staff; more mental health centres will be opened this year.
- Israel: training of a group of 10 young child psychiatrists.
- Malta: prior to reform, training in applied management technique was given to all staff. Management structure is based on an executive management team, headed by a chief executive officer answerable to a board of directors who are responsible for all health sectors. The management system was completed, decentralized from top management structure to line managers. This has enhanced accountability and responsibility for resource utilization amongst all decision-makers. Over 17% savings in operational budget were attained, allowing new initiatives to be funded without increasing the budget.
- Portugal: 1999-2000 development of a rehabilitation educational programme in 3 of the 5 regions of Portugal; new posts have been created (“health helpers" for home care).

8. Linking with others sectors
Examples were already mentioned.

9. Monitoring community mental health

- Israel: database of all psychiatric inpatients; periodic statistical abstract; periodic national health survey on mental health problems and their determinants.
- Malta: finalization of the management's financial and internal control system, based on accruals and on input/output, where all line expenditure is linked to a performance indicator.
- Portugal: National psychiatric census (November 2001); 1st national psychiatric morbidity study in the community; development of national mental health system adapted to and
compatible with the national health information system; definition of mental health indicators.

- San Marino: improvement of a data analysis system.

10. Supporting more research
- Andorra: study on comparative incidence of first psychotic episodes of Andorran and emigrant population.
- Portugal: various local and regional studies, but not national (except those of evaluation of national projects concerning mental health, alcohol and drugs).

Other points
- Israel: psychiatry services will be covered by insurance in 2003; help line for people with stress due to a traumatizing war situation.
- Portugal: task force to design forensic psychiatry regional centre, taskforce to elaborate good clinical practice guidelines for depression and psychotic disorders.

Similarities between countries in sub-region:
- process of reforming of the mental health system;
- initial stage of anti-stigma actions;
- lack of trained staff in primary health care;
- users’ movements/organization still at the beginning;
- various human resources problem, especially at the level of nurse, child and adolescent psychiatrists.

Differences
- Andorra and San Marino because of their size; local and national level are the same (Malta has however more availability of services and access).
- Israel, because of the war situation.

Proposals:
- more sharing of experience and collaboration;
- creating a real and dynamic network.

Central Europe sub-region
Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia, Slovenia, The former Yugoslav Republic of Macedonia.
Steering member: Hungary; substitute: Lithuania.
12 countries present: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Estonia, Hungary, Poland, Romania, Slovakia, Slovenia, The FYR of Macedonia.

Dr Tringer presented a brief update of the situation according to the topics and not the countries.

Legislation
A lot of variations within the countries are registered:

- there are laws either on health in general including mental health or separate mental health acts (Croatia, Bulgaria, Hungary, Estonia), laws in active preparation (Bosnia and Herzegovina, former Yugoslav Republic of Macedonia), laws waiting for endorsement (Romania);
- Federation of Bosnia and Herzegovina has law on the protection of the mentally ill;
- Patients Advocacy Act and the Law of Protection of Rights of Mental Patients are being discussed by the Parliament in Slovenia.

Mental health policy

- Majority of countries claimed for more precise governmental policies (Poland, Hungary).
- Mental health policies are present in Estonia (is in process of preparing a mental health policy development document), Romania, Bulgaria (has a programme for mental health of the citizens launched in December 2001), Hungary (has a public health programme in which mental health is one of the 5 priorities).
- In FYR Macedonia a national master plan is expected to be adopted as an official strategy following the collaboration between WHO and Macedonia within the operation *Alternative solutions for social integration of mentally ill patients*.

Service development

- In general there is a shortage of services.
- Important developments are registered in Bulgaria (pilot project initiated in Sofia to establish 5 new services for the severely mentally ill in the community), Poland, Estonia, Slovakia, FYR Macedonia.
- Bulgaria, Bosnia and Herzegovina, Hungary struggle with the shortage of specialized services for children and adolescents.
- There are no specific programmes for minorities, refugees, disaster affected population, elderly and children in Romania.

De-institutionalization

- Important steps are registered in Poland, Czech Republic, Slovakia.
- A delay in the process occurs in Hungary.

Governmental involvement

- Positive experiences in Poland, Hungary, Slovakia.
Innovative seminar initiated by the Federation of Bosnia and Herzegovina for decision makers in functioning of the community mental health services and future collaboration with social services.

Quite negative experiences in Bulgaria because of political conflicts.

Difficulties in collaboration with the ministries.

**Role of the media**

Active media campaigns in Poland and Croatia; exhibition with beneficiary handcrafts and theater festival in Romania; radio campaigns in Hungary and Slovakia; lectures on TV and radio in Czech Republic; [http://www.pcf.lf3.cuni.cz/sddz/akce.html](http://www.pcf.lf3.cuni.cz/sddz/akce.html).

Passive attitude of the media in Bulgaria.

**NGO activity**

Positive events in Poland, Bosnia and Herzegovina, Slovakia.

Low representation in Hungary (some family organizations, but negative influence of the church, anti-psychiatry attitude).

**Financing of the system**

Most of the countries are confronted with shortage of financial resources.

Some changes occurred in Slovenia (new financing system since 2002 based on nr. of admissions) and Hungary (the introduction of a DRG system had quite a negative impact – distortion of statistical evidence).

**Staff**

Lack of non-medical professionals (social workers, psychologists, psychiatric nurses): Bulgaria, Hungary, Slovenia, Romania, etc.

Introduction of specialization in psychiatric nursing in Bulgaria.

Federation of Bosnia and Herzegovina - training in cognitive therapy, rehabilitation of the chronically mentally ill, in community mental health for nurses, social workers, psychologists.

Long tradition in education and training of professionals in Czech Republic.

**GPs’ involvement**

No involvement in Bosnia and Herzegovina.

Positive experience in Hungary.

Other topics touched: corruption activities in pharmaceutical companies, psychotherapy training. Topics not touched: patients’ rights (there is mainly a concern with the rights of the family and community, but less focus on individuals).

**Discussions**

Dr Rutz suggested that depression and suicide may be an entrance bridge to GPs.
Dr Bornemann stressed the importance of interdisciplinary resource involvement.

**West Europe sub-region**

Austria, Belgium, France, Germany, Ireland, Liechtenstein, Luxembourg, Netherlands, Switzerland, United Kingdom.

Steering member: Austria; substitute: Germany.

4 countries present: Austria, Switzerland, Netherlands and United Kingdom.

**United Kingdom**

Positive aspects:

- *National Health Service Plan* – outlines investment in new models of service (see [www.doh.gov.uk/nhsplan/nhsplan.htm](http://www.doh.gov.uk/nhsplan/nhsplan.htm));
- *Making it Happen* – a guide to delivering mental health promotion (see [www.doh.gov.uk/mentalhealth/makingithappen.htm](http://www.doh.gov.uk/mentalhealth/makingithappen.htm));
- *The Mental Health Policy Implementation Guide* – sets out service specifications for new service models (see [www.doh.gov.uk/mentalhealth/implementationguide.htm](http://www.doh.gov.uk/mentalhealth/implementationguide.htm));
- *National Strategy for Suicide Prevention in England* – (a link to the site is available from [www.doh.gov.uk/mentalhealth](http://www.doh.gov.uk/mentalhealth));
- National Institute of Mental Health in England – will develop a distinct and clear set of priorities for mental health;
- specific strategies for mental health services for women and ethnic minorities;
- guidelines on services specification for support of carers of people with mental health problems;
- guidance to local mental health services to promote employment (“employment support team”);
- national anti-discrimination campaign concentrating on 3 perpetrators: employers, media, young people; (suggestion to target other medical professions).

Negative aspects:

- diversion of mental resources to other fields;
- difficulties in recruiting staff; (the case also in Germany);
- permanent reorganization of mental health services is resource consuming.

**Netherlands**

Positive aspects:
primary care is a top priority;
there is a mental health care task force on “socialization”/reintegration into community;
tries to go from a supplier driven system to a demand/need driven system;
there is a task force on prevention;
tries to harmonize financing laws, which in most of western countries are fragmented.

Federal countries as Austria, Switzerland and Germany encounter a specific situation, due to the construction of the state itself.

**Austria**
- A country mental health report was published in 2001.
- 7 of the 9 provinces have a mental health plan.
- Attempts have been made at integrating budgets.
- Anti-stigma campaigns at general level or schools have been carried out.

**Switzerland**
Cooperation between national and cantonal agencies was improved for social services.

**Discussions**
Main discussions focussed on stigmatization of mental health personnel and psychiatrists themselves (Dr Rutz, Dr Katschnig) and on very low wages for social workers in psychiatry (Dr Yastrebov).

Dr Xerry pointed out the need of an internal system of control of the level of expenditure. He also emphasized the importance of mixed sexes admissions.

Dr Rutz added that indeed one of the progresses of psychiatry has been the mixing up of wards.

**North Europe sub-region**
Denmark, Finland, Iceland, Norway, Sweden
No country present

**Update received from Finland:**
- health services high on the political agenda;
- guidelines for regional and local actors, for decision makers and professionals in personal mental health services;
- Government quality recommendations on mental health: local support is provided for mental health and well-being of the population; basic public services are provided to support people; human rights are respected; treatment is provided along planned lines; ambulatory care is prioritized, inpatient care is provided when needed; collaboration is encouraged in health sector; the structure and quantity of mental health personnel is appropriate; stress at work is under control; training at work is provided;
• major Government projects: *Meaningful Life* – an interministerial programme to develop activities in the field of mental health; *Swallow* - training programme to increase mental health capabilities in primary care;

• Parliament activity in promoting mental health issues: a special fund for child mental health projects (10 million Euro) and more funds to support mental health service development (approx. 30 million Euro).

**Update received from Sweden**

The National Action Plan for Health Care stipulates the need of improvements in mental health care. Funds will be distributed to municipal and county councils to improve the availability and quality of health care. The county councils are responsible for:

• offering early and adequate support to children and young persons presenting signs of mental problems;

• developing the content of care for children and young persons with mental problems and substance abuse;

• catering to the caring needs of young persons between the ages of 16 and 25 through coordinated initiatives from child and youth psychiatry and adult psychiatry;

• paying special attention to persons with mental functional impairment, so that their psychiatric and somatic caring needs are provided for through advanced cooperation between county council primary care, psychiatry and social services;

• identifying older persons with psychiatric needs and offering them treatment.

**Update received from Norway:**

• National Mental Health Programme for 1999-2006 – aim: to strengthen preventive measures, increase qualified services in the municipalities and to improve the accessibility and quality of specialized services;

• newly established directorate for health and social affairs – responsible together with MoH for the further implementation of the mental health programme;

• new laws put into force since January 2001: the specialized health services act (psychiatry is included), mental health act, patient’s rights act, health personnel act;

• GP reform put into practice since summer 2001 – to secure the consistent availability of the public to the primary health services;

• transfer of the responsibilities for the specialized health services from the countries to the state;

• a major reorganization of the central health authorities:
  • Ministry of Health;
  • Directorate of Health and Social Affairs;
  • National Institute for Diseases Control – screening, determining incidence and prevalence of various diseases, registration of risk groups;
The Norwegian Board of Health - independent role and function in regards with the MoH, supervision and control of the health services rendered to the public and supervision of health disciplinary cases.

**Final discussions**

Dr Rutz briefly reminded about some forthcoming mental health meetings: AEP Congress in Stockholm, European Summit hosted by Finland, Athens meeting, Conference on elderly and adolescents in Germany, WPA Congress in Yokohama.

He expressed his satisfaction regarding the increasing dialogue and collaboration with HQ (elaboration of Atlas project, documents on suicide depression, on epilepsy, concrete collaboration at policy level). He also emphasized the limited number of staff in Mental Health Unit in EURO and asked the counterparts to take it into consideration.

Dr Xerry expressed his trust in a future collaboration and that WHO would facilitate and foster such collaboration.

Dr Moskalewicz suggested inviting speakers from other European countries too at the forthcoming meetings.

Topics of discussion for the next meeting:

- Financing;
- Human resources and curricula;
- Training/education;
- Patients’ rights.
Annex I

LIST OF PARTICIPANTS

**Albania**
Dr Erol Como, Chief, Ambulatory service in PHC Department, 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

**Bosnia and Herzegovina**
Dr Abdulah Kucukalic, c/o Federal Ministry of Health, Sarajevo

**Bulgaria**
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**Croatia**
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**Czech Republic**
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**Estonia**
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**Finland**
Professor Vappu Taipale, Director General, National Research and Development Centre for Welfare and Health-STAKES, Helsinki

**Georgia**
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**Greece**
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**Hungary**
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Slovakia
Dr Peter Breier, Head, Department of Psychiatry, General Hospital Ruzinov, Bratislava

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Sweden
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Switzerland
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The Former Yugoslav Republic of Macedonia
Professor Vitomir Micev, President, Macedonian Medical Association, Skopje

Ukraine
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United Kingdom
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Romanian speakers and participants
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Dr Dan Prelipceanu, Romanian League for Mental Health, Bucharest
Dr Radu Teodorescu, vice-president, Romanian League for Mental Health, Bucharest
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