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Approaching Mental Health Care Reform Regionally: The Mental Health Project for South-eastern Europe

SOUTH-EASTERN EUROPE HEALTH NETWORK

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Approaching Mental Health Care Reform Regionally: The Mental Health Project for South-eastern Europe

Report on the Implementation of the SEE Health Network's
"Enhancing Social Cohesion through Strengthening Community Mental Health Services in South-eastern Europe" Project

Sarajevo, December 2008

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FOREWORD

It was with great pleasure that we accepted the invitation to introduce this final report on the Mental Health Project for South-eastern Europe. It offers a clear and detailed account of the impressive and fruitful efforts made over the past six years by the nine countries of South-eastern Europe under the Stability Pact's Social Cohesion Initiative, with the aim of developing modern and socially responsible mental health services that respect the needs and the rights of service users, and that fully recognize the community's duty to offer care in and as part of the community.

To sum up the achievement is not difficult: in six years the countries have converted an aspiration into a reality, formulating a vision for the humane treatment of those suffering from mental disorders, developing new policies and mental health legislation, elaborating mental health reform strategies, and beginning the transition to community-based care by the creation of one or more pilot community mental health centres. These community centres are now centres of excellence which showcase best practice. They also provide the focus for programmes of professional training for mental health and primary health care professionals, public awareness raising, and advocacy. Given the excellent results attained by these centres, the stage has been well and truly set for the participating countries to roll out the next phase, the generalization of the pilot model as the way forward for mental health care in South-eastern Europe.

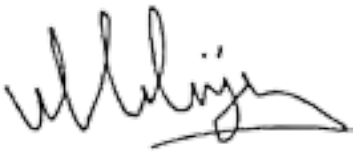
After the long years of development and achievement, it is easy to forget the starting point. Mental well-being and psychiatric services had been severely affected by war, economic turbulence, and humanitarian disaster. To many it must have seemed that the human rights, social inclusion, and modern evidence-based treatment of those suffering from mental disorders and their carers would be a low priority for the exhausted and insolvent countries of the region, with their traumatized populations and outmoded services concentrated in stigmatizing mental hospitals, rife with neglect and abuse. Securing political support was therefore essential to the success of the process, as was the recognition that social reconstruction, peace, and democracy all depend on the mental well-being and solidarity of the population. Nor was such political support lacking for the creation of community mental health centres that would place mental well-being symbolically at the heart of the community by offering support to the most vulnerable members of society, resulting in a powerful message that stigma, exclusion and neglect would no longer be accepted.

This new political and social solidarity has nowhere been more clearly expressed than through the international partnership that created the Mental Health Project of the Stability Pact for SEE. The nine countries that signed the Dubrovnik Pledge offered their contributions enthusiastically at every level, political, managerial and clinical, throughout the duration of the project, while the WHO Regional Office for Europe and the Council of Europe were equally unwavering in their support. Generous funding from many countries, with Greece and Belgium in the forefront, but also including Italy, Switzerland, Slovenia, Sweden, and Hungary, facilitated the honest sharing of ideas and experiences and the gradual implementation of good practice at a series of extremely fruitful seminars and workshops, which resulted in an effective model of community-based care, based on a shared vision, but sensitive to local needs and resources.

The high-political nature of the policy and strategic components of this project should not be allowed to obscure the equally crucial and effective steps taken by participants on the ground to establish community services. Effective reforms require both good policy and consistent implementation. This report describes the process very well, but cannot possibly do justice to the many coordinators, professionals, representatives, and experts involved at the various stages. Those involved will join us in remembering the emotional exchanges on vision and values, as

well as the singing of traditional songs, arm in arm, the many foreign experts who dedicated their holidays to offer training, and the local multi-disciplinary teams eager to apply the lessons. Most of all, however, they will recall, as we do, attending the opening ceremonies for the community centres in the nine countries, in the presence of the respective health ministers, meeting the enthusiastic staff, patients, and carers, and hearing first hand of their delight at the changes and their impact.

One indicator of the success of the Mental Health Project for South-eastern Europe is that these original pilot community mental health centres are now gradually being replicated, not only within the original Stability Pact for SEE countries, but also by other countries in the Region. If imitation is the sincerest form of flattery, the initiators and implementers of the Mental Health Project should take great pride in their achievement. They have made a difference and will leave behind them a sustainable legacy, with a network of committed and competent persons that stretches across South-eastern Europe and is both ready and able to push these reforms forward. The implementation of community-based mental health services has not been completed and much remains to be done, but a very good start has been made.



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The staff of the SEE Mental Health Project would like to take this opportunity to express their gratitude to the many individuals and institutions who have done so much to make this project possible and have contributed to its success over the past six years.

We are particularly grateful for the commitment and support consistently shown by the Steering Committee members and the governments and ministries of health they represent, both as participating and donor countries. Special mention must be made of the Ministry of Health of the Federation of Bosnia and Herzegovina, the Ministry of Health and Social Welfare of the Republika Srpska, and the Ministry of Civil Affairs of Bosnia and Herzegovina, as representatives of the lead country and initiator of the project.

It would have been very difficult to imagine, or indeed implement, the project without the energy, warmth, and great personal commitment of the three members of the Executive Committee, Dr Goran Čerkez, Assistant to the FBiH Minister of Health, Professor Athanassios Constantopoulos, representing the Greek Government, and Dr Maria Haralanova, Regional Adviser on Public Health Services of the WHO Regional Office for Europe.

The project also benefited immeasurably from the advice and guidance of the WHO Regional Office for Europe's Regional Advisers for Mental Health, Dr Wolfgang Rutz and his successor Dr Matthijs Muijen, particularly with regard to the design of workshops, choice of trainers, and ensuring recognition of the project at international level. We are also very grateful for the recognition and support expressed by Dr Marc Danzon, WHO Regional Director for Europe, and Dr Nata Menabde, Deputy WHO Regional Director for Europe.

The main credit for the success of the project should go to the dedicated and inspiring management and staff of the Country Offices and the Community Mental Health Centers who have achieved so much over the past six years.

A final word of thanks is due to the many expert and highly professional trainers and consultants who contributed to ensuring that the workshops and training programmes, which were such a large and useful element of the project, were both so effective and enjoyable. The project staff would like to express their thanks to Dr Michelle Funk of the Department of Mental Health and Substance Dependence, WHO headquarter for her assistance in the selection of trainers and training programmes.

No list of acknowledgements could be complete without expressing our gratitude to those who made the project possible: the governments of Belgium, Greece, Hungary, Italy, Slovenia, Sweden, and Switzerland and the WHO Regional Office for Europe without whose generous donations nothing could have been achieved.

We would also like to take this opportunity to remember two of the project's first and most faithful friends, Professor Andrej Marušič, former Director of the Slovenian Institute of Public Health, and Mr Tomo Lučić, former Minister of Health of the Federation of Bosnia and Herzegovina, both of whom did so much during the early stages of the project to secure its future at a time when it seemed uncertain, both died earlier this year, extremely prematurely, at the respective ages of 43 and 46, to the shock and great regret of their colleagues and friends throughout the region.

Some Statistics on Mental Health

Worldwide, mental disorders are among the leading causes of ill health:

- Around 450 million people currently suffer from such conditions, worldwide.
- One in four people in the world will be affected by mental or neurological disorders at some point in their lives.
- One in four families has at least one member with a mental disorder at any point in time.

The spread of mental illnesses is increasing:

- Currently accounting for 12% of the total burden of disease, by 2020 mental illnesses may represent 15%.
- Depressive disorders are currently the fourth leading cause of disease and disability, but may rank second by 2020.
- In Europe, one in five persons will develop depression during their lifetime.

Mental disorders in the WHO European Region:

- Stress-related conditions account for half of all disability in certain European countries.
- Mental health problems account for up to 30% of consultations with general practitioners in Europe.
- Some 33.4 million people in Europe suffer from major depression in any given year.
- Seven out of every 1000 people (slightly over 3 million adults) will be affected by schizophrenia, with onset in adolescence in 33% of cases.
- One in four European adolescents shows one or more mental symptoms, in particular, depression: in a recent national study, 8% of all girls and 2% of all boys aged 16 met the criteria for severe depression, while 14% of girls and about 5% of boys were found to be moderately depressed.
- About 41 million adults are estimated to be abusing or dependent on alcohol. In one northern European country, 45% of men who committed suicide were alcohol abusers. In one of the Baltic states, 40% of traffic accidents are alcohol-related. Despite the severity of these problems, about 66% of people are untreated. In one western European country, the economic costs of alcohol reached 1.4% of gross domestic product (GDP) in 2000.
- Suicide is a major cause of death in adolescents and young adults, but other at-risk populations include farmers in changing societies. Suicide rates range widely from 2 to 44 per 100,000 population. The highest rates in the European Region are also the highest in the world.

Adapted from the Mental Health pages of the WHO Regional Office for Europe website
www.euro.who.int/healthtopics/HT2ndLvlPage?HTCode=mental_health

INTRODUCTION: A MODEL APPROACH TO MENTAL HEALTH REFORM

Issues of mental health tend to come to the fore during periods of social stress and change, crisis and transition. As social and economic structures change, individuals and groups find themselves subjected to increased and additional pressures. It becomes harder to maintain a reasonable standard of living; support groups become less effective and may even disappear; there is greater risk of isolation or social exclusion due to deracination, weakening social ties and institutions, and social atomization.

While the increase in such pressures has been a general feature of modernization and post-industrial society, there can be little doubt that the countries of South-eastern Europe (SEE) have suffered a particularly severe combination of factors during the past twenty to thirty years, including:

- 'Transition' from socialist to full market economies,
- A decade of war and armed conflict,
- A hardening of social divisions along ethnic and religious lines,
- Exacerbated processes of social exclusion, and
- A weakened capacity of state systems to care for the most vulnerable in society and promote their well-being.

Project title: "Enhancing Social Cohesion through Strengthening Community Mental Health Services in South-eastern Europe"
Starting date: June 2002
Estimated End Date: December 2008
Project Budget: EUR 3,168,000
Lead: Bosnia and Herzegovina
Beneficiary countries:

- Albania,
- Bosnia and Herzegovina,
- Bulgaria,
- Croatia,
- Montenegro,
- Republic of Moldova,
- Romania,
- Serbia, and
- The former Yugoslav Republic of Macedonia

Donors and Partners:

- Belgium,
- Greece,
- Hungary,
- Italy,
- Slovenia,
- Sweden,
- Switzerland,
- Council of Europe, and
- The WHO Regional Office for Europe

"Enhancing Social Cohesion through Strengthening Community Mental Health Services in South-eastern Europe" or the Mental Health Project for South-eastern Europe, as it is normally called, was designed to support transition to a community-based model of mental health care. The chief aims were (1) to assist the participating countries in meeting the developing mental health needs of their most vulnerable citizens and (2) to develop a framework for constructive and lasting regional cooperation in the mental health field, which would nevertheless accommodate the many and complex differences between the participating countries.

When the SEE Mental Health Project was launched in June 2002, it was therefore clear to all involved that it would be an ambitious project.

The main goals of the Project were:

1. To produce a general reform of mental health legislation and policy, *and*
2. A general reform of service provision in the countries of the South-eastern European region, *and*
3. To ensure the initial phases of implementation through the establishment
   - Of national mental health bodies,
   - Pilot community mental health centres (CMHCs), and

- Co-ordinated training programmes for mental health professionals and other stakeholders in the process.

This was the first attempt to carry out simultaneous health care reform in the countries of the region to a common plan, compatible with European and WHO targets and strategies. Even at an early stage, the model of regional cooperation used was recognized as a particularly useful one and was adapted in the design of other health care reform projects under the South-east Europe Health Network and the Stability Pact for SEE*.

Implementation has not disappointed this early promise, and by the end of 2008 all the SEE Mental Health Project's goals will have been achieved, and the network of national mental health bodies will be ready to enter the next phase: building on the pilot CMHC projects to work towards final implementation of the regional and national mental health reform action plans. This process will be facilitated by the transformation of the regional project office in Sarajevo, Bosnia and Herzegovina, into a Regional Health Development Centre for Mental Health in SEE.

* The Regional Cooperation Council (RCC) was officially launched on 27 February 2008, as the successor of the Stability Pact for South Eastern Europe. For more information visit *www.rcc.int*

From the WHO Fact Sheet on Mental Health Promotion

Mental health is more than the absence of mental disorders

- Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.
- Mental health is the foundation for well-being and effective functioning for an individual and for a community.

Mental health is determined by socio-economic and environmental factors

- Mental health and mental health disorders are determined by multiple and interacting social, psychological, and biological factors, just like health and illness in general.
- The clearest evidence is associated with indicators of poverty, including low levels of education, and in some studies with poor housing and poor income. Increasing and persisting socio-economic disadvantages for individuals and for communities are recognized risks to mental health.
- The greater vulnerability of disadvantaged people in each community to mental health disorders may be explained by such factors as the experience of insecurity and hopelessness, rapid social change, and the risks of violence and physical ill-health.
- National mental health policies should not be solely concerned with mental health disorders, but also recognize and address the broader issues which promote mental health. This requires mainstreaming mental health promotion into policies and programmes in government and business sectors including education, labour, justice, transport, environment, housing, and welfare, as well as the health sector...

Cost-effective interventions exist to promote mental health, even in poor populations

- Early childhood intervention (e.g. home visiting for pregnant women, pre-school psycho-social interventions, combined nutritional and psycho-social interventions in disadvantaged populations);
- Support to children (e.g. skills building programmes, child and youth development programmes);
- Socio-economic empowerment of women (e.g. improving access to education, microcredit schemes);
- Social support to the elderly (e.g. befriending initiatives, community and day centres for the aged);
- Programmes targeted at vulnerable groups, including minorities, indigenous people, migrants and people affected by conflicts and disasters (e.g. psycho-social interventions after disasters);
- Mental health promotion in schools (e.g. programmes supporting ecological changes in schools, child-friendly schools);
- Mental health promotion at work (e.g. stress prevention programmes);
- Housing policies (e.g. housing improvement);
- Violence prevention programmes (e.g. community policing initiatives); and
- Community development programmes (e.g. 'Communities That Care' initiatives, integrated rural development).

WHO is working with governments to promote mental health

- To implement these effective interventions, governments need to adopt a mental health framework to advance other areas of health and socio-economic development and thereby engage all relevant sectors to support and evaluate activities designed to promote mental health.
- WHO supports governments by providing technical material and advice to implement policies, plans and programmes aimed at promoting mental health.

Adapted from the Mental Health pages of the WHO Regional Office for Europe website.
www.euro.who.int/document/mediacentre/fs0303e.pdf

Contrasting Paradigms: Dehumanization versus Re-socialization

"Human Rights Commissions found "appalling and unacceptable" conditions when they visited several psychiatric hospitals in Central America and India during the last five years. Similar conditions exist in many other psychiatric hospitals in other regions, in both industrialized and developing countries. They include filthy living conditions, leaking roofs, overflowing toilets, eroded floors, and broken doors and windows. Most of the patients visited were kept in pyjamas or naked. Some were penned into small areas of residential wards where they were left to sit, pace, or lie on the concrete floor all day. Children were left lying on mats on the floor, some covered with urine and faeces. Physical restraint was commonly misused: many patients were observed tied to beds. At least one-third of the individuals were people with epilepsy or mental retardation, for whom psychiatric institutionalization is unnecessary and confers no benefit. They could well return to live in the community if they could be provided with appropriate medication and a full range of community-based services and support systems.

Many hospitals retained the jail like structure of their construction in colonial times. Patients were referred to as *inmates* and were for most of the day in the care of *warders*, whose supervisors were called *overseers*, while the wards were referred to as *enclosures*. Seclusion rooms were used in the majority of the hospitals. In over 80% of the hospitals visited, routine blood and urine tests were unavailable. At least one third of the individuals did not have a psychiatric diagnosis to justify their presence there. In most hospitals, case file recording was extremely inadequate. Trained psychiatric nurses were present in less than 25% of the hospitals, and less than half the hospitals had clinical psychologists and psychiatric social workers."

From Box 3.2, 2001 World Health Report, p. 51

"Community care is about the empowerment of people with mental and behavioural disorders. In practice, community care implies the development of a wide range of services within local settings. This process, which has not yet begun in many regions and countries, aims to ensure that some of the protective functions of the asylum are fully provided in the community, and the negative aspects of the institutions are not perpetuated.

Care in the community, as an approach, means:

- Services which are close to home, including general hospital care for acute admissions, and long-term residential facilities in the community;
- Interventions related to disabilities as well as symptoms;
- Treatment and care specific to the diagnosis and needs of each individual;
- A wide range of services which address the needs of people with mental and behavioural disorders;
- Services which are coordinated between mental health professionals and community agencies;
- Ambulatory rather than static services, including those which can offer home treatment;
- Partnership with carers and meeting their needs;
- Legislation to support the above aspects of care."

2001 World Health Report, p. 50

MENTAL HEALTH AS A PUBLIC HEALTH ISSUE

Mental Health came to prominence on the international agenda *as a public health issue* gradually during the last decade of the twentieth century. The main reason for this was the growing awareness during the latter half of the twentieth century of the human and economic costs to society and the individual suffering involved in poor mental health. There was a consensus that major reforms were needed in mental health policy and care, with a shift away from custodial, and in some cases quasi-penitentiary, systems towards the provision of care in the community. This was based on what amounted to a revolution in the options available for treatment, both in terms of new psychotropic drugs and of forms of therapy, and on recognition of the urgent need to reverse the trend towards dehumanization of the mentally ill and secure respect for their basic human and civil rights and their autonomy and dignity as individuals. A number of factors thus played a role:

- A growing understanding that mental health problems are not a matter of personal culpability or defect, but like most other diseases and disorders the result of a complex combination of biological, psychological, and social factors;
- A growing understanding that stigmatization of those with mental health problems is itself a major problem and source of human rights violations and discrimination, compounding the suffering of the mentally ill and hindering their recovery and reintegration into the mainstream of social and economic life;
- A growing understanding of the extent of the problem, with some 450 million people worldwide suffering from mental health problems (mental or neurological disorders or psychological problems like those related to alcohol and drug dependency) and one in four people likely to do so at some point during their lifetime, so that major depression ranks as the leading cause of disability world wide;
- And, perhaps most importantly, growing recognition that advances in the aetiology and diagnosis of mental disorders and in the development of psychotropic drugs, as well as of the benefits of humane treatment that respects the rights and dignity of the consumer and empowers them as participants in their own recovery, mean that effective and cost-efficient therapies, which allow the social reintegration of those with mental health problems, already exist.

The new consensus on public health was nicely summed up by former WHO Director-General Gro Harlem Brundtland in October 2001, in her foreword to the World Health Report, when she stated that "we have the means and the scientific knowledge to help people with mental and brain disorders. Governments have been remiss, as has been the public health community. By accident or design, we are all responsible for this situation. As the world's leading public health agency, WHO has one, and only one option – to ensure that ours will be the last generation that allows shame and stigma to rule over science and reason." *

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* World Health Report 2001, *Mental Health: New Understanding, New Hope*, page x.

THREE DECADES OF ADVOCACY AND POLITICAL PROGRESS ON MENTAL HEALTH

The Italian Model of Mental Health Reform

"Reflecting the paradigm shift from hospital to community, far-reaching policy changes have been introduced in a number of countries. For example, Law 180, enacted in Italy in 1978, closing down all mental hospitals, formalized and accelerated a pre-existing trend in the care of the mentally ill. The major provisions of the Italian law state that no new patients are to be admitted to the large state hospitals nor should there be any readmissions. No new psychiatric hospitals are to be built. Psychiatric wards in general hospitals are not to exceed 15 beds and must be affiliated to community mental health centres. Community based facilities, staffed by existing mental health personnel, are responsible for a specified catchment area. Law 180 has had an impact far beyond Italian jurisdiction. "

From the 2001 World Health Report on Mental Health (p. 51)

It was in response to this growing consensus that some governments in Europe and elsewhere initiated reforms during the 1970s and 1980s to tackle the issue of mental health care policy and service provision, notably in Italy. Progress has been gradual and de-institutionalization at best a qualified success:

"Among the reasons for the lack of better results are that governments have not allocated resources saved by closing hospitals to community care; professionals have not been adequately prepared to accept their changing roles; and the stigma attached to mental disorders remains strong, resulting in negative public attitudes towards people with mental disorders. In some countries, many people with severe mental disorders are shifted to prisons or become homeless." (2001 World Health Report, p. 51).

The early 1990s saw further developments: the governments of Latin America launched the first regional initiative to promote transition towards community-based care (the Caracas Declaration) in 1990; President George H. Bush declared the 1990s the *Decade of the Brain*; and in 1991, the United Nations General Assembly adopted the *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*. Nevertheless, the WHO could still report in 2001 that "In most developing countries, there is no psychiatric care for the majority of the population; the only services available are in mental hospitals. These mental hospitals are usually centralized and not easily accessible, so people often seek help there only as a last resort. The hospitals are large in size, built for economy of function rather than treatment. In a way, the asylum becomes a community of its own with very little contact with society at large. The hospitals operate under legislation which is more penal than therapeutic." (2001 World Health Report, p. 52).

In 1993, the European Community received a mandate regarding public health under the Maastricht Treaty (since replaced by Article 152 of the Amsterdam Treaty), but there was no specific mention of mental health. It was only after an initiative by the Finnish Minister for Health, in 1997, that the European Commission began to focus on mental health as a public health issue. This was followed by the Key Concepts programme in 1997-98, the main aim of which was to define central concepts and priorities for mental health promotion at the level of the European Community (including the definition of mental health to be applied). It would not be until 2005, however, that the EU would begin work on a Green Paper on Mental Health policy.

In the meantime, two very important initiatives of the World Health Organization helped to change the environment in Europe:

- The first was the 2001 World Health Report on the theme *Mental Health: New Understanding, New Hope*, from which we have already quoted. This report summed up the progress that had taken place over the previous decade or so in the aetiology, treatment, and overall approach to mental health, as well as setting

Stigma and the Treatment Gap in the WHO European Region:

The 52 Member States of the WHO European Region show a wide spectrum of development in mental health policy:

- Thirteen countries of the WHO European Region have neither initiated reform processes leading to community-based care, nor stated their will to start,
- Twenty five countries have initiated a partial reform,
- And only thirteen have established it in full.

All countries have to work with limited resources, while prejudice and stigma hamper the development of mental health policies. The WHO Task Force on De-stigmatization has found that schizophrenia is heavily stigmatized in most European sub-regions, while depression, addiction, senile dementia, and epilepsy can lead to deprivation of human rights and highly diminished access to decent living conditions or adequate education. In some countries, the mentally ill remain effectively incarcerated in institutions that not merely fail to provide them with appropriate treatment but compound their suffering by infringing their basic rights, de-socializing, and to a large extent dehumanizing them. In some European countries, poorly executed de-institutionalization has resulted in neglect and abandonment of the severely mentally ill. In some European capital cities, some 50 % of the homeless are psychotic.

Although the consequences of mental ill health can easily account for a third or more of all health care costs, many countries in the European Region spend less than 3% of their health budgets on mental health care. Often it is the poorest countries which allocate a lower share. As a result:

- There is a considerable treatment gap:
  - 47% of people suffering from major depression;
  - Between 36% and 45% of people with schizophrenia;
  - 75% of the children and adolescents who suffer severely from mental disorder (10% of the total age group);
  - And 60% of epilepsy sufferers (in some countries).
- Allocation of general hospital beds for psychiatric patients referred from community-based mental health care is just 60% of the world average.
- As many as 60% of all patients with mental disorders continue to be treated in large and poorly managed psychiatric institutions (over 500 beds) in some countries.
- Primary health care services are inadequately integrated with mental health services in 34 of the 52 countries of the region.
- Essential psychotropic drugs are adequately available in primary care in only one in five European countries.

There is no excuse for this. We know today that mental health can be promoted, that most mental disorders can be managed, treated and even prevented, and that effective intervention strategies exist. Mental health is a most important, maybe *the* most important public health issue and even the poorest society must find the resources to promote, protect and invest in mental health.

Statistics taken from the WHO Regional Office for Europe website.
www.euro.who.int/healthtopics/HT2ndLvlPage?HTCode=mental_health

out what would become the new consensus on mental health policy and service provision at both the national and international levels and a blueprint for reform of existing mental health care systems away from custodial towards community-based primary care.

- The second was the entrenchment of the report's position as reference point for all further discussion of mental health in January 2005, when the WHO organized the European Ministerial Conference on Mental Health in Helsinki, in partnership with the Council of Europe and the European Union. The conference was attended by the health ministers from 52 European countries, who agreed a *Declaration on Mental Health* and an *Action Plan for Europe*, with 14 briefing papers on various aspects of policy and service provision.

WHO's ten recommendations for action on mental health:

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.

This platform was used by the European Union as the basis for its October 2005 Green Paper on Mental Health, the first step towards the establishment of an EU mental health strategy:

"The January 2005 WHO European Ministerial Conference on Mental Health established a framework for comprehensive action, and created strong political commitment for mental health. It invited the European Commission, a collaborating partner of the conference, to contribute to implementing this framework for action, in line with its competencies and the Council's expectations and in partnership with the WHO. This Green paper is a first answer to this invitation. It proposes to establish an EU-strategy on mental health. This would add value: by constituting a framework for exchange and cooperation between Member States; by helping to increase the coherence of actions in the health and non-health policy sectors in Member States and at Community level; and by allowing involvement of a broad range of relevant stakeholders into building solutions." (From the EU Green Paper, Improving the Mental Health of the Population, p.3).

MENTAL HEALTH IN SOUTH-EASTERN EUROPE

Although a somewhat variable term, for the purposes of this project, South-eastern Europe refers to the nine participating countries, Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Montenegro, The Republic of Moldova, Romania, Serbia, and The former Yugoslav Republic of Macedonia.

As this makes clear, the SEE region includes five of the six successor states of the former Yugoslavia. The region is home to some 58 million people, but demographic data are unreliable. This is due to its recent turbulent history, with a series of economic and humanitarian crises and wars over the past three decades that has led to major population and refugee movements.

RELEVANT RECENT HISTORY OF THE SEE REGION

During the twilight years of communism (late 1980s), the economies of Bulgaria, Yugoslavia, and Romania went through their own separate crises, with massive inflation and impoverishment. In Bulgaria and Romania this led to the more or less violent replacement of the communist authorities and a slow and painful period of transition to a market economic system. The then Yugoslavia, by contrast, suffered a drawn-out process of break-up and war that lasted through most of the 1990s, with an incalculable cost in human suffering and economic destruction. From 1991 to 1995, war and partition in both Croatia and Bosnia and Herzegovina resulted in hundreds of thousands of people wounded, dead, or missing, and the displacement of more than two million others, their homes and lives destroyed, many never to return. There was tens of billions of dollars in damage to infrastructure and industry. This was accompanied by economic sanctions and isolation for Serbia and Montenegro and political instability in The former Yugoslav Republic of Macedonia.

As the situation in the former Yugoslavia calmed somewhat, after the signing of the Dayton peace agreement (1995), both Bulgaria and Albania suffered economic meltdown, in 1996 and 1997 respectively, the latter requiring a full scale humanitarian intervention. The situation in Kosovo was also steadily worsening, threatening the stability of the neighbouring republics of Albania and The former Yugoslav Republic of Macedonia, as well as the internal stability of Serbia and Montenegro, and producing renewed major movements of refugees and internally displaced persons.

In 2006, the Republic of Montenegro seceded from the Union of Serbia and Montenegro, while in February 2008 the Yugoslav Province of Kosovo declared its independence, a declaration which has been recognized by a number of countries, but rejected by others.

As this summary suggests, although none of the countries in the region has suffered any additional major economic crisis since the millennium, the political situation continues to be tense and progress is slow. Many of the countries suffer from low population growth rates and aging populations. This is not unrelated to plummeting real GDP levels, falling living standards, and increasing levels of actual poverty, which were endemic for most of the 1990s. There has been some economic and social recovery since the turn of the century, as GDP per capita has increased modestly and poverty levels appear to have been falling in most of the countries of the region. The benefits, however, are not evenly spread in society and there is justified concern over increasing economic inequality, social exclusion, stress on social welfare and health care systems, and the porous social security safety-net.

Dr M. Pavličić, former Minister of Health of Montenegro, has summed up the situation with regard to his country as follows:

"For over a decade, our immediate living environment has been the ground of transitional changes, interethnic conflicts, economic crisis, and migration. Processes within the economic milieu brought about a sharp decrease in employment, family disruption, and alienation, with a tendency of increasing number of people with mental health problems. In general we are witnessing an ever more open manifestation of social pathologies, alcoholism, substance abuse, delinquency, crime, depression, and suicide. As a traditional society with a rigid value system in which illness is taken as a flaw, and mental illness as a shame of the family, it is very difficult to create a social climate which is open and accepting of new, civil, and rational ways of treating the mentally ill. Stigmatization of people with mental illness and their families thrives on prejudice and impedes the development and implementation of the country's strategy for mental health protection."

In the words of the recent WHO Report on Health and Economic Development in South-eastern Europe, "the break-up of the former Yugoslavia in 1991 and the collapse of communism resulted in profound system-wide changes and the rapid emergence of macro-level stressors such as the erosion of safety nets, the restructuring of markets, the deepening of poverty and inequalities through unemployment and the devaluation of real wages, pensions and social benefits. This was followed by a decade of loss of human and social capital….. during the 1990s economic development in the south-eastern part of Europe fell significantly compared to the countries of central and eastern Europe (CCEE) that joined the EU in 2004, and even more so compared to the member states of the European Union before May 2004 (EU-15). The region – with the exception of Croatia – has a low level of GDP per capita compared to the new EU members. While other economies in transition experienced a recovery from the "transformational recession" after 1991/1993, the South-east European economies experienced a deeper fall during 1989-1993, and a period of stagnation until 1999."

The cumulative impact of this temporal and geographical concentration of 'macro-stressors' is that mental health issues have become an increasingly important and visible component of public health.

This is the background against which the Mental Health Project for South-eastern Europe was launched and developed. It is important to make clear that the SEE Mental Health Project was a pioneering attempt at the regional coordination of mental health promotion. It was one of the first practical responses to the WHO 2001 Mental Health report, and its inception and implementation largely preceded serious response within the European Union or in other parts of the world. In fact, it might be said that the WHO report helped ensure that an independent regional initiative based on specific local factors and needs resonated with the donor community and the international institutions on whose support it would depend.

THE PATH TOWARDS REGIONAL COOPERATION

As the above summary makes clear, relations were poor both between and within countries, while conflict, political instability, and economic pressures combined as major stressors acting on the general population throughout the region. Without remedial action on the part of the international community, and the European Union in particular, there was no reason to believe that the region would move spontaneously towards stabilization and better internal relations, never mind towards closer, mutually beneficial, relations with the rest of Europe.

The international community and the local governments were anxious to find ways to alleviate the situation and promote regional cooperation. This was particularly true, given the general hope that it would be possible to draw the countries of the region into ever closer relations with the European Union, culminating in membership,

a goal that was impossible without the prior establishment of functioning mechanisms for regional cooperation. The idea was that the common goal of EU membership would help the countries establish regional-level structures and mechanisms, preparatory to integration with European ones, particularly in areas where progress was only possible on the basis of cooperation and mutual benefit.

This led to the establishment in 1999 of the Stability Pact for South-eastern Europe, on an initiative of the European Union. Its purpose was to act as a framework for the promotion of stability in the region, with the long-term strategic goal of Euro-Atlantic integration. It was, in other words, to be a 'school for membership,' preparing the countries of the region for the type of policy processes and cross-border cooperation that are the essential fabric of the European Union itself. The Stability Pact for SEE was supported actively by all the major members of the international community and international organizations, including the Council of Europe, the Council of Europe's Development Bank, the United Nations and its agencies, including the WHO Regional Office for Europe, and the Bretton Woods institutions.

The Stability Pact for SEE placed particular emphasis on the promotion of (1) democracy and human rights, (2) economic prosperity, and (3) security issues and established working tables for each area. Each working table involved a number of initiatives.

Given the severe deterioration over the previous decade both in public health and in the quality of the health services, and in recognition of the role of health as a basic human right and vital contributor to social and economic progress and of its neutrality and potential as a catalyst for regional cooperation, the ministers of health of the SEE region began looking for ways to put health on the Stability Pact for SEE agenda. This identification of public health as integral to socially cohesive economic development coincided with a new initiative by the WHO Regional Office for Europe, which in September 2000 adopted a new strategy called *Matching Services to New Needs*. The WHO Regional Office for Europe's primary focus since then has been to support Member States in developing their own policies, health systems, and public health programmes, preventing and overcoming threats to health, anticipating future challenges, and advocating for public health. In December 2000, the SEE health ministers therefore approached the WHO Regional Office for Europe for assistance.

In January 2001, the WHO Regional Office for Europe and the Council of Europe joined forces to boost health and equity as basic human rights in the SEE region and, in April 2001, founded the South-east Europe Health Network as a political and technical platform of regional cooperation in public health in SEE. It comprises the 9 countries of the SEE region, 8 neighbour and donor countries, including Greece, Hungary and Slovenia, and four international organizations, including the WHO Regional Office for Europe and the Council of Europe, involving more than 200 political and technical professionals.

In May 2001, health was consequently added to the agenda of the Stability Pact's Social Cohesion Initiative (Working Table II: Economic Reconstruction, Co-operation, and Development).

In cooperation with the World Health Organization, the European Union, and the Council of Europe, the Stability Pact for SEE organized a forum of the Health Ministers of South-eastern Europe in Dubrovnik, in September 2001. Its main purpose was to address the pressing need for major structural reform of health systems across the South-eastern Europe region in the light of the WHO strategic recommendations.

The meeting resulted in the signing of *The Dubrovnik Pledge: Meeting the health needs of vulnerable populations in South-eastern Europe*, the text of which is appended to this report as Annex 1.

The health ministers used the opportunity to stress "the damaging effects on health of recent wars, continuing unrest and conflict, as well as the economic hardships faced by the populations of SEE during their countries' tran-

sition to market economies" and to "accept the challenge to play a key role in strengthening the fundamental human rights of our societies and of vulnerable populations and individuals within them to effective health care, social well-being and human development, in line with the principles of the World Health Organization and the Council of Europe" (quotes taken from the Dubrovnik Pledge).

Amongst other goals, they stressed the need to focus on access to appropriate, affordable, and high-quality health care services and to strengthening community mental health services, as well as establishing regional networks and systems for the collection and exchange of social and health information. They ended the declaration with a call to international donors for financial assistance and to the WHO Regional Office for Europe and the Council of Europe for technical and policy support.

The SEE Health Network Functions:

- Promote implementation of the Dubrovnik Pledge.
- Act as prime mover in obtaining and sharing experience of implementation at all levels.
- Assist the Council of Europe, WHO Europe, and the Stability Pact for SEE Social Cohesion Initiative in defining high-priority areas for international action.
- Stimulate and participate in international cooperation.
- Steer, monitor, and evaluate the implementation of regional projects for health development.
- Facilitate and support the development of health development actions plans, including technical assistance in analysis of the economic, social, and health implications of particular policy options, and to promote and assist in building up partnerships and mobilization of resources.
- Promote and facilitate inter-sectoral coordination at national level and the involvement of other government sectors in health actions.
- Cooperate with Stability Pact for SEE bodies and partners through the Social Cohesion Initiative to promote actions addressing health issues in or closely linked with action programmes for social cohesion.
- Advice other international organizations and donors ready to support reforms in different health sectors on health issues in the South-eastern European region.
- Assist in the identification of emerging health issues that require collaborative actions or their study.
- Foster the exchange and dissemination of information.

Adapted from www.euro.who.int/stabilitypact

Overall, the Dubrovnik Pledge constituted the region's first ever cross-border political alliance in health and was recognized as a huge political victory for peace and cooperation, which made health a cornerstone of the Stability Pact's Social Cohesion Initiative. As such, it was strongly supported by the international community.*

A new mechanism was created in 2001 to ensure implementation of the Pledge and regional projects within its framework: the SEE Health Network. For the first time, the SEE countries carried out a joint assessment of their public health situation, particularly with regard to vulnerable groups. They also took the first steps towards a regional health agenda. Within three months, initial funding had been secured for three of the first seven health projects planned: on mental health, communicable diseases, and food safety and nutrition.

The first project to begin implementation was the mental health project. The regional project office was located in Sarajevo, Bosnia and Herzegovina, in June 2002,

* The aspirations and goals of the Dubrovnik Pledge were reaffirmed by the Second Health Ministers' Forum on Health and Economic Development in South-Eastern Europe in the 21st century, held in Skopje, The former Yugoslav Republic of Macedonia on the 25th to the 26th of November 2005. A copy of the resulting Skopje Pledge is appended to this report as Annex 2.

because the SEE Mental Health Project was Bosnia and Herzegovina's proposal to the SEE Health Network. The reform of the mental health services towards community-based care had started in Bosnia and Herzegovina as early as 1996, under extremely difficult conditions, as the country was just beginning to recover from the war. After five years of continued effort, and thanks to considerable financial and technical assistance from the international community, a country-wide network of community mental health centres had been established and was in operation. Bosnia and Herzegovina consequently felt confident that it could provide trustworthy leadership in a joint endeavour, by drawing on its already extensive experience in mental health reform.

The proposal met with the approval of the other countries in the SEE Health Network and of the WHO Regional Office for Europe and the Council of Europe as joint sponsors of the Network, as well as of Greece as main potential donor. It was particularly timely both in that Mental Health would be the topic of the 2001 World Health Report and because Mental Health had been placed securely on the agenda in South-eastern Europe as a result of a meeting on the topic of "Mental Health and Stigma in a World of Crisis," held in Athens, Greece, in June, 2001, under the joint aegis of the WHO Regional Office for Europe and the Hellenic Ministry of Health and Social Solidarity.

The meeting produced the "Athens Declaration on Mental Health and Man-Made Disasters, Stigma and Community Care," signed by 54 representatives from 17 countries and international organizations. Mental health professionals representing national governments of South-eastern Europe expressed their deep concern about the ongoing violence within and outside the region and its impact on the mental health of the public, the persistence of stigma and discrimination against persons with mental disorders and their families, and the limitations of mental health care and social support provided by outmoded institutions.

The Community Mental Health Centre in Doboj – An Example of Good Practice in Bosnia and Herzegovina by Dr Vjekoslav Kovačević

A community mental health centre with a catchment area of some 92,000 people and a cooperative agreement with the local hospital was established in Doboj in 1996 as part of Ministry of Health-led primary health care reforms.

By 1999, the Centre's facilities had been reconstructed, equipment provided, sheltered housing adapted and outfitted, and professional team-development completed, in cooperation with psychiatric hospitals in Belgrade, Banja Luka, Pesaro, and Trieste. Educational support was provided by the Health Centre in Doboj, WHO, HealthNet International, and Swedish Psychiatric, Social and Rehabilitation Project for Bosnia and Herzegovina (SweBiH).

The Centre opened to the public on August 26, 1999. Its focus is primarily on the prevention and treatment of mental disorders based on the community-psychiatry model, with continuous follow-up of persons with mental disorders after hospitalization and social and occupational rehabilitation. A shelter was also opened as part of a re-socialization and rehabilitation programme. It is financed by the Doboj Health Centre and donations. The CMHC also helped establish *Nada–Doboj,* a mutual assistance User Association.

The Doboj CMHC aims are:

- To change community attitudes towards the mentally ill,
- To reduce the duration of hospitalization,
- To reduce the number of beds at the psychiatry department,
- To ensure continued professional education,
- To strengthen the role of primary health care, and
- To coordinate all institutions at the local level.

Problems encountered related mostly to inadequate legal provisions, resistance within the profession, and financing.

By 2003, two further teams had been formed at Doboj: one devoted to the prevention and treatment of addiction diseases, the other to working with children and adolescents.

They appealed to regional governments, the WHO Regional Office for Europe, and the European Union vigorously and systematically to pursue the process of de-stigmatization and the development of community mental health services that could guarantee the patient's rights to appropriate mental health care, as well as to education, housing and employment, and reintegration into society.

Due to the success of the meeting and the fact that Greece had 16 years experience in reforming her own mental health services, the WHO Regional Office for Europe welcomed Greece's participation in the Dubrovnik Forum and support for the "Enhancing Social Cohesion through Strengthening Community Mental Health Services in SEE" project, as main donor and partner.

The first concrete result of the Dubrovnik Pledge was thus the SEE Mental Health Project, which was officially approved for implementation at the 4th meeting of the SEE Health Network, in May, 2002, in Hilleroed, Denmark.

THE BENEFITS OF APPROACHING MENTAL HEALTH CARE REFORM REGIONALLY

Mental health care reform is a difficult and complex task under the best of circumstances, as Professor Constantopoulos' account of his experience in Greece makes clear (see box on the reform of Greek psychiatric institutions). The process began two decades ago and has not yet reached completion. Even with largely independent funding, the support of the European Union (or its predecessors) and of government, there will always be significant resistance from vested economic, professional, and institutional interests, as well as local resistance motivated by stigma and discrimination. Reform requires a revolution in popular mentality, as much as in the treatment of the mentally ill.

The situation is even more complex under conditions of political instability and resource scarcity, where mental health is too often given a low priority. The mentally ill, after all, are not a much courted political constituency, particularly when confined in custodial institutions.

A regional approach can have many benefits under such circumstances. By linking the professional communities and relevant bureaucratic bodies (health authorities and ministries) across the region and by linking them with similar bodies outside the region, whether at the level of the European Union or wider international bodies like the Council of Europe and the World Health Organization, one raises awareness of the issues and exponentially increases the capacity for policy development and advocacy. The transfer of knowledge and expertise as to what to do and how to do it is facilitated, while making it more difficult for a given individual country to ignore the consensus or delay reforms. This is particularly important, since traditional custodial forms of treatment of the mentally ill have displayed scant respect for basic human and civil rights or their autonomy and dignity as individuals.

By developing a common blueprint for reform, based on internationally agreed principles, goals, and standards, while naturally taking country-specific aspects into account, one simultaneously reduces the expense and effort that would be required by each of the participating countries, if they were following separate processes, and largely eliminates the danger of a given country taking a wrong turn or pursuing counterproductive and harmful reforms.

Finally, a regional approach is more effective in raising public awareness and combating stigma, as the process gains in authority and scope.

Greek Psychiatric Reform and Harmonization with EU Standards

Prior to the commencement of reform, psychiatric services in Greece were provided almost exclusively by nine large psychiatric hospitals, often under inhuman conditions.

In a lecture delivered at the third workshop under the SEE Mental Health Project (2003), Professor A. Constantopoulos distinguished four phases following on from Greece's accession to the EEC and the establishment of a National Health System. EEC Regulation 815/84 allowed for funding and monitoring by the Community.

The first phase lasted from 1985 to 1989, when reform was driven by the Ministry and the EEC and supported by a small group of progressive psychiatrists. Obstacles included inertia and reaction from within the existing system (both the General Hospitals and the Asylums), while stigma led both individuals and local government to oppose the establishment of new units. Human resources were inadequate and bureaucracy cumbersome and time-consuming, causing difficulties regarding the required Greek co-funding.

During the second phase (1989-1993) the pace of reform slowed significantly. Although professional support grew and the EEC continued to exert pressure, political instability and mounting resistance both within the asylum system and the local communities obstructed implementation, and the Mental Health Centres were de-linked from the hospitals, without adequate alternative provision. EEC funds could not be absorbed, except through the uncoordinated involvement of NGOs in service provision. A positive step was the creation of a Department of Mental Health, while international organizations began to provide assistance in dealing with abuses and bad practices at the infamous Leros institution, a process which continued during the later stages.

The third phase (1993-1999) saw improvements at the Ministry of Health (both in funding and know-how) and the return of the Mental Health Centres to the Hospitals. A Mental Health Plan was introduced, and continued EU funding was secured.

The fourth and current phase (1999-2003) saw continued support from the Ministry of Health for reform and an increasing number of mental health professionals working in the new structures. Mental health services, with the exception of Attica, had been sectorized, though there was still resistance both from within the major institutions and the local communities.

Although the reform was well established and moving faster, with 5 psychiatric hospitals to be closed by 2006, and the remainder expected to close by 2015, the local authorities continued to oppose the establishment of community units, and there were no specialized facilities or programmes for groups with special needs, leading to bed block and continued stigmatization.

In Professor Constantopoulos' view, the reform of psychiatric services is only the beginning of the real process of reform, which is concerned with the change of the mentality of the people and the abolition of prejudices and discrimination towards fellow human beings who have the misfortune at some point in their lives to suffer mental ill health, something that awaits one-in-four of us during our life span.

Some Common Challenges to Mental Health Reform in the SEE:

The following are a sample of the challenges identified as common to all the SEE countries on the basis of assessments carried out under Component One of the Mental Health Project for South-eastern Europe:*

- Existing models of social insurance disadvantage community-based models of care, as only bed-based activities are considered legitimate treatment expenses.
- Community mental health services cost much the same in the long run, but the transition period entails additional spending, which can be difficult to obtain.
- New approaches require new curricula for tomorrow's graduates and updating for experienced staff, especially in the form of mental health nursing programmes.
- Good mental health provision requires new partnerships with non-health agencies: criminal justice, education, social welfare and housing, child services, senior services, and learning disability services. Potential barriers to partnership are:
  - Structural (different agencies responsible for the same client group);
  - Procedural (different planning cycles and budgetary cycles);
  - Financial (differences in funding priorities and distribution methods);
  - Professional (professional self interest and autonomy, inter-professional competition for clients, threats to job security, and conflicting views about clients interests and roles);
  - Status and legitimacy (organizational self interest and autonomy and differences in legitimacy between elected and appointed agencies).

Four broad principles help overcome these difficulties:

- Articulating a shared vision: clarifying the purpose of collaboration and mobilising commitment around user-centred goals, outcomes, and mechanisms;
- Clarifying roles and responsibilities;
- Providing incentives and rewards that promote organizational behaviour consistent with agreed roles and responsibilities and harness organizational self-interest to collective goals;
- Ensuring accountability for partnership: monitoring achievements in relation to the vision, holding individuals and agencies to account for the fulfilment of their part of the vision, and providing feedback on progress towards the vision.

Successful implementation of policy depends on leadership at all levels. The core group responsible for developing the policy will need to engage, educate, and encourage staff at all levels. To create a majority for change, a critical mass of practitioners will need to support the vision and be prepared to change their attitudes and practice. Within each group, leaders will emerge who are willing to take the lead. They will need to be supported, through training courses and development networks, which bring key opinion formers together. Some key components for any development programme for budding leaders are:

- Taking account of the user movement;
- Understanding organizational cultures and how to change them;
- Creating alliances with likeminded people;
- Understanding the need for support mechanisms;
- Working to change cultures from within;
- Understanding what motivates people;
- Accessing the latest information on mental health services; and
- Utilising models of change.

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* Described in the SEE Mental Health Project report on Mental Health Policies and Legislation in SEE, available at www.seemhp.ba

THE MENTAL HEALTH PROJECT FOR SOUTH-EASTERN EUROPE

Supported by the WHO Regional Office for Europe and the Council of Europe, the SEE Mental Health Project was the first project to be initiated under the South-eastern European Stability Pact's Social Cohesion Initiative. It was also the first activity of the South-east Europe Health Network. Officially inaugurated in September 2002, the SEE Mental Health Project originally covered only seven countries: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Romania, Serbia and Montenegro, and The former Yugoslav Republic of Macedonia. This expanded gradually to nine, as the Republic of Moldova joined the project in 2003 and the Union of Serbia and Montenegro was dissolved in 2006.

The SEE Mental Health Project has proved a pioneering approach to issues of public health and has provided a model for subsequent regional initiatives. Initially expected to last for just two years, the project will in fact run until December 2008, with a much expanded remit. It has achieved its principle goals of:

1. Establishing a regional coordination body for mental health policy, with national mental health bodies in each of the participating countries;
2. Reviewing and comparing national mental health legislation and policies, where they existed, and drafting a joint statement on mental health and recommendations for government regarding the establishment of a regional framework on mental health that encompasses the transition from institutionalized towards community-based care, based on the principles of the right to mental health, human dignity, and social inclusion;
3. Revision and preparation of new mental health legislation and policy by each of the participating countries, based on the regional framework and the agreed principles;
4. Establishment in all of the participating countries of at least one substantial pilot project on the community-based model, allowing the training of staff in the new techniques and modalities and their gradual introduction to the main user and stakeholder constituencies: the psychiatric profession, primary health care pro-

Project justification:

Risk factors for developing mental health disorders steadily increased across the SEE region during the socio-political and economic crises of the 1980s and 1990s. They included large-scale unemployment, poverty, migration, political instability, and a pervasive sense of insecurity. As post-war societies, certain of the participating countries faced particularly complex challenges with regard to the deteriorating mental health of their populations.

Several concerns were identified as common to all SEE countries:

- Lack of interest in or political commitment to mental health issues,
- Inadequate mental health policies and legislation,
- Over-reliance on custodial institutions,
- Stigmatization of and discrimination against the mentally ill,
- Absence of community-based mental health services,
- Absence of effective inter-sectoral linkages,
- Detachment of mental health services from primary health care,
- Low budgets for both health and mental health services,
- Paucity of managerial and leadership skills,
- Absence of standardized data collection systems,
- Insufficient participation of nongovernmental organizations (NGOs).

Although the participating countries showed considerable differences in levels of mental health care development, they all demonstrated a strong commitment to transforming the traditional institutional care into community-based care.

fessionals, social workers, psychologists, and most importantly those suffering from mental health problems themselves;

5. Government commitment that these pilot projects form the basis for a comprehensive reform of the national mental health systems, in a coherent and regionally coordinated fashion, in accordance with the national policies and the regional framework put in place by the project.

In short, the SEE Mental Health Project has initiated and carried out the initial stages of a comprehensive and coordinated process of mental health care reform in South-eastern Europe, in line with (and to a large extent in advance of) similar European and global processes. It has resulted in new and consistent national legal and political frameworks, coordinated within a regional framework, supported by a network of functioning institutions at all levels, and compatible with the developing European framework.

Organizational structure

The SEE Mental Health Project has both a political and an operational aspect:

- The *political* aspect is the responsibility of the Steering Committee, which includes representatives from the nine member countries, the project's two main sponsors, the World Health Organization Regional Office for Europe and the Council of Europe, and the donor countries.

- The *operational* side of the project is the responsibility of three bodies:
  1. The Executive Committee, including representatives of the lead country (Bosnia and Herzegovina), the WHO Regional Office for Europe, and the principal donor (the Greek government),
  2. The Regional Project Office, based in Sarajevo, and
  3. The individual country offices in each of the nine participating countries.

A regional declaration on mental health was presented to the regional health ministers and all the countries have drafted new or revised existing mental health legislation and policies, in accordance with its recommendations.

These national mental health policies are in the process of implementation in all nine participating countries. The first and already completed stage was the establishment of pilot project community mental health centres in all the countries. These pilot projects have ensured that institutional and administrative issues have been identified and solutions found before rolling out a more general reform, while also acting as the basis for significant training programmes for mental health and primary health care professionals (e.g. general practitioners), introducing the new mechanisms and modalities, and allowing the development of new and inclusion of existing user associations. In those countries which already had community mental health centres or an ongoing reform process, the project has ensured that they are in line with the general principles of modern mental health promotion.

It is important to stress that the institutions created during this project have been incorporated into government funding mechanisms and will continue to play their role of developing and coordinating national and regional mental health policy, *with government support,* while acting as a bridge to the European and global levels and ensuring both the maintenance of high levels of professional expertise locally and active involvement in the further development of European approaches to mental health policy.

Thanks to the support of the WHO Regional Office for Europe, in terms of technical and financial assistance, and the SEE Health Network's leadership role in maintaining political commitment and securing funding, it has

proven possible to extend the project's duration and scope and push reforms even further forward than originally envisaged. Donor response to the project's goals has increased in recognition of progress made and results achieved. This has resulted in unanimous support for the ongoing transformation of the SEE Mental Health Project into a joint regional programme of collaboration in the field of mental health.

FUNDING

The project budget for the six years of its existence has totalled some 3.2 million Euro in donations. The table on funding provides a breakdown of how this money was spent by component. It does not take into account the contributions made by the participating countries.

As the table makes clear, donor funding was concentrated largely on the first two components (the policy workshops and development of the pilot CMHCs). The funds spent on the third component went largely for training and similar initiatives. The implementation of the pilot projects (the community mental health centres) involved considerable in kind contributions or resources allocated by the participating countries (premises, seconded staff and professional salaries, equipment, vehicles, running costs, etc.). The reliance on resources provided by the participating countries during the final phase was particularly important in ensuring the sustainability of the reforms, as this depends on their being cost effective as well as therapeutically so and thus on the existence of an incentive for the country governments to continue implementation and generalization of the reforms. In practice, the reforms were found to involve the reallocation of existing resources and even entail savings, while ensuring much improved therapeutic results.

The project budget was provided by donations from the Greek, Belgian, Italian, Swiss, Slovenian, Swedish, and Hungarian governments, as well as from the WHO Regional Office for Europe. The Greek government's donation was particularly significant, as the table makes clear. Overall, it provided approximately half the total project budget and an even greater proportion in the initial stages. This was thanks in part to the fact Greece held the Presidency of the European Union at the time that the project was initiated, partly to that country's commitment to the Balkan region, and partly to the fortunate circumstance that Greece was at the time itself undergoing a process of far-reaching reform of its mental health care system and so had a particular interest and understanding of the timeliness of the mental health problematic in South-eastern Europe.

Breakdown of project funds by donor and component: 01.09.2002 – 31.12.2008 (in Euro)

DONORS	Component I	Component II	Component III	TOTAL
Belgium		131,000	388,000	**519,000**
Greece	539,000	600,000	400,000	**1,539,000**
Hungary		9,000		**9,000**
Italy	74,000	280,000		**354,000**
Slovenia	50,000	32,000	22,000	**104,000**
Sweden	29,000			**29,000**
Switzerland			298,000	**298,000**
WHO	94,000	132,000	90,000	**316,000**
TOTAL	**786,000**	**1,184,000**	**1,198,000**	**3,168,000**

Component One	**Nov 2002**	1st Workshop: Review of mental health policies and legislation in SEE, 4-6 November 2002, Ljubljana, Slovenia
	Feb 2003	2nd Workshop: Review of mental health services in SEE countries, 21-23 February 2003, Ohrid, The former Yugoslav Republic of Macedonia
	Jun 2003	3rd Workshop: International recommendations and experience in mental health policies and legislation, 8-10 June 2003, Veliko Tarnovo, Bulgaria
	Sep 2003	4th Workshop: Review of mental health policy development in SEE countries, 14-17 September 2003, Sinaia, Romania
	Oct 2003	5th Workshop: International recommendations and experience in mental health legislation and human rights, 5-8 October 2003, Sarajevo, Bosnia and Herzegovina
	Nov 2003	6th Workshop: Review of mental health policy and legislation in SEE – Regional dimension and recommendations to governments, 23-25 November 2003, Ljubljana, Slovenia
Component Two	**Feb 2004**	7th Workshop: Organization of mental health services in South-eastern Europe, 19-21 February 2004, Zagreb, Croatia
	Jul 2004	8th Workshop: Adopting the model of community mental health services in SEE, 13-15 July 2004, Tirana, Albania
	Oct 2004	9th Workshop: Community mental health service management – International experience and recommendations, 28-30 October 2004, Belgrade, Serbia and Montenegro
	Mar 2005	CMHC in Strumica, The former Yugoslav Republic of Macedonia, inaugurated
	Apr 2005	CMHC in Blagoevgrad, Bulgaria, inaugurated
	Apr 2005	10th Workshop: Monitoring activities and outcomes in the pilot CMHCs, 12-16 April 2005, Chisinau, Republic of Moldova
	Apr 2005	CMHC in Chisinau, Republic of Moldova, inaugurated
	Apr 2005	CMHC in Vlora, Albania, inaugurated
	May 2005	CMHC in Kotor, Montenegro, inaugurated
	Jun 2005	CMHC in Prnjavor, Bosnia and Herzegovina (Republika Srpska), inaugurated
	Oct 2005	CMHC in Nis, Serbia, inaugurated
	Nov 2005	CMHC in Mostar, Bosnia and Herzegovina (Federation of BiH), inaugurated
	Jan 2006	CMHC in Zagreb, Croatia, inaugurated
	Mar 2006	CMHC in Bucharest, Romania, inaugurated
Component Three	**Apr 2006**	11th Workshop: Training Priorities, 14-15 April 2006, Sofia, Bulgaria
	Nov 2006	Training: Leadership and Management – Community Team Leadership
	Mar 2007	Training: Leadership and Management – Strategic Development
	May 2007	Training: Leadership and Management – Strengthening Leadership Capacity
	Oct 2007	Case Management Training the Trainers Workshop
	Ongoing	In-country Training in Case Management and PHC practitioners' training
	2009...	Regional Health Development Centre for Mental Health in SEE

STEPPING STONES: A COORDINATED APPROACH TO MENTAL HEALTH REFORM

As explained above, the SEE Mental Health Project's overall goal was to establish community mental health services as the cornerstone of mental health reform in South-eastern Europe. This was done by ensuring the active participation of all the countries of the region in a joint process. A regional office was established in Sarajevo, Bosnia and Herzegovina, and coordinating offices for mental health were created with government support in each of the countries. National teams, including leading experts in mental health and government representatives, were then involved in a series of processes, first at regional, but increasingly at country level, the purpose of which was to create a common programme for mental health reform and to begin the implementation of sustainable and comprehensive reforms in each of the participating countries.

This required considerable preparatory work, gathering information about the existing national mental health care systems, as well as on national mental health policies, strategies, relevant legislation, and existing or planned reform processes, particularly in Albania, Bosnia and Herzegovina, and The former Yugoslav Republic of Macedonia, where the community-based model was already in the process of implementation. Next came the process of developing a common vision, with the assistance of international consultants and guidance materials, largely provided by the WHO headquarters in Geneva. The resulting vision was expressed in a Joint Statement and set of Recommendations presented to the health ministries of the region (see pp.40-1). This set the scene for the following phase, namely the development of new or revision of existing national policy and strategy documents and legislation, on the one hand, and the establishment of pilot community mental health centres in each of the participating countries, on the other, with a view to putting in place a model of service provision that could be rolled out as part of countrywide reforms. The final phase was to use the centres as the bases for advocacy and training programmes to raise awareness of mental health issues and the need for mental health reform, amongst the public, the mental health professions, and national and local government, and thus prepare the ground for generalization of the reforms and replication of the pilot project.

The project was divided into three components:

Component One took place between September 2002 and March 2004 and focused on the development of national mental health policies and legislation that comply with international and European standards. It resulted in the Joint Statement and Recommendations, which express the common vision for mental health reforms in SEE.

Component Two lasted from March 2004 to March 2006 and focused on establishing a common regional model for community mental health care services, including the establishment of operational pilot community mental health centres (CMHC) in each participating country.

Component Three began in April 2006 and has focused on the development of training curricula and programmes for mental health professionals and public health care practitioners in community mental health and on implementing actual training. It will complete in December 2008.

The final phase of the project involves the transformation of the Regional Office in Sarajevo into a Regional Health Development Centre for Mental Health in SEE, which will continue to work with the relevant national authorities responsible for mental health in each of the participating countries on their common goal of furthering mental health reform and replicating the pilot projects as the basic modality of providing community based mental health care. The Regional Centre will also act as a gateway for communication and cooperation with international experts and institutions and processes at the European and global levels.

Interview with Professor Toma Tomov, Member of the Steering Committee of the SEE Mental Health Project, on the significance of the shift to community based care, by Ms Alema Kazazić

How would you describe the difference between traditional and community psychiatry?

One new aspect of how to help people with mental illness is to get them into the community as full members, which means developing jobs for them and providing them with skills and the capacity to run their homes. Community psychiatry tailors its intervention in line with these needs, which ordinary biological psychiatry is insensitive to. Suddenly, there is a major area in the care and treatment of psychiatric illness that, in this part of the world, has never been covered by programmes, professional roles or training. This has become the core of the community care model we are developing.

How difficult is this shift for psychiatrists trained in the old system?

It is a very major change, with the extension of care into territories like social welfare or professional training, and does not correspond to the traditional understanding that most medical doctors and psychiatrists have of their obligations to patients. Some of them feel quite frustrated by the fact that they find themselves improperly trained to respond to this new policy. Different people react differently to frustration and some express this in a denial that community psychiatry is relevant or scientific or that it makes a difference.

In your view, what are the main characteristics of this new approach which is also being promoted by the Mental Health Project for South-eastern Europe?

The argument that this project is trying to put forward is that quality of life with mental illness must be our major achievement, rather than thinking of medicine and psychiatry as contributing only to the cure of cases. Other professions such as social work, psychiatric nursing, clinical psychology, and psychosocial rehabilitation need to bring their own perspectives of mental illness and of what present-day interventions can contribute to the well being of these people. As a result of these contributions people with severe mental illness will become fully capable of living side by side with us, in our own households and in our own environment. And we need to begin to develop tolerance of the fact that they are different - we must not just see them as ill and unsuited. This is provoking a major shift in our culture, in how we relate to different people. Each one of us from this part of the world is facing this shift, not only vis-à-vis the new opportunities that have opened to all our countries in view of joining the larger Europe, but also in revisiting our relations as a neighbourhood.

What is the meaning of mental health for an individual and for a society?

If you have good mental health, it means that you have not been arrested in your psychological development. Psychological development is about autonomy, about gaining independence from your parents, from the authorities, and from the limitations of your life, while you are growing and developing. So, if we can put the countries of Europe on a scale of psychological development, we could say that the paternalistic approach of providing care for our children in our part of the world has very much damaged our societies from the point of view of equipping these communities with enough adult, independent-thinking individuals. We are very easily overwhelmed whenever we must give our opinion, our point of view, our standpoint on issues of any nature. We think that by fostering an attitude of tolerance to difference and by developing skills to get along with people who are different on a daily-basis, we are actually fostering the individual growth and development of everybody in the community. We believe that that is the agenda for our societies in South-eastern Europe. If we want to catch up with development in Western Europe, we must pay more attention and invest a great deal of good will and effort into developing more independence, more individuality, and liberate ourselves from imposed opinions and superstition.

COMPONENT ONE: THE DEVELOPMENT OF NATIONAL MENTAL HEALTH POLICIES AND LEGISLATION

Objectives:

- Drafting of national mental health policies and action plans.
- Review existing mental health legislation, with recommendations for improvement.

Outputs:

- Mental health policy and legislation assessment questionnaire (country level).
- Overview of mental health policies and legislation (regional report).
- Draft *Mental Health Policy and Action Plan* (country level).
- Joint Statement, accepted as a preamble to national mental health policy documents.
- Joint recommendations to Governments (regional level).

Any reform process must begin with a double process of setting out goals, based on a common vision of what it is hoped the reforms will achieve, and taking stock, with a thorough review and critical assessment of the *status quo* and how it relates to that vision. This is not just because it is important to know what one hopes to achieve and whether one's hopes are realistic, though these aspects are of vital importance to both the success and usefulness of any reform process, but also because only in this way can one ensure that all involved enjoy a common understanding and are committed to the same goals. It is crucial to ensure the active participation of all stakeholders and to elicit not merely their consent but their active commitment to a process they share responsibility for. This common vision must then be institutionalized through the binding instruments of national policies, action plans, strategies, and legislation.

It was the business of Component One to bring into being this common vision and its institutionalization, in a process that involved the following steps:

- Reviewing existing national mental health policies and legislation, based on a questionnaire developed for the purpose;
- Drafting a regional level Joint Statement of principles for the development of mental health policy and legislation by the participating countries;
- Preparing joint recommendations to the governments of the participating countries; and
- Drafting the actual Mental Health Policy and Action Plan documents for each country.

Component One	**Nov 2002**	1st Workshop: Review of mental health policies and legislation in SEE, 4-6 November 2002, Ljubljana, Slovenia
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The first component thus progressed through the development of a questionnaire for mental health policy and legislation assessment to the identification of a number of fundamental principles for mental health reform for recommendation to the ministers of health. This process was significantly facilitated by the guidance and expertise provided by WHO-recommended international consultants in mental health system reforms.

It was a fortunate coincidence that the WHO Mental Health Policy and Service Guidance Package became available at the point it was needed most, as the country teams grappled with their first drafts of national mental health policies.

Work began in September 2002, with the questionnaire, and finished in March 2004, with the production of the Joint Statement. All participating countries have adopted the proposed policy documents and action plans and new legislation has either been passed or is pending.

The modality chosen was a series of six technical workshops attended by country managers and technical experts from each of the SEE countries, the regional project manager, representatives of the host country, members of the Executive Committee of the SEE Mental Health Project, WHO temporary advisers, and WHO Regional Office for Europe representatives. *

The **First Technical Workshop** took place from the 4th to the 6th of November, 2002, in Ljubljana, Slovenia. It was hosted by the Slovenian Public Health Institute.

A working group prepared the methodological framework for review of existing mental health policies and legislation in South-eastern Europe. At the workshop itself, the country directors then presented their national mental health systems, revealing a number of commonalities:

- Lack of financial resources, coupled with poor lobbying and fundraising capacities;
- Lack of government interest, coupled with political instability;
- Oversized and poorly managed mental hospitals;
- Stigma;
- Inadequate legislation;
- Absence of community-based mental health services;
- Lack of appropriately trained staff at all levels;
- Poor information systems regarding the spread and severity of mental health problems or monitoring and evaluating mental health services;
- Low level of NGO or user association participation.

The proposed survey questionnaire was then presented and revised in line with feedback from the participants.

The **Second Technical Workshop** was held in Ohrid, The former Yugoslav Republic of Macedonia, from the 21st to the 23rd of February, 2003. The revised questionnaire was approved and a three month deadline agreed for the completion of the country assessments and developing draft country reports.

The workshop itself discussed standards for and appropriate models of community mental health care. This discussion aided the identification of areas of potential confusion and what the next country level activities should focus on.

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* The Reports from all eleven technical workshops are available at www.seemph.ba

It was at this point that the participants were familiarized with the WHO Mental Health Global Action Plan (MH-GAP), as the ultimate framework for mental health reform. It was presented by Dr Itzhak Levav on behalf of the WHO Department of Mental Health and Substance Dependence.

The **Third Technical Workshop** was held in Veliko Tarnovo, Bulgaria, on the 8th to 10th of June, 2003. It focused on international recommendations and experience in mental health policies and legislation, and particularly the introduction of international and EU standards.

WHO temporary advisers, Dr J. Jenkins and Dr C. Rickard, presented the **WHO Mental Health Policy and Service Guidance Package**, as well as introducing a specially designed template to facilitate group sessions, which was used to walk each country through the steps involved in developing a mental health policy and plan. Each country also had separate group sessions to discuss and provide advice on the issues identified as particularly important to their specific case.

Accessing the resources of the International Community

WHO data shows that 40.5% of countries still have no mental health policy and 30.3% have no programme. The main modality of mental health care for the past two hundred years has been and in many countries continues to be the institutionalization of people perceived as different. The task of reform is to help such people regain their full citizenship and start recovering. Partnerships with the public, non-governmental organizations, and above all the user movement are essential means to this end.

This is naturally a daunting task for government, professionals, or stakeholders in any given country. Fortunately, as in other areas of public health policy, there is already a considerable store of experience with mental health policy development and reform and the relevant international organizations, and particularly the WHO, have built up networks of expert consultants ready to share their experience, advise on likely challenges and on best practices, and provide training. These experts have at their disposal a continuously developing library of materials on how to formulate mental health policy and what it should contain.

Participants at the various SEE Mental Health Project workshops were consistently impressed by the quality of these WHO temporary advisers (i.e. expert consultants) and the usefulness of the materials provided for their practical work. They singled out as particularly useful **The WHO Mental Health Policy and Service Guidance Package** for the assessment and review of existing mental health policy and service provision.

The **WHO Mental Health Policy and Service Guidance Package** consists of a series of interrelated modules. Its central module, **Mental Health Policy, Plans and Programmes,** provides detailed information for policy-makers and public health professionals on how to develop and implement policy through plans and programmes.

- A *policy* outlines a vision, values and principles, identifies areas for action and who will take responsibility for it, and establishes strategic priorities.
- A *plan* provides a detailed scheme for implementing strategic actions.
- A *programme* sets out a logical sequence of interventions for some targeted mental health issues.

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The essential steps in developing a mental health policy are:

1. Assess the population's needs;
2. Gather evidence;
3. Consultation and negotiation;
4. Exchange with other countries;
5. Set out the vision, values, principles, and objectives;
6. Determine areas for action;
7. Identify the major roles and responsibilities of different sectors;
8. Conduct pilot projects.

This is followed by the development of a mental health plan, which comprises strategies representing the lines of action thought most likely to realize the mental health policy for a given population. They are often formulated by conducting a SWOT analysis, i.e., by identifying the **s**trengths, **w**eaknesses, **o**pportunities and **t**hreats associated with current mental health services and programmes. The plan sets priorities for the major strategies and establishes the timeframe and resources:

1. Determining the timeframe of each strategy,
2. Calculating its cost and the total cost of the plan for the year,
3. Adjusting the timeframe to the financial resources,
4. And re-planning both timeframe and resources annually.

Aspects of the policy and plan are then translated into programmes, which define the concrete mental health interventions for a given population for a particular problem or disorder:

1. Identifying the issue or problem to be addressed,
2. Setting out programme objectives,
3. Choosing appropriate programme interventions,
4. Describing the programme activities,
5. Identifying responsible agents,
6. Setting out a timeframe,
7. Drawing up a budget,
8. Evaluating the programme.

Even under the best of circumstances, successful transition from policy to programme is a slow process, requiring the mobilization of political will. It may take five to ten years before results are felt.

Finally, a SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis was produced for each country, developing the preliminary analyses presented at the first workshop:

- **Common strengths** included international support and pilot projects in the field of mental health;
- **Common weaknesses** were poor financing, resistance to change, poor inter/intra-sectoral collaboration, lack of training programmes, inadequate information systems, and strong stigma and discrimination against the mentally ill;
- The most important **common opportunity** was the SEE Mental Health Project, with ongoing WHO Regional Office for Europe commitment, with the potential it offered for improvement of

mental health policy and legislation, harmonization of regulations with international and EU standards, and the development of public education projects, user groups, a mental health information system, intersectoral collaboration, and training for mental health professionals in community-based care;
- The main **threats** were political instability, community resistance, conflict of interest, changing priorities, and lack of sustained financing.

The exercise also revealed differences between the countries. While the commonalities were to serve in establishing priority strategies at the regional level, the differences were seen as opportunities for experience sharing and helping each other.

The **Fourth Technical Workshop** focused on review of mental health policy development in the countries of South-eastern Europe and was held from the 14th to the 17th of September, 2003, in Sinaia, Romania. It marked the shift from theory to practice, as it involved working actively on the formulation of draft mental health policies by each SEE country, based on international recommendations and the preceding assessment of existing mental health policies.

Each country presented a review of current mental health policy and legislation. This was followed by group work on proposed draft national mental health policy documents, focusing on setting out the vision, values, principles and objectives of the policy and determining areas for action, taking into account the fact that every country was at a different stage in the process and consequently required different inputs, support, and action plans.

The WHO Module on mental health policy, plans, and programmes was used as a base for working on the national drafts (see above Box). For some countries this exercise involved review of an existing policy, while for others it involved further development of the draft policy document. Country representatives were asked to set out strategic steps required for the completion of draft policies by the end of November 2003, identifying problem areas and how they might be addressed, and outlining constraints likely to be faced.

All the countries agreed to draft a joint statement on mental health policy development and use it, wholly or partially, as a preamble to their national mental health policies.

The **Fifth Technical Workshop** covered international recommendations and experience in mental health legislation and human rights and took place in Sarajevo, Bosnia and Herzegovina, from the 5th to the 8th of October, 2003. The principal objectives of this Workshop were:

1) To provide training in using the WHO framework for developing, reviewing, adopting, and implementing mental health legislation;
2) To identify the international and regional conventions and standards related to mental health, human rights, and legislation; and
3) To promote discussion and debate between participants on the development, review, adoption, and implementation of mental health legislation in their respective countries.

The Workshop in Sarajevo was sponsored by the *Swedish Psychiatric, Social and Rehabilitation Project for Bosnia and Herzegovina* (SweBiH) and used the Draft WHO Manual on Mental Health Legislation, the WHO checklist on mental health legislation, and a selection of provisions from mental health legislation.

Getting mental health law right (based on a presentation by Dr Margaret Grigg at the 5th technical workshop)

People with mental disorders are exposed to a wide range of human rights violations. In many countries they lack access to basic mental health care. Stigma and misconceptions affect their day-to-day lives, leading to discrimination and the denial of even the most basic rights: shelter, food, the right to vote, marry, and have children, not to mention access to employment, education, and housing.

Mental health legislation has a crucial role to play in:

- Preventing such human rights violations and discrimination;
- Promoting the autonomy and liberty of people with mental disorders;
- Promoting access to mental health care and community integration; and
- Protecting the rights of mentally ill offenders.

Despite its importance, 25% of countries worldwide have no legislation on mental health at all. The WHO is working in a variety of ways to remedy this situation.

- First, by providing technical guidance materials on mental health, human rights, and legislation. The most important is the *WHO Manual on Mental Health Legislation* which provides information on international norms and standards, as well as practical guidance on how to draft and pass effective mental health law and strategies. The Manual is an important advocacy document, as it establishes the minimum standard consistent with human rights conventions and principles.
- Second, by organizing international and national forums and workshops to familiarize mental health representatives with key issues related to mental health, human rights, and legislation. These forums and workshops (1) outline WHO's framework for developing and implementing mental health legislation, (2) offer technical information and training on international standards related to the rights of people with mental disorders, and (3) provide training on the steps required to assess, develop, and implement mental health law.
- Third, by provision of direct technical support to countries undertaking mental health law reform: guidance on issues and provisions that should be considered, discussed, and included in mental health law, as well as reviewing drafts and providing suggestions for improvement.
- Fourth, by developing a faculty of consultant experts available to help countries develop their mental health law.

Human rights and mental health (based on a presentation by Dr Matt Muijen and information provided by Dr Michelle Funk at the 5th technical workshop)

The world over, persons with mental disorder are denied basic human rights. Worse still, legislation often justifies or condones such discrimination. This is because the more specific international human rights instruments relating to mental health and disability are non-binding resolutions, which has given rise to the misconception that legislation is at the discretion of governments. This is not the case. Binding international human rights law guarantees the basic human and civil rights of people with mental disorders, just like those of every one else. The non-binding resolutions are aids to guide governments in meeting this obligation.

The important rights related to mental health protected in international conventions and technical standards include:

- the right to the highest attainable standard of physical and mental health,
- the right to rehabilitation and autonomy,

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- the right to least restrictive services,
- the right to community based services,
- the right to informed consent,
- the right to refuse treatment,
- the right to non-discrimination,
- the right to protection against inhuman and degrading treatment,
- the right to protection from scientific and medical experimentation,
- the right to privacy, and
- the right to protection of good living conditions.

The main United Nations instruments relevant to human rights are:

- The Universal Declaration of Human Rights.
- The International Covenant on Civil and Political Rights (e.g. the right to vote, freedom of expression, and protection from torture and inhuman and degrading treatment).
- The International Covenant on Economic, Social and Cultural Rights (e.g. the rights to housing, education, health, employment, and protection from discrimination).

Non-binding United Nations instruments that specifically address the rights of people with mental disorders include:

- *The United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, which establish standards for treatment and living conditions within psychiatric institutions and create protections against arbitrary detention.
- *The Standard Rules*, which establish citizen participation by people with disabilities as an internationally recognized human right, particularly regarding the drafting of any new legislation on matters that affect them.

The main instruments of the European human rights system are:

1. *The European Convention for Protection of Human Rights and Fundamental Freedoms* and the associated Case Law of the European Court of Human Rights, which has the authority to hear cases brought to it by 'victims' of human rights violations. This has allowed the court to elaborate and expand on what is required of governments in order to ensure the rights of people with mental disorders, notably in the areas of:
   a. Rights related to involuntary admission to mental health institutions,
   b. Rights related to care and treatment within mental health facilities, and
   c. Protection of civil rights.
2. *The Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment* which lays down standards to prevent mistreatment of persons with mental disorders.
3. *The European Social Charter*, which guarantees their right to independence, social integration, and participation in the life of the community.
4. *The Convention for the Protection of Human Rights and the Dignity of the Human Being with Regard to the Application of Biology and Medicine (1997)* which includes rights related to informed consent for people with mental disorders.

The Council of Europe also provides guidance for developing policies and laws concerning the rights of people with mental disorders in its:

1. *Recommendation 1235 on Psychiatry and Human Rights* (1994), and
2. *White paper on the protection of the human rights and dignity of people suffering from mental disorder* (2000).

The **Sixth Technical Workshop** took place in Ljubljana, Slovenia, on the 23rd to the 25th of November, 2003 and considered the draft regional report on mental health policies and legislation, as well as preparation of the Joint Statement and Recommendations on Mental Health Reform.

LESSONS LEARNED FROM COMPONENT ONE

Component One finished on schedule with its major goals attained. The process of policy and legislative review was complete, and a consensus had been developed as to the main principles for mental health policy in the region and how to go about realizing their implementation in ways that respected the different circumstances specific to each country. This progress was encapsulated in the Joint Statement on Mental Health Reform signed by representatives of all participating countries and the 12 Principles of Mental Health Reform recommended by the participants to their governments (see box on page 41).

The model of regional cooperation under the Stability Pact for SEE Initiative for Social Cohesion proved a particularly useful one and has been applied as a template for other projects approved for implementation within the South-east Europe Health Network.

The country teams confirmed the usefulness of the newly drafted WHO materials and tools as instruments and guidance for the development of mental health policies and legislation in their respective countries.*

Group work proved particularly effective as a way of identifying elements of mental health legislation of relevance to the process of reform, such as issues related to non-protesting patients, involuntary admission and treatment, and mentally ill offenders. This facilitated the process of identifying shortcomings in existing legislative documents, including unclear legal definition of terms, which can lead to major confusion in interpreting the law.

While participants agreed that their existing national mental health legislation contained most of the desirable components, there were major problems with implementation. They concluded that effective reform would require good and productive relations with decision makers within the relevant authorities as well as with user associations. This point was of particular importance, as the next stage was to ensure that the proposed mental health policies be actually endorsed by government and converted into legislation and practical reforms.

* The relevant WHO documents are available at www.who.int/mental_health/policy/essentialpackage1/en/index.html

Summary of the Report on Mental Health Care in SEE (based on a presentation by Dr Clare Townsend at the 6th technical workshop):

The countries of the SEE have generally experienced poor and deteriorating economic circumstances, poor and unstable governance, civil conflict, and vulnerability to regional instability and global trends. Unemployment rates in particular compare unfavourably with EU countries.

- Data on poverty were clearly very widespread in all the participating countries: 50 % of Moldavians, 18% of Romanians, and 17% of Albanians live in absolute poverty or less than US$1 per day, while even larger proportions of the population live below the relative poverty line, or less than US$3 per day.
- Mental health literacy, overall awareness of mental health issues, and understanding of the spectrum of mental illness and disability were limited.
- Human rights violations were an area of concern in a number of country reports.
- Stigma continued to contribute to under or non-reporting of mental illness and underutilization of existing services.
- Few of the participating countries had discrete mental health budgets and mental health was not a prioritized area for health spending.
- As a result, people with mental illness were one of the least powerful and most vulnerable groups in the community.
- Acute and chronic depression and PTSD and enduring personality change were major mental health concerns.
- There had also been increases in suicide and suicidality.
- Alcohol and drug abuse were increasingly important social and mental health problems with significant consequences for morbidity and mortality.

The country reports highlighted three major human resource issues:

1. The limited availability of mental health professionals, particularly social workers, psychologists and non-medical staff.
2. Inadequate remuneration and resources to encourage expertise and professionalism in mental health.
3. The lack of speciality training in psychiatry and mental health for all professionals working in the field, including GPs.

Mental health care was centralized and hospital focused. Hospital care and conditions were frequently substandard and inferior to the care provided to consumers with physical health needs. Hospitals had poor links with primary and secondary care or with families and the community.

Each country had broached the problem of mental health reform, but few had progressed beyond the initial stages and implementation faced significant challenges. Major areas identified for reform included:

1. Downsizing existing psychiatric hospitals,
2. Reducing occupancy rates,
3. Decentralizing,
4. Developing integrated mental health care in the community, and
5. Developing and enhancing human resources to support the community mental health focus.

Countries were found to be at various stages in the mental health policy development process. More than half did have a mental health programme or plan. Key issues and areas for action were similar and in line with the WHO's 10 principles.

All countries also had some form of mental health legislation, but further review was necessary in many cases. A framework was therefore presented to assist them and to ensure data consistency for the final report.

Joint Statement

Considering that:

- mental health is still frequently regarded as low priority by governments and the community in general;
- mental health is strongly related to social cohesion and the establishment of a stable and democratic civil society;
- in many areas mental health leadership is limited and resources are inadequate;
- a dominant culture of neglect and exclusion of people with mental illness still widely exists, most clearly expressed in the continued existence of large mental institutions that not only fail to meet the needs of people with mental illness but that also infringe their rights;
- a movement towards mental health reform in the SEE region is developing in response to a growing awareness of the severe and complex mental health issues experienced by post-conflict countries and countries in transition;
- the Mental Health Project for South-eastern Europe is one of seven public health strategies agreed to at a historic political meeting of regional health ministers in Dubrovnik, Croatia, in September 2001;
- over the past two years the project has developed into a crucial regional initiative that promotes and contributes to increased understanding, cooperation and reconciliation at country, regional and international levels;

this joint statement:

- was developed by representatives of the eight countries taking part in the Mental Health Project for South-eastern Europe *Enhancing social cohesion through strengthening community mental health services in South-eastern Europe*: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, the Republic of Moldova, Romania, Serbia and Montenegro, and The former Yugoslav Republic of Macedonia;
- sets out a common vision for reforming mental health policy and services within the SEE region that reflects the regional context in which the reforms are to occur; and
- calls for sustained action in order to secure the following improvements.
  - Mentally ill, disabled or vulnerable persons must be guaranteed the same human and civil rights as all other citizens in society.
  - Mental health care systems in the region have a duty to protect human rights and respond effectively to the impact of catastrophic events and social disruption on both individual and society, and particularly on vulnerable groups such as children, young people, women and the elderly.
  - Mental health is an integral part of individual and community health and well-being, development and restoration. People have a legitimate right to expect good mental health care.
  - Comprehensive mental health systems that are evidence-based, effective, acceptable and sustainable must be developed and implemented. They must span the spectrum of mental health needs from initiatives that promote mental health and prevent mental illness, to those that ensure recovery and prevent relapse.
  - Old-fashioned institutions must be downsized and abolished.
  - Action must be taken to ensure the development of strong leadership and cooperative action by governments, professional associations, nongovernmental organizations and organizations for consumers, carers and civil society.

cont./

- Governments must ensure that mental health systems are adequately supported in terms of both financial and human resources.
- The work of the Stability Pact for SEE in the area of mental health is being carried out within an agreed framework for cooperative action across the region. Comprehensive assessments undertaken as part of the Mental Health Project for South-eastern Europe both highlight the need for change and serve as catalysts for reform. The project provides best-practice examples of mental health reforms – these include policies, legislation, community initiatives, and training.
- Mental health is everybody's business – and the time for mental health reform is now. Investment in mental health is essential for social and economic development. Both existing and new resources are required to support the reform process, particularly the establishment and further development of community-based treatment and care.

The twelve principles for mental health reform recommended to SEE governments.

Principle 1: Mental health must be treated as a priority area in the sphere of health.
Principle 2: Mental health risk factors in transitional environments must be identified and pre-empted with appropriate strategies.
Principle 3: People outside the health system must have access to care in the community for their mental and physical health needs. This could be secured through a variety of health strategies oriented towards both population and individuals.
Principle 4: There is an urgent need to raise general awareness of mental ill-health and to develop initiatives that support mental health reform, that encourage social inclusion, that crate inclusive environments and that combat stigma and discrimination.
Principle 5: Mental health services must be de-institutionalized and community-based services must be established at the same time. Community services must be equitable, accessible and acceptable, and directly linked to other sectors.
Principle 6: Adequate resources must be found to underpin strong national policies and action plans for mental health, and to provide line budgets that will secure the further development of the mental health system and service provision.
Principle 7: Ministers of health to ensure substantial increase of the mental health workforce, and the promotion of expertise and innovative roles and responsibilities for allied mental health professionals.
Principle 8: Strong professionalism is vital in supporting change in the mental health system. This could be achieved by facilitating access to new professional skills, knowledge and attitudes; by addressing the concerns of professionals; by actively involving them in the process of change; and also by actively involving the users and their families.
Principle 9: Other sectors must be invited to join forces on policy and planning initiatives and budgetary allocations to support mental health interventions that cross sectoral borders.
Principle 10: Active support must be given to clearly articulated initiatives in governance building, formulated in consultation with all stakeholders.
Principle 11: The quality of mental health services must be secured by the introduction of clinical and service standards. These must be monitored constantly through the framework of clinical governance to ensure that quality is sustained and improved.
Principle 12: Adequate resources must be committed to developing and maintaining an evidence-based information system for mental health services to provide effective ongoing monitoring and evaluation of the delivery of mental health care, and ensure the further development of the services.

COMPONENT TWO: ESTABLISHMENT OF PILOT COMMUNITY MENTAL HEALTH CENTRES

The drafting of a national mental health policy and the revision of legislation mandating a transition from institutionalized to community-based care, while a major achievement in itself, would naturally risk becoming a dead letter in the absence of a clear and explicit programme of implementation.

Objective:

- Adoption of a common model of community mental health services, including the establishment of a pilot community mental health centre in each participating country.

Outputs:

- Questionnaire for mapping the current mental health services and planning future community mental health services.
- Regional recommendations concerning the essential elements of a community mental heath centre.
- Inauguration of ten community mental health centres.

It would have been both unreasonable and inadvisable to approach implementation through a full-scale immediate transformation of the mental health services in each of the participating countries. It was therefore decided that the implementation of reforms should be phased, allowing both expected and unforeseen difficulties to be tackled in manageable form and providing the profession, users, and the administrative and institutional framework time to become familiar with the model and its advantages, reducing the natural resistance to major change.

The first phase of implementation, following the work on policy and legislation carried out in Component One, involved the establishment of at least one pilot community mental health centre (CMHC) in each participating country, at a suitable location, with a sufficient catchment area, and links to a major psychiatric hospital, as well as local general medical services.

This would allow administrative and institutional modalities to be fully explored, while also acting as a base for the provision of training to mental health professionals and associated professions, including general practitioners. It would also facilitate certain transitional arrangements, such as the secondment of psychiatrists from psychiatric hospitals to the clinics, as the modality was tested, its advantages experienced, and professional commitment built.

Such a transitional pilot project also allowed the development of a system of referrals to be worked out, both to the centre by psychiatric institutions and general practitioners, and by the centre back to psychiatric wards in general hospitals and psychiatric institutions.

Finally, and perhaps most importantly, it would give time to develop links with social services, non-governmental organizations, user associations, local authorities, and the community to ensure that community-based care would not lead to neglect and the social abandonment of persons with mental disorders.

On the community-based model, the centre is only the hub, supporting the goal of successful social reintegration of those with mental health issues. Mechanisms for this social reintegration must therefore be developed and exist. They do not magically appear. Moreover, it requires time and effort to develop community willingness to work with the centres towards the goal of social reintegration, while a successful pilot project is naturally the most convincing argument for replication of reforms countrywide.

The national project managers therefore shared an understanding that the overall success of the project would depend on the performance of these pilot CMHCs. The CMHCs were to serve as the manoeuvring ground for imple-

menting new mental health policies, applying new professional skills, demonstrating gains from user participation, and building an attitude of acceptance of the mentally ill in the community. Component Two was, therefore, largely dedicated to the process of actually establishing the centres in the participating countries. The first activities, which lasted through 2004, centred on four further workshops, the purpose of which was to develop a model of community mental health centre suitable for conditions in the region and strategies for establishing one in each of the participating countries and for monitoring their progress. Given the political nature of Bosnia and Herzegovina and Serbia and Montenegro, it was decided to establish two pilot centres in each of the two countries.

The workshops were followed by the process of actually establishing the centres, which lasted through most of 2005 and early 2006. Successful and timely establishment was also a reliable test of the commitment of the SEE governments to reform. As the centres came online and began offering services, the earlier verbal support of the governments became a reality.

Component Two	**Feb 2004**	7th Workshop: Organization of mental health services in South-eastern Europe, 19-21 February 2004, Zagreb, Croatia
	Jul 2004	8th Workshop: Adopting the model of community mental health services in SEE, 13-15 July 2004, Tirana, Albania
	Oct 2004	9th Workshop: Community mental health service management – International experience and recommendations, 28-30 October 2004, Belgrade, Serbia and Montenegro
	Mar 2005	CMHC in Strumica, The former Yugoslav Republic of Macedonia, inaugurated
	Apr 2005	CMHC in Blagoevgrad, Bulgaria, inaugurated
	Apr 2005	10th Workshop: Monitoring activities and outcomes in the pilot CMHCs, 12-16 April 2005, Chisinau, Republic of Moldova
	Apr 2005	CMHC in Chisinau, Republic of Moldova, inaugurated
	Apr 2005	CMHC in Vlora, Albania, inaugurated
	May 2005	CMHC in Kotor, Montenegro, inaugurated
	Jun 2005	CMHC in Prnjavor, Bosnia and Herzegovina (Republika Srpska), inaugurated
	Oct 2005	CMHC in Nis, Serbia, inaugurated
	Nov 2005	CMHC in Mostar, Bosnia and Herzegovina (Federation of BiH), inaugurated
	Jan 2006	CMHC in Zagreb, Croatia, inaugurated
	Mar 2006	CMHC in Bucharest, Romania, inaugurated

"As the development needs of our society were identified during the transitional period of the 1990s, the Ministry of Health came to recognize the extreme urgency of reforming mental health care. Reforms were started in large part thanks to support provided by the WHO Regional Office for Europe in 2000 and received crucial reinforcement in 2002 from the extremely timely involvement of the Stability Pact's SEE Mental Health Project. Major progress has been made on the path towards establishment and implementation of the community mental health approach, in place of the old custodial institutional model. All four of the main health system functions have been successfully addressed - stewardship, service provision, financing, and resource generation. A national mental health strategy and legislation have been endorsed, while a range of community mental health services has been put in place. Given the stage that has been reached, the SEE Mental Health Project clearly has a major contribution to make to the continuity and sustainability of the reform processes."

Dr Stojan Bajraktarov
Psychiatrist at the Skopje CMHC and former WHO National Professional Officer
in The former Yugoslav Republic of Macedonia

As Component Two was dedicated to the organization of community mental health services, a natural place to begin was with the *WHO Module on Organization of Mental Health Services*. While, the module introduces the ingredients of successful service delivery models, it does not prescribe a single model for organizing services, which depends on the context of implementation. It describes and analyses the current status of service organization around the world, providing guidance and identifying key issues, including barriers and solutions.

To facilitate the process and ensure consistency of country data, a questionnaire was designed to map current services and plan future community mental health services in the area in which the pilot CMHC would be located. The data thus collected was sufficient for the initial development of country level implementation plans. The resulting picture allowed the general conclusion to be drawn that improvements were needed in all segments of service provision – promotional, preventative, diagnostic, therapeutic, and rehabilitative. All countries agreed that existing promotional and preventative activities were inadequate, insufficient, sporadic, and poorly organized, while diagnostic procedures were also unsatisfactory and seriously hampered by a lack of trained staff. Rehabilitative services were provided largely as part of hospital treatment, so that the development of effective and adequately funded rehabilitation programmes and providing high quality training for mental health professionals stood high on the list of priorities.

Specific findings of importance to the establishment of the centre may be summed up under the following headings:

1. **Funding:** Existing mental health services were primarily government financed (through the health insurance funds).

2. **Premises:** Five countries said that premises for the CMHC had been identified, while the remainder indicated that the process was ongoing.

3. **Information Systems:** Information systems were generally inadequate. The major deficiencies related to the evident lack of linkages and coordination. The processes for generating clinical and management information within the existing mental health system were cumbersome, inefficient, and time-consuming. The situation was somewhat better in Serbia, where software had already been developed.

4. **Pharmaceuticals:** Lists of essential psychotropic drugs (available free of charge) were revised, where necessary. All countries agreed to work towards making new generation antipsychotics and antidepressants affordable to all who need them.

5. **Intersectoral Linkages:** Linkages between the mental health services and community organizations, such as welfare organizations, religious organizations, schools, housing agencies, correctional institutions, vocational services, etc., were found to be extremely weak. Under existing circumstances, the little cooperation that occurred between the sectors was often prompted by individuals, rather than their respective institutions, and was focused on individual cases on an *ad hoc* basis. In other words, whether a person received the necessary support depended on individuals, whose decision reflected their personal choice rather than an official duty.

6. **Results:** The collection and maintenance of data on the clinical and social results of treatment were unsatisfactory. Detailed indicators and methods of measurement needed to be elaborated before the implementation of community services. Outcome data was to contain not only rough clinical outcomes, but also standardized data on the level of functioning in different social and vocational settings for each individual.

7. **Assistance Required:** Types of assistance required during implementation would include:
    - Technical assistance in information systems development,
    - Development of managerial and clinical guidelines,
    - Multidisciplinary team building,
    - Establishing therapeutic and supervised residential services in the pilot area,
    - Support to local psychiatric wards in general hospitals to reach higher standards of care, including implementation of hospital diversion programs and mobile crisis teams,
    - Involvement of more trained personnel in social welfare system,
    - Supported employment programs,
    - Continuing training in community mental health care.

The **7th Technical Workshop** was held in Zagreb, Croatia, from the 19th to the 21st of February, 2004, and focused on potential pitfalls in this process and the need for a comprehensive framework for implementation, addressing both managerial and technical aspects of the process at both regional and country levels.

The **8th Technical Workshop** focused on the model of community mental health services to be adopted in South-eastern Europe and was held in Tirana, Albania, on the 13th to the 15th of July, 2004. Its aim was to identify, explore, and adopt the most suitable structural and managerial frameworks for the pilot community mental health centres, given the regional and country contexts and the wider aim of mental health reform. The preliminary country operational plans, developed during Component One, formed the basis for discussions with consultants and the future role of regional and international consultants was also addressed.

This meeting reached agreement on the essential elements of the pilot CMHCs, specifying their main goal as demonstrating that community-based mental health services are a feasible, affordable, and effective alternative to mental hospitals, reducing admissions to mental hospitals and allowing the discharge of current patients to supported arrangements in the community. They also agreed that their core target population would be people with serious mental illness.

Regional recommendations for CMHCs drawn up at the 8th Technical Workshop

1. CMHCs will prioritize people with serious mental illness and should offer an alternative to hospitalization.
2. Staff will be multidisciplinary, including at least psychiatrists, mental health nurses, social workers, and psychologists. The team will comprise a minimum of eight full-time staff and will ideally include occupational therapists and rehabilitation and employment specialists.
3. Each member of staff should have a position description specifying their role, responsibilities, and lines of accountability. In addition, the tasks common to all team members should also be described.
4. The CMHC team should be able to offer continuing treatment and care that is appropriate to patients' needs.
5. Services provided by CMHCs shall be available at least during working hours, with cover available during nights and weekends.
6. Each CMHC will serve a defined catchment area with a population between 50,000 and 120,000 inhabitants.
7. Each CMHC should be located in the community it serves and not in a hospital building.
8. CMHCs must be provided with guaranteed funding that ensures a sustainable service beyond the duration of the pilot project.
9. CMHCs should be officially recognised mental health units of the mental health service. The responsibilities and linkages of CMHCs with primary care, hospital and other secondary and tertiary sector services, and agencies responsible for welfare, promotion and prevention should be clearly specified.
10. The role of CMHCs needs to be supported by enabling mental health policy and legislation.

The **9th Technical Workshop** was held in Belgrade, Serbia, from the 28th to the 30th of October, 2004, and focused on learning from the experiences of other countries in mental health reform. Presentations were made by individuals who had made major contributions to the reform processes in Spain, Italy, and Sweden, while Professor Harry Minas examined the Australian experience from the point of view of mental health as freedom. Italian expert Dr Mario Reali also presented on continuity of care and Spanish expert Dr Carlos Artundo explained intersectoral co-operation, as key concepts on which the effectiveness of community based mental health care provision depends.

The **10th Technical Workshop**, held in Chisinau, Republic of Moldova, from the 12th to the 16th of April, 2005, was the last to be held under Component Two. It worked on the issue of monitoring the activities and results of the pilot community mental health centres, as it would be of crucial importance to be able to determine their effectiveness, as well as to assess the degree and importance of difficulties encountered and resistance faced. If performed effectively, such evaluation exercises reveal both the strengths and weaknesses of new services and facilitate adjustment, innovation, and generalization of the model.

The workshop also provided an opportunity for introducing the Information Systems Project, which had been proposed by Bulgaria and approved for implementation within the SEE Health Network. Its implementation has been closely linked with the SEE Mental Health Project and directed by the same Steering Committee. The project has had a number of objectives, starting with the development and implementation of standardized information systems for patient management at the pilot CMHCs, but with a view to rolling it out later across the national mental health systems of the participating countries, leading ultimately to the creation of fully integrated national and regional information systems. The objectives are

1. to ensure the adequate, appropriate, and consistent collection and management of patient and treatment data;
2. to facilitate the operations of the institutions responsible for persons with mental disorders and mental health issues, as well as coordination and cooperation between them;
3. to promote a culture of active identification and engagement with individuals and groups at risk of social exclusion, particularly those suffering from mental disorders or illnesses;
4. to facilitate coordination and cooperation between the countries of the region in harmonizing and implementing mental health policy and targets.

REVIEW OF KEY CONCEPTS OF COMMUNITY MENTAL HEALTH CARE

Presentation on Continuity of Care

Experience has shown that the best therapeutic attitude is to follow the patient. The present situation is such that the patient suffers considerable discontinuity of care. Real continuity of care cannot exist without organizational structure – it has to be practically facilitated. The community mental health centre provides the basis for changing established psychiatric practice. If fragmentation of services is to be prevented, the CMHC and other mental health services must be connected.

Where are most patients? At home. Appropriate treatment means getting to know the patient at home. Without knowing his or her habitat, it is very difficult to make the correct diagnosis. Mobile teams are, therefore, essential. Our first objective should be to deliver care to the patient at home whenever possible and suitable. Continuity of care also means having a programme, which can only be implemented where strong linkages exist with other medical services used by our patients.

Continuity of care as an organizational system		
CMHC and other psychiatric services	CMHC and other health and social institutions	CMHC and other public and private institutions relevant to health
Home Psychiatric hospital admission ward Day hospital Psychiatric services at general hospital (psychiatric beds and consultation) Prison Forensic hospital	General hospital ward Health centre – GP, nurses and home care assistance staff Homes for the elderly Residences for vulnerable groups (abused women, children, adolescents)	Social services Housing agencies Employment agencies Education and culture Religious organizations Family and user associations Self-help Voluntary associations
The therapist attends the patient everywhere		

Continuity of care and professional responsibility		
No exclusion of any person in need residing in the CMHC's catchment area.	Priority of needs vs. service provision based on selection by illness (the problem of waiting lists).	*You are my patient.* (The different intensity of therapeutic relationship in private and public services.)
Three ethical and professional principles		

Continuity of care and the centrality of the person
Home care as the first option not only for nurses and social workers, but also for psychiatrists. Family, home, habitat, and neighbourhood are fundamental for the correct diagnosis and treatment. Rights and power of patients in different institutional contexts: home, outpatient service, day care, regular employment, or participation in artistic groups vs. occupational therapy. Rights of patients in closed institutions: privacy, religion, communication, association, dressing, personal space, make-up. Individual therapeutic project and the use of available techniques and methodologies.
The project of treatment is mine and cannot be delegated

Presentation on Intersectoral Collaboration

Intersectoral collaboration is based on the understanding that health is determined by multiple, interrelated factors and that creating and maintaining health requires action from all sectors whose work corresponds to the various determinants of health. Intersectoral action makes possible the joining of forces, knowledge, and means to understand and solve complex issues whose solution lie outside the capacity and responsibility of a single sector.
Intersectoral collaboration takes place with:

- Other government sectors such as economy, labour, education, environment, etc.,
- Various government levels: federal, regional, municipal, etc.,
- Non-governmental representatives (voluntary, non-for-profit, private and other organizations.

Collaboration within the health sector (intrasectoral) and between sectors (intersectoral) is essential if the complex needs of persons with mental disorders or problems are to be met. Most successful collaboration is a dynamic and flexible process, perceived as a win-win situation, and includes vertical as well as horizontal linkages and collaboration.

In order to contribute to the strengthening of intersectoral collaboration, the mental health sector should (i) involve other sectors in the policy formulation process, (ii) delegate responsibilities to other agencies, (iii) set up information networks with other agencies, and (iv) establish intersectoral national advisory committees.

Examples of levels of collaboration:

Basic level:	Data sharing
Higher level:	Consultation and planning
Advanced level:	Working together in planning and delivery of services
Highest level:	Joint funding arrangements and managerial responsibility

LESSONS LEARNED FROM COMPONENT TWO

Component Two was completed with the successful inauguration of community mental health centres in all the participating countries, on the basis of work done, with the assistance of international consultants, in the four preparatory technical workshops. The bulk of the work in Component Two was therefore carried out by the country teams themselves and this reflected the transfer of responsibility and effective project-ownership. It was clear to all involved that success or failure in moving towards effective reform would depend upon not merely the performance of the individual pilot project centres, but also the ability of project members to solicit and engage the practical commitment of their respective governments and relevant institutional and professional bases.

The participants clearly recognized the crucial importance for this purpose of establishing procedures for project documentation, the introduction of research elements, and the development of a system for monitoring and evaluation. Particular attention was paid to developing linkages with a number of regional and international experts and organizations capable of providing support and guidance.

Although considerable consensus had been developed during the first component as to the general principles of the transition from institutional to community-based care and the role of the community mental health centres, detailed discussion revealed that the representatives of the participating countries initially had rather different ideas as to what a CMHC should do and it took considerable group work to elaborate a common understanding of the purpose and scope of the pilot CMHCs. This provided a valuable lesson in the importance of rendering explicit what are assumed to be common understandings - all too often they disguise real differences in viewpoint that can be overcome if discussed openly at the beginning of the process, but come to appear fundamental once implementation is already underway and the differences are instrumentalized in practice.

A further important point learned during this process was that a concerted and explicit effort must be made to think outside the terms of the existing psychiatric structures, in particular with regard to identifying individuals or groups who are either ignored or fall through the net of the existing mental health services. It is all too easy to create new structures that continue to fail to reach them. This was reinforced by the fact that psychiatric morbidity rates were increasing across the region, without a corresponding increase in service utilization. Meeting the challenges of reform required approaching this paradox with imagination, so as to determine whether the root cause for underutilization is that services are inaccessible, unacceptable, or unaffordable, or something altogether different.

As the complexity of the task became clearer to the country teams, they became increasingly interested in ensuring face-to-face discussion on matters of practical implementation. The need for regular exchange of experience between the community medical health centres in the various countries and between the national mental health centres, during the process of implementation and reform, was also stressed. Participants were also anxious that the contribution of technical experts not be restricted to the regional level and requested that visits be arranged to each country to discuss and advise on implementation. As a result, it was agreed that international consultants and regional experts would provide sustained support to the country teams and visit the individual countries as required during the remainder of Component Two.

Dr Valery Tsekov, Deputy Minister of Health on the importance of the SEE Mental Health Project and the Information Systems Project (2005):

"Issues related to mental health are particularly pressing not only in our country but in the whole civilized world. They are increasingly becoming a grave medical, social, and economic problem to society. Reform in the field of mental health is therefore one of the key priorities in the executive programme of the Bulgarian Ministry of Health.

Our policy aims at the protection and improvement of the nation's mental health by introducing modern standards of prevention and treatment of mental disorders and providing equal and adequate access to mental health services for all people with mental health problems. Our task is to accomplish the transition from institutional mental health care to community-based mental health services, to overcome the existing social exclusion of the mentally ill and to promote their social integration.

The Bulgarian Mental Health Policy and the 2004 - 2012 National Action Plan are in line with all of the European mental health policy principles. These principles are also promoted in the 2007 – 2012 National Health Strategy, which will soon be ratified by the Bulgarian government. The outcome of these two projects - the Mental Health Project, and the Information Systems Project – will be of great importance for the successful implementation of the Strategy. I am convinced that your efforts will contribute to the improvement of health care in Bulgaria and to Bulgarian accession to the European Union."

The importance of intersectoral links was brought home to the team members, both as a result of discussions with experts with experience in conducting such reforms in other countries and as a clearer vision of the role of the community mental health centres developed. The needs of people with severe mental illness require an integrated approach from different perspectives – social, medical, educational, financial, and juridical.

The role of formal co-ordination between the mental health care services and the most relevant state agencies was also clearly recognized, and all countries agreed to make contacts with professional teams in the social welfare sector and develop joint action plans specifying roles and lines of accountability.

It was also recognized, in this regard, that the work that had already been done in the areas of policy development, preparation for mental health legislation, and the establishment of pilot community mental health centres required expansion to include a major programme of workforce education, a process of reduction in size of mental hospitals, and community education and engagement.

Finally, there was consensus that, although further planning and implementation would have to be sufficiently flexible to accommodate the differences between the countries, clear adherence to common standards consistent with European norms was a requirement. This could only be promoted and achieved by the maintenance of a continuing regional dialogue, exchange of information and experience, cooperation in problem-solving, and a common commitment to best practices.

COMPONENT THREE: TRAINING OF MENTAL HEALTH PROFESSIONALS AND PRIMARY HEALTH CARE PRACTITIONERS IN COMMUNITY MENTAL HEALTH

Objective:

- Training of the pilot CMHC staff in a select number of modules in community mental health care and of primary health care workers in the CMHC catchment area in community mental health.

Outputs:

- Training needs assessment.
- Identification of and agreement on training priorities.
- Leadership and Management training of trainers (regional level).
- Case Management training of trainers (regional level).
- Case Management (country level).
- Training of primary health care practitioners (country level).
- Compilation of training resources produced for and by the SEE Mental Health Project.

With the development of mental health policy and legislation largely completed during Component One and the initial establishment of the community mental health centres completed during Component Two, the main goal in Component Three was entrenching and developing the pilot reforms, with a view to preparing for a countrywide process, in line with national action plans and strategies.

This required a focus on training. There was a clear need for a training needs assessment and training priorities to be agreed. The first logical step after that was to start training staff actually employed in the pilot mental health centres in the innovative techniques required by the transition to community-based care, with a particular stress on case management and team work that combines psychiatric and psychological expertise with the capacity to reach into the community and work on the social reintegration of the patients. A second form of training clearly required was of primary health care practitioners, who needed to be educated in the new task of the early detection of mental health problems and filtering potential patients towards the community and mental health centres at an early stage, rather than towards the psychiatric institutions when problems were already well advanced. A properly functioning link between primary health care and the community mental health centres was recognized as essential to the effective delivery of quality mental health services in the long run. A final crucial area of training was in leadership, management, and advocacy, as the role of the pilot projects was to initiate a wider process of reform and replication of the new service model, in which the Centre staff were expected to take a lead role.

As this summary suggests, the activities involved in Component Three took place largely at the country level. The key regional activity was the 11th technical Workshop on training priorities, held from the 4th to the 6th of May, 2006, in Sofia, Bulgaria, as a joint event of the Information Systems Project and the SEE Mental Health Project. The workshop included a presentation of the principles for and the preliminary results of training needs assessment in the participating countries, as well as an exploration of the knowledge and skill-base required for work in community mental health, with a view to curriculum development.

A number of guidelines were drawn up with regard to training:

- Given their very different circumstances, each of the participating countries should develop a training plan making clear requirements for the coming two years:
  - priority training areas,
  - target workers (e.g. nurses, social workers),
  - expected results,
  - when and how the training should be delivered,

  with external technical assistance in developing this training plan to be provided where appropriate.

- As far as possible, training should take into consideration local needs and existing resources, using existing expertise within the country and links with existing continuing education programs. The importance of empowering local trainers was recognized and it was agreed that each country should identify local trainers with expertise in case management, to attend two regional 'training the trainers' (ToT) workshops.
- The training module should be a combination of case management skills and team development skills.
- There should be two national trainers per country, trained at the training the trainers workshops, who would then work with the CMHC teams in the participating countries.
- Training should be approved by the ministries of health and certified by appropriate institutions/universities.
- Training should be supervised and subject to follow up, to ensure quality and assess its impact (particularly in terms of case management). To this end, a pre- and post- training questionnaire was developed and a training evaluation report prepared.

As this component had not reached completion at the time this report was written, in lieu of lessons learned we append descriptions of the main training programmes.

Component Three	**Apr 2006**	11th Technical Workshop: Training Priorities	
	Nov 2006	Training: Leadership and Management – Community Team Leadership, Belgrade, Serbia, 27-29 November 2006	
	Mar 2007	Training: Leadership and Management – Strategic Development, Budva, Montenegro, 5-7 March 2007	
	May 2007	Training: Leadership and Management – Strengthening Leadership Capacity, Skopje, The former Yugoslav Republic of Macedonia, 27-29 May 2007	
	Oct 2007	Case Management Training the Trainers Workshop, Sarajevo, Bosnia and Herzegovina, 14-16 October 2007	
	Ongoing	In-country Training in Case Management	
		Albania	May 2008
		Bosnia and Herzegovina	November 2007, February 2008
		Bulgaria	November 2007,
		Croatia	May 2008, October 2008
		Montenegro	October 2007, December 2007
		Republic of Moldova	December 2007, May 2008
		Romania	November 2007
		Serbia	December 2007
		The former Yugoslav Republic of Macedonia	April 2008, September 2008
		PHC practitioners' training in community mental health care	
		Albania	May 2007
		Bosnia and Herzegovina	May 2007
		Bulgaria	June 2007
		Montenegro	June 2007
		Republic of Moldova	April 2007
		Serbia	May 2007

REVIEW OF MAIN TRAINING PROGRAMMES

The programmes were preceded by a training needs assessment coordinated by Dr Margaret Grigg, the purpose of which was to identify the workforce, determine their current training, and develop strategies to improve the knowledge and skills of workers before they are employed in community mental health services. Education priorities for the existing workforce should be informed by their roles, implemented through a wide range of training strategies, and underpinned by a commitment to lifelong learning. Analysing the data from the countries in SEE, Dr Grigg found that:

- The different country projects had diverse workforces with a wide variety of training needs. While training would be essential to the development of the projects, to be effective it would need to be individually tailored to the specific needs of each project.

- Some projects appeared to have unrealistic expectations of training. Moreover, they would be facing many implementation challenges and system problems that could be mistaken for knowledge and skill deficits. Training alone would not necessarily result in improved practice.
- There was also variation in the activities of the projects, which had focused on different priority groups and implemented different models of community care, reflecting the historical organization of their respective national mental health services, community demand, and the existing skills and interests of the workforce.

While there was agreement on broad training areas, such as case management and multidisciplinary teamwork, the specific training needs of each project within these core areas appeared to vary and there was a need to identify the knowledge and skills of community mental health workers to guide curriculum development. After careful consideration of the country training needs assessments' results and consultation with WHO consultants and country teams, the Regional Project Office therefore proposed a focus on training in leadership and management, case management, and community mental health care for primary health care practitioners.

Leadership and Management

The focus on leadership and management training was a logical choice, due to the pilot nature of the CMHCs. If the intention was a three phase process of establishment, developing functioning mechanisms and modalities, and rolling out of the model through the health care system, then those involved would require significant management and leadership skills. This module was therefore designed as a training of trainers consisting of three topics:

1. **Community Team Leadership,**
2. **Strategic Development,** and
3. **Strengthening Leadership Capacity.**

The training module on leadership and management is designed for current and potential team leaders and managers working in community mental health teams, inpatient care, crisis resolution, assertive outreach, and staffed accommodation. Its aim is to help leaders develop effective management and leadership skills to sustain and develop their teams.

The training was conducted by Ms Shubhada Watson and Professor Peter Ryan, while the participants were community mental health workers: country managers, mental heath professionals from CMHCs, and primary health care practitioners, from all the participating countries:

"The First Training Workshop on Community Team Leadership focused on:

- Leading and managing change,
- Reflecting on various concepts of leadership,
- Applying leadership and change management skills to develop increasingly effective approaches to community liaison and care coordination,
- Leadership skills and management strategies in practice,
- Strategic management and transition management,
- Identification of stakeholders,
- Evidence–based working,
- The concept of coaching,
- Effective teamwork, and
- The concept of conflict management.

The Second Training Workshop on Strategic Development focused on:

- Change management – review and feedback on individual assignments,

- Reflections on the psycho-dynamics of neutralizing or capitalizing on negative experiences,
- Stakeholder analysis, and
- Personal development planning.

The Third Training Workshop on Strengthening Leadership Capacity focused on:

- The distinction between management and leadership,
- Leadership models (evidence-based, situational, contingency, and transformational model),
- Examining organizational issues,
- Organizational culture, and
- Building innovation in mental health services.

Participants developed their capacity for:

1. Critical and reflective awareness of the core characteristics, roles and tasks of multi-disciplinary teams, and the value of diversity within teams.
2. Critical and reflective awareness of contemporary theoretical concepts of management and leadership and their relationship to change and resistance to it.
3. Applying this knowledge critically in the implementation of strategies to develop effective approaches to community liaison and care co-ordination.
4. Development of evidence-based strategies for day-to-day working and for leading change within their team.
5. Developing leadership skills which enable the creation of a positive and cohesive team culture.
6. Developing an approach to team practice which encourages optimal service user involvement in the process of care.

The training took place over six whole day workshops, held in three sequences of two days."*

Case Management

This was followed by the training programme on case management, which was adopted as the main frame of reference for the pilot community mental health initiatives undertaken in this project. In essence, case management is an approach to care which:

- Engages high risk severely mentally ill patients with complex needs who are resistant to contacting services,
- Proactively reaches out to people in the community,
- Assesses needs comprehensively,
- Develops individually tailored care packages, and
- Effectively co-ordinates care across agencies, while
- Optimizing the recovery potential of service users.

The effectiveness of case management as a means of reaching and engaging with severely mentally ill clients is well supported by research. It is a key tool in facilitating community-based care and reducing the need for and impact of hospitalization, whether by reducing frequency of admission or length of stay.

An international working group meeting was held from the 8th to the 9th of May, 2007, in Zagreb, Croatia, to discuss the development of the Case Management Module, including:

- Implications regarding the SEE context and its variations,
- Adaptation of the case management model to the context,

* Extract from training programme and report

- Development of a manual to be part of a capacity building strategy which is realistic, and
- Assumptions in reference to the case management manual, including comprehensive assessment, monitoring and review, the strengths and achievements of service users, and links to the community networks.

Training the Trainers in Case Management

This was followed by two two-day regional 'training the trainers' events, attended by an average of two trainers from each country, who would take the lead role in training at country level. The whole process was led by Professor Peter Ryan. The training schedule followed that outlined in the draft manual on case management prepared for the purposes of the project.

- **Day One: Overview**

Introducing the program and providing an overview of key issues, such as identifying the target group, values in case management, core tasks of CMHCs, etc.

- **Day Two: Engagement and Assessment**

Exploring engagement strategies, strengths assessment, and positive risk taking.

- **Day Three: Comprehensive Assessment**

Exploring the use of more specific assessments to gain in-depth understanding of client needs (mental state, signs and symptoms, health and social needs, risk of self harm, harm to others, and suicidal behaviour, family and system assessment, and substance abuse).

- **Day Four: Care Coordination and Use of Community Resources**

Learning about the core principles of care coordination in a CMHC context and how to link with existing community resources, as well as how to tackle relapse prevention, medication adherence, family support, effective problem solving, and developing community supports and networks.

The regional 'training the trainers' event was followed by training of the CMHC staff in each of the participating countries. An outline report of the training given in Montenegro by Paul O'Halloran and Ray Baird during the autumn of 2007 is given below:

Training commenced with an orientation day: meeting the team, exploring expectations and specific concerns and needs of each of the community teams and the hospital staff invited to participate in the training event. It gave the trainers an opportunity to introduce themselves and learn about some of the cultural issues regarding community based mental health services in Montenegro.

The training manual was discussed at length, allowing the teams to select what they thought the most appropriate material for use during the four days of training. This ensured that the training was geared to their needs and resulted in high levels of participation and responsiveness. The resulting programme was as follows:

- **Day 1:** Delivering Case Management
    - Introduction

- Outline of programme
- Clarifying Expectations

Teams including a mixture of stakeholders discussed the following questions:

- What are the main aims of the CMHC?
  - I.e. what is the vision & was it set up to do?
- What are its main activities?
  - I.e. What services/interventions does it provide?
- What are its main client groups?
  - I.e. what are the main diagnoses of clients?
- Where are the GAPS in service provision?
  - Are there key client groups missing out on interventions?

This was followed by a number of exercises:

- Feedback from Small groups (What are the key issues emerging? What are the priorities for action?).
- Building the CMHC Vision and Purpose.
- What is needed for working with Severely Mentally Ill clients in the community?

- **Day 2**

The second day began with the presentation of reflections on Day 1 and was followed by a presentation and discussion of definitions and principles of case management as a system to facilitate recovery for persons with severe mental illness.

The participants then took part in a number of exercises and activities:

- Discussion & clarification of main points of presentation (in small groups)
  - How do we apply these to local CMHC Work?
  - What are you applying already?
  - What will need to change in the CMHC to make case management work?

- Feedback from Small groups
  - What are the key issues & emerging priorities?

- Implementing Case Management in the CMHC
  - What needs to be done locally?
  - What do you have control over that you can change?
  - What are 3 priority actions the team can undertake in the next 3 months?
  - What is needed from International Colleagues to help?

Homework was set for the teams to work on before the final days of training were delivered on the following topics:

1. CMHCs: the need to clarify team purpose and understand the client group;
2. CMHCs: converting principles into actions, practicing case management through multi-disciplinary team meetings;
3. CMHCs: development of relationships with available community resources;
4. Hospital: starting to use case management with inpatient client group;
5. Hospital: developing relationship with CMHC and other identified stakeholders.

- **Day 3**

The third day involved a process of reengagement with the teams and feedback on the homework exercises. There was also a presentation of the principles of engagement and a number of related team exercises.

- **Day 4**

The final day focused on the topics of valuing diversity and managing change, with additional clarification of issues from day three. This included exercises on how to engage community resources, how to plan with regard to the principles of care and the identification of the next steps for teams.

The Croatian Take on Case Management

The focus on case management was particularly stressed by the Croatian national team, who had previously found in it an attractive and useful way to approach mental health care reform and the transition to a community-based model. Their thoughts and experiences prior to the training were expressed by Dr Slađana Štrkalj Ivezić as follows:

'In Croatia, we first need to explore and decide upon the best way of reforming the specialist mental hospitals and clearly define it in the national mental health policy. When recommending hospitalization, one needs to answer the question why this patient cannot be treated in the community. Psychiatric services in Croatia have no experience in providing this sort of treatment in the community. There is also a lack of professional and political will to get down to changing the system. There is no doubt, however, that coordinated care is important for people suffering from psychotic disorders and that it reduces the need for hospitalization, especially in younger patients, who can return to school or work faster.

The treatment of people with mental health disorders usually requires a variety of skills, knowledge, and capabilities and the best results are attained through multidisciplinary team work. The case management model includes a treatment coordinator and treatment coordination based on the assessment of individual needs. An effective and feasible case management model for countries where community psychiatry is in its nascence, like Croatia, requires significant modifications of existing models or the integration of different models to fit the situation on the ground, based on a thorough knowledge of its available services, human resources, the level of training and expertise, and facilities. It is, therefore, critical to analyse the situation in each area, examine the existing services and facilities, and discuss possibilities of establishing collaboration between what is already there and the new services to be introduced, making sure that change is gradual and closely monitored. There must be a clear distinction between what can be done immediately and what cannot, what we can achieve on our own and what we need help with, and how to get the required help.

We established a Community Rehabilitation Centre at the Vrapče psychiatric hospital to help one group of patients who required frequent hospital treatment and could not recover sufficiently to live and work independently. The team comprises one psychiatrist, one psychologist, one social worker, one nurse, one social pedagogue and one occupational therapist. They work on a half-time basis on hospital premises, as this was the only possibility available at the time the programme's initiation.

Patients are referred by the treating psychiatrist, who informs the patient about the purpose of the treatment under the community rehabilitation programme. The patient receives an appointment for initial interview and is advised to bring documentation of his prior treatment. Family members may be present. At the end of the assessment, a treatment plan is discussed together with the patient and a case manager is nominated. The treatment plan implies a variety of psychosocial procedures carried out in the Centre, including psycho education (psychiatrist), social skills training (social worker, social pedagogue, occupational therapist), employment training (occupational therapist), stress and anxiety control (psychiatrist, occupational therapist), health self-care including

Who does case management benefit most?

Case management is commonly said to work best with 'psychotic' clients and research studies have focused on 'severely mentally ill adults with a primary diagnosis of schizophrenia,' even though a wide variety of other client groups have also been targeted (e.g. with learning disability and mental illnesses, dual diagnosis clients, and the homeless). It is not easy to describe a 'typical' client. The following two case profiles, provided by Dr Vladimir Ortakov, Country Project Manager in The former Yugoslav Republic of Macedonia, give detailed accounts of the type of complex circumstances that CMHCs in South-eastern Europe are working with.

Branko
Branko (30) has used the mental health services for about twelve years now. He has been attending the CMHC in Skopje for three years. The onset of his disorder dates back to his college days, when he dropped out due to loss of volition and concentration. He is unemployed and lives alone, but close to his parents' house. He was diagnosed with a mild form of schizophrenia, with predominant symptoms of loss of initiative, avolition, and emotional flattening.

Former treatment in psychiatric institutions
Branko has been treated in a number of different psychiatric institutions, mainly as an outpatient. He was admitted as an inpatient for short periods, mainly on the insistence of his father, who wanted to deal with his 'disobedience.' The main treatment was medication. Branko managed to save some money and participate occasionally in group psychodrama and group psychotherapy sessions.

Community mental health treatment
According to his individual plan, developed at the CMHC, Branko participates in planned activities. He has a talent for painting, which is supported by the occupational therapist, and attends an English language course. The nurse, who is his case manager, ensures he takes his medicines, reinforcing his understanding of their effects and the importance of taking them regularly. His case manager also manages his family's psychological education, which is done by a psychologist, to help them accept the 'reality' of his disorder. Branko was an active tennis player before the onset of his disorder and he is encouraged to play tennis and give private tennis lessons, which he has now been doing for more than three years successfully.

Kosta
Kosta (68) has a thirty year history of schizophrenia. He was almost permanently hospitalized in the Psychiatric Hospital in Negorci for 15 years. His official guardian is a distant relative who lives in Skopje, who would visit him regularly.

Treatment in the psychiatric institution
At the Psychiatric Hospital in Negorci, he was treated regularly with medicines. There was little opportunity for rehabilitation, whether in the form of occupational or work therapy. His guardian tried on many occasions to take Kosta home, but due to his highly developed institutionalization, Kosta himself insisted on being readmitted, often becoming very upset and agitated after only a few days out of the hospital.

Community mental health treatment
Four years ago, Kosta was admitted to a CMHC Temporary Residential Shelter in Skopje. During a year of residence, his individual plan focused on regaining 'living skills,' e.g. personal hygiene, maintaining a hygienic living environment, basic cooking skills, shopping, money handling. The main task, however, was reducing the degree of institutionalization. Kosta has been living in the community for three years, with regular visits by the team from the protected home. He has his own retirement fund and lives in his own apartment. He continues to attend the CMHC rehabilitation programme three times a week, with the focus now on ensuring he takes his therapy regularly and on maintaining social contacts established with other users.

a balanced diet programme and physical exercise (nurse, occupational therapist), creative therapies (occupational therapist), cognitive interventions (psychologist), and social anxiety (psychologist).

The selection of the case manager for a specific patient is often related to assessment of what his or her most pressing difficulties are. Also taken into account are positive counter-transference, other team members' suggestions, the patient's opinion, and case manager's consent. The case manager is involved in both group and individual interventions, when the patient's needs fall in the field of his or her expertise. Otherwise, the case manager refers the patient to the appropriate professional and acts as coordinator. Team meetings are held weekly to evaluate progress and discuss difficulties.

A look at how this Croatian case management model fits in with other common models reveals that it combines the individual and group approaches with some elements of the clinical, empowerment, and rehabilitation models. We also use some elements of the assertive outreach model, as one part of our daily living skills training is carried out outside the hospital. We still do not provide home visits and lack 24-hour service availability. Consequently, we cannot include patients who refuse to join the programme on hospital premises. This problem should be resolved in the near future by moving the Centre out of the hospital compound, by enlarging the pool of professionals, and by defining financing arrangements for these services.'

Training General Practitioners to Treat Patients with Mental Health Problems

The final aspect of training related to the role of general practitioners, both with regard to the early detection of mental health problems and to the value of the CMHCs as an alternative to medicalization and hospitalization in a major institution.

The training programme consisted of a series of modules developed at the Institute of Mental Health, Belgrade, together with colleagues from the Institute of Public Health, Sarajevo, and the Committee for Human Rights of the Norwegian Medical Association. The programme was divided into four modules, consisting of four working days each (16 days in total). Topics could be selected and modules adapted to the needs of specific groups of participants.

The topics for training were selected by a multidisciplinary team, which considered the needs of general practitioners in the region. Topics were prepared in the forms of lectures, followed by group work and case presentations by general practitioners. All lectures are prepared in written form and printed together in a manual.

A pre-evaluation questionnaire was used to assess the level of GPs' knowledge before training, followed-up by short anonymous self-reporting questionnaires after completion, to measure change in knowledge and attitudes, as well as satisfaction.

A general practitioner's view of continuous education in community-based mental health

"Given that the project is ending later this year, it is very important to find ways to continue with implementation of the training modules of Component 3 afterwards. It would be very useful for the existing family medicine teams, if the proposed module were to take the form of continuous education to develop their skill base in mental health and their understanding of the role and technical capabilities of the mental health centres, while improving monitoring and follow-up of people with mental health problems. Continuous education is also important for the mental health centre staff, not all of whom have had a chance to participate in programmes conducted to date. "

Dr Anđa Sušić,
General Practitioner and Deputy Director of the Doboj Health Centre, Bosnia and Herzegovina

COUNTRY PROFILES

While the SEE Mental Health Project was a regional initiative and maximum effort was made to ensure that the processes in the various participating countries went forward in a consistent, coherent, and coordinated fashion, their experiences and results naturally reflect the major differences in their situations both before and during the lifetime of the project.

Each of the country teams was therefore invited to provide a short profile of the process as it unfolded in their own country. The material provided was so rich and detailed that we are unfortunately unable to present here anything more than an edited summary. Each profile, nonetheless, presents some basic milestones in mental health reform with regard to the adoption of national mental health policies, strategies, and legislation. In some cases, there is discussion of the political process and challenges and obstacles faced. Others focus upon the development of the community mental health centres and the services they offer. Statistical indicators have not been provided, as a detailed, independent and comprehensive assessment of the performance of the Centres is being conducted, the results of which will be published separately when they become available. In most cases, the directors of the centres offer some closing reflections on the experience as a whole and the lessons they and their teams have learned from it, as well as the identification of present and future challenges.

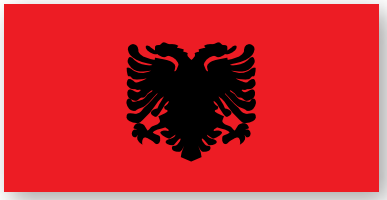
As a supplement to the rather impersonal profiles, we have appended a number of statements by the team of the community mental health centre at Strumica in The former Yugoslav Republic of Macedonia, which make clear that the process has involved more than simply changing the way in which a service is provided. For the service providers themselves, involvement in the process has clearly involved an awakening, a realization of the humanity they share with those they serve, and a real and passionate desire to ensure that the seed they have helped to plant progresses to maturity, the shared goal of a humane revolution in mental health care.

COUNTRY PROFILE

ALBANIA

Adapted from material contributed by Dr Zana Kokomani, Country Project Manager in Albania

Capital city: Tirana
Population: 3,069,275
Area: 28,748 km2
CMHC: Vlora
Catchment: 130,000



PROCESS MILESTONES

Mental health care reforms in Albania began in 1990.

National Policy for Mental Health Services Development was adopted in 2003.

Operational Plan for Mental Health Services Development was adopted in May 2005.

Community Mental Health Centre was inaugurated in Vlora on the 23rd of April, 2005, associated with the Vlora Psychiatric Hospital.

Comprehensive training programmes have been conducted for GPs and mental health professionals.

CMHC PROCESS

The Albanian mental health strategy provided for the establishment of a pilot community mental health centre at Vlora integrated within the national mental health system.

The town of Vlora was chosen because of the existence of the Vlora Psychiatric Hospital, the first psychiatric institution established in Albania. Administratively, the Centre is part of the Psychiatric Hospital, but with a clear status and division of tasks. The Centre is responsible for patients after discharge from the hospital, allowing their needs to be monitored and managed closely. This has helped in reducing the number of psychiatric beds, from 280 to 240.

The primary focus is on patients with acute and chronic psychotic conditions.

Patients are seen either at the Centre or at home. The Centre team is made up of two psychiatrists, seven nurses, a social worker, a psychologist and a cleaner.

The Centre is spacious and well equipped, with rooms for group activities, cooking, individual consultations, and a reception area, as well as a garden. There is a vehicle on loan from the Psychiatric Hospital for home visits.

The services provided include:

- individual psychotherapy sessions,
- group sessions with families,
- psycho-education,
- rehabilitation activities (cooking, gardening, sewing), and
- support to self-help groups, including a patients association.

The Centre is authorized to prescribe psycho-tropic medicine. Referrals due to drug abuse have increased and capacity in this area needs reinforcement.

EXPERIENCES AND LESSONS LEARNED

Both the experienced and the new staff members have benefited from a number of training sessions. Training on Mental Health Problems provided to public health care professionals had a particularly positive impact, improving relations with the GPs of the Vlora area, and developing a better understanding of the purpose and work of the Centre and of the importance of working directly with it. GPs were also provided training in communicating with patients with mental health problems and the early detection of mental health problems in primary care.

Initial organizational challenges faced by the Vlora CMHC that have been successfully overcome include:

1. Psychiatrists were assigned to work at the Centre by the hospital for periods of a month, which was not conducive to quality of service. The service therefore tended to focus on crisis intervention and depot therapy at home. While these are important community services, some patients found it difficult to perceive continuity of treatment, with different doctors entering and leaving their life. When they found that their doctor was not at the centre, they went to the hospital. This was largely because the psychiatrists were unwilling to work solely or mainly at the Centre. They were cautious about giving up their professional base at the Psychiatric Hospital and perceived a move to the Centre as a demotion.
2. Relations with GPs could have been better, as efforts to establish relationships and ensure continuity of treatment were sometimes perceived as interference rather than an invitation for cooperation. Contact with the public health care services has therefore been stepped up to improve the referral system and information materials have been prepared.

COUNTRY PROFILE

BOSNIA AND HERZEGOVINA

Adapted from material contributed by Dr Joka Blagovčanin Simić, Country Project Manager in Bosnia and Herzegovina

Capital city: Sarajevo
Population: 3,842,527
Area: 51,209 km2
CMHC: Mostar (West) and Prnjavor
Catchment: Mostar: 65,000
Prnjavor: 50,000

PROCESS MILESTONES

Bosnia and Herzegovina is lead country for the SEE Mental Health Project.

Mental healthcare reforms began in 1996 and have involved the establishment of 61 Community Mental Health Centres to date.

Mental Health Policy and the Law on Protection of Persons with Mental Health Disorders were adopted during 2003-2005.

Two Community Mental Heath Centres were opened under the project in Mostar and Prnjavor in 2005.

Community outreach programmes to raise public awareness of mental health issues and the work of the Centres have been conducted on a regular basis since 2005.

Since 2006, regular training in community mental health and case management has already produced noticeable changes for the better. There has also been leadership and management training.

Bosnia and Herzegovina consists of two entities (the Republika Srpska and the Federation of Bosnia and Herzegovina), as well as one district (Brčko District). There are two ministries of health, one for each entity. The demolition of psychiatric facilities in Bosnia and Herzegovina during the war made reform unavoidable, while the dramatic deterioration in mental health after the war increased the urgency of establishing adequate mental health services in the community. Due to this combination of factors, there was a double process, beginning in 1996, with laws, policies, and community mental health centres established in both entities. It was on the basis of this experience that Bosnia and Herzegovina suggested and was able to take a lead role in developing mental health reform as the focal area for the first regional project under the SEE Health Network.

Indicative of Bosnia and Herzegovina's continued commitment to mental health reform are two recent developments:

- The agreement by the two entity health ministries to create a permanent module for long-term training in mental health in the community, under component three of the SEE Mental Health Project. The module will be integrated into university curricula for both undergraduate training and postgraduate specialization in public health, neuropsychiatry, and family medicine (general practice). The same modules will be used as the basis for permanent programmes in the continuous education of the CMHC staff and family medicine teams.

- The recent agreement between the SEE Mental Health Project and the Swiss Government regarding a longitudinal research study on progress achieved to date and priorities for the next phase of mental health reform: *Situation Analysis and Community Mental Health Service Assessment in Bosnia and Herzegovina*. The study is being funded by the Swiss Agency for Development and Cooperation, while implementation is by the Federal Ministry of Health and the Ministry of Health and Social Welfare of Republika Srpska, through the SEE Mental Health Project and the Coordinating Centre for Mental Health of Republika Srpska, and financial management by the FaMi Foundation. The results of this study will become available later this year and will serve as the basis for identifying priorities and so developing specific community mental health programmes for implementation under this useful framework for collaboration and partnership.

CMHC PROCESS

The project opened two Community Mental Health Centres in Bosnia and Herzegovina, one in each of the constituent entities (RS and FBiH). The Prnjavor (RS) CMHC was inaugurated on the 27th of June, 2005, during the 10th meeting of the SEE Health Network, held in Banja Luka. The Mostar Centre (FBiH) became operational in April 2005, with the official inauguration in November 2005. The agreement of the two ministries of health to establish community mental health centres in the town of Mostar and Prnjavor was warmly welcomed by both the professional and local communities. The harsh consequences of the recent war have pervaded almost every aspect of life in these towns, making the demand for broad-spectrum mental health services even more pressing.

"Bosnia and Herzegovina is an excellent example of successful reform. This is evident from the transformation of professional attitudes towards a more accepting approach, which has resulted in increased user satisfaction and empowerment. Equally significant has been the recent opening of a further five community mental health centres in the municipalities of Teslić, Prijedor, Milići, Modriča, and Eastern Sarajevo, over and above those planned for and funded under the project itself, the existing 43 in the Federation of Bosnia and Herzegovina, the existing 16 in the RS, and one in Brčko District. In addition to regular funding, the RS and the Italian governments have agreed a project for 2008-9, worth a further 600,000 Euros, to ensure the outfitting and sustainability of these five new centres, as well as to extend the provision of training and continuous education in community mental health care for mental health professionals throughout the health system. In this way, the entity health ministries are making clear their commitment to continued quality implementation of the reforms institutionalized under the SEE Mental Health Project."

Vesna Puratić, Regional Manager of the SEE Mental Health Project.

The CMHCs prioritize people with serious mental illness and provide the following services:

- assessment,
- crisis intervention,
- case formulation including treatment plan,
- psycho-pharmacotherapy,
- consultation – therapeutic session for users and their families,
- psycho-education,
- referral to hospital,
- referral to psychosocial rehabilitation programmes,
- mobile teams and home visits.

The CMHCs are located in Community Health Centres and have teams including a neuropsychiatrist, one or more psychologists, an occupational therapist, nurses, and social workers. Activities are closely coordinated with the Community Health Centres and the local General Hospitals (with psychiatry wards). The priority is to treat people with chronic mental illness. The Mostar Centre also offers a service of providing check-ups to veterans, victims of the war, and similar socially vulnerable groups for the purposes of social and health insurance. In Prnjavor, mobile visits play a major role, as 80 percent of the catchment area is rural.

Secondary and tertiary mental health services in the FBiH are provided by the University Hospitals in Sarajevo, Tuzla, and Mostar and in psychiatric wards in the general hospitals of the other larger towns in the Federation. In the RS, they are provided by the University Hospital Psychiatric Clinic in Banja Luka, psychiatric hospitals in Jakeš and Sokolac, as well as the psychiatric wards in six general hospitals. There are two shelter houses and one 'cooperative,' as well as three user associations active within the country.

EXPERIENCES AND LESSONS LEARNED

Perhaps the most important lesson learned from the process has been the importance of developing consensus within the profession and good relations between the profession and the government institutions responsible for policy and, equally importantly, for ensuring that good policy is translated into good practice, with adequate funding. We have learned that it is crucial to the success of the process to institutionalize changes and to provide space for the new approach to put down roots and grow, not just through legislation and in government documents, but through training programmes and teaching practice. Existing and new generations of doctors and mental health professionals must be introduced to the new community-based ways as the basic way of treating people with mental problems. It must become second nature and that can only be done by introducing it as a constituent element of both undergraduate and post-graduate training. That is why, with the support of both entity health ministries, we have embarked on the introduction of new training modules in community based mental health care provision for use at the universities throughout the country and the model of care crystallized under this project will become the standard model for the Bosnian and Herzegovinian health care system.

"Making this new approach a reality has meant developing a new and clear mental health policy and action plan, with intensive and comprehensive training for all professional grades working with mental problems and disorders, and putting in place legislation in both entities to allow reorganization of the psychiatric services and secure legal protection for the human rights of people with mental disorders.

While considerable progress had been made in this regard by 2002, when implementation of the SEE Mental Health Project began, the project came at just the right time and saved the newly-reformed mental health services from stagnation and regression. The new initiatives introduced by the project's regional and national offices were of major assistance in ensuring that many of the new mental health centres 'survived' the transitional period, while the two model mental health centres established under the project have an important role to play in training and the introduction of new diagnostic and therapeutic techniques throughout the country."

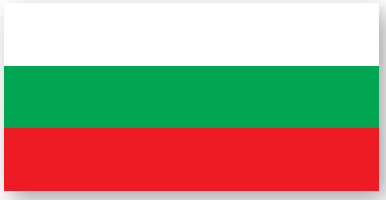
Prof. Ismet Cerić,
Former Head of the Sarajevo University Hospital Psychiatric Clinic and WHO focal point for mental health in the Federation of Bosnia and Herzegovina.

COUNTRY PROFILE

BULGARIA

Adapted from material contributed by Dr Hristo Hinkov, Country Project Manager in Bulgaria

Capital city: Sofia
Population: 7,761,049
Area: 111,000 km2
CMHC: Blagoevgrad
Catchment: 80,000



PROCESS MILESTONES

A Mental Health Policy has been elaborated and formulated.

A National Council for Mental Health, comprizing representatives of all concerned institutions was established.

Training is planned for the newly hired staff of the community mental health centre.

The pilot community mental health centre was inaugurated on the 8th of April, 2005, in Blagoevgrad.

CHMC PROCESS

The staff includes 1 psychiatrist, 6 psychologists, 4 nurses, and 4 social workers. Services provided relate to the early detection of psychiatric disorders and the diagnosis and treatment of all types of psychiatric problems, with a special focus on persons with mental disorders that affect their abilities to cope with stress-provoking life events and social adaptation in general. The Centre provides a variety of programs for psychosocial rehabilitation and re-socialization.

Long-term treatment and supportive measures keep these patients in a stable condition, facilitating their life in the community. Because of the nature of their illness, some require a personal care coordinator to ensure the successful realization of their individual therapeutic plan.

The Day care unit deals with clinical problems occurring during the phase of the stabilization, including relapses, stressful social events, housing, home care.

The Centre offers the following rehabilitation programs:

1. Social club
2. Therapeutic kitchen
3. Looking for a job
4. Communication skills
5. Management of symptoms

6. Supported employment
7. Transitional occupational place
8. Home care and crisis intervention

LINKS WITH OTHER PROGRAMMES

In 2003, the Ministry of Social Welfare and Labour began two major PHARE-financed mental health programmes: "Improvement of the quality of life of the people with mental disabilities" and "De-institutionalization through provision of community based services for risk groups." A number of day-care centres, shelter homes, and general hospital psychiatric wards have been opened under them, most with mental health information centres.

EXPERIENCES AND LESSONS LEARNED

The popularity of the Centre is spreading. The usefulness of the rehabilitation unit's services is increasingly recognized by local professionals, as improving patient compliance, reducing the incidence of relapse, and promoting psychological stabilization. Experience has shown that coordinated provision of services by medical and social teams delivers a clear pay-off. Although there were difficulties, misunderstandings, competitive tensions, and resentments in the beginning, this has developed into mutual support and collaboration. The model is highly adaptable and promotes staff morale.

Case Study

- E. S. is 51 year-old man, suffering from paranoid schizophrenia for more than 20 years. He established contact.
- He studied architecture in Moscow, married a Russian girl, and came back to Bulgaria.
- The trigger is high levels of stress due to professional failure. He started to feel tension and physical weakness, left his family, and divorced. He now lives with his mother. He is unemployed and considers the disease an obstacle to a fruitful life.
- He was first diagnosed by a friend (psychiatrist) in late 1985, whom E.S. had asked for help over his military discharge. Over the past 20 years, he has been hospitalized 7 times.
- He often complains of feelings of despair and is very frustrated by his symptoms. He has frequent anxious thoughts about disasters and wars. Reality testing is good.
- E.S believes the medicine he takes has a positive impact on his symptoms, but thinks he needs an additional drug because of his feelings of tension, depression, and insomnia.
- E.S. needs some occupation, which he links to his desire for communication and social contacts. He has well defined requirements as to the job, but is afraid he might not be able to manage it.
- His disease carries a risk of social exclusion, due to his difficulty establishing social contacts. There is a risk of neglect behavior.
- E.S. is aware of his disease and strongly motivated to overcome it. He wants to live a normal life and to feel himself of full value. He understands the effects of the medicines and how they help him. He shows willingness and consistency in his therapy and shows an active interest in medical developments.
- E.S. has completed Lieberman modules on social skills and independent living in the day care center. In 2005, he was given communication skills training, to improve his ability to establish and maintain relationships. In 2007, he passed the "Control over symptoms" and "Job seeking" modules. He is an active member of the Psychiatric Patients' Council.

COUNTRY PROFILE

CROATIA

Adapted from material contributed by Dr Neven Henigsberg, Country Project Manager in Croatia

Capital city: Zagreb
Population: 4,437,460
Area: 56,542km2
CMHC: Zagreb
Catchment: 84,000

PROCESS MILESTONES

Mental health legislation has been harmonized with international standards.

A Croatian Mental Health Institute was established, with responsibility for mental health policy and plans.

A comprehensive mental health strategy has yet to be drafted, but separate strategies have been developed to address mental health risk factors and facilitate access to care by vulnerable groups.

The overall environment, including the health authorities, supports restructuring the mental health services and developing a community-based system. The implementation of legislative measures has, however, been impeded by lack of resources. Recent reforms have contributed to promotion of patients' rights and improved inter-sectoral cooperation. International cooperation regarding development and research activities has been improved.

The pilot community mental health centre in Zagreb, Croatia, was officially inaugurated in January 2006.

Professional training programmes have been carried out for GPs, nurses, and social workers.

Limited community outreach has been conducted.

CMHC PROCESS

The pilot CMHC in Croatia is located in the western part of Zagreb, an area with two major psychiatric hospitals, one with 881 hospital beds and 354 health professionals and the other with 558 hospital beds and 160 health professionals.

The CMHC team comprises two nurses, one occupational therapist, four psychologists, eight working and two supervizing psychiatrists. Psychiatrists and psychologists are on part-time appointment to the CMHC, with part-time appointments to other institutions, including psychiatric and general hospitals. This has improved linkages to the network of highly-skilled professionals and already existing services, especially in terms of case management, treatment formulation, and referral.

Services are provided during the day to all population groups, but with special attention to the needs of the socially vulnerable, people with chronic mental disorders, and families or carers of people with mental disorders. Patients are referred by their GPs or self-referred. First contact is usually made by the team nurse and most services are appointment-based.

Services include:

- the early detection of first episodes,
- daytime crisis interventions,
- out-patient therapeutic services,
- therapeutic, crisis, and rehabilitation services for the chronically mentally ill,
- linking abused children and adolescents, drug addicts, the elderly, and war victims to national or local networks,
- counselling for carers and families,
- support to pregnant and nursing women,
- early interaction training (interaction in families with children up to 3 years of age),
- living skills training,
- occupational training,
- rehabilitation workshops, and
- organizing home help and support services.

The costs of services are reimbursed by compulsory health insurance. Hospitals have retained the staff members on their payrolls and medicines are paid for by compulsory health insurance. This model offers significant incentives for participating hospitals and mental health professionals. The hospitals are primarily interested in less expensive treatment alternatives, while the professionals can retain their existing contracts, follow-up patients during hospitalization, and are linked with the university.

The long-run aim is to ensure the CMHC's sustainability by full integration within the national health system. There are plans to replicate the model in other areas of Croatia and funding is currently being secured for three more community mental health centres in the towns of Osijek, Dubrovnik and Varaždin.

COUNTRY PROFILE

MONTENEGRO

Adapted from material contributed by Ms Tatijana Mandić Đurišić, Country Project Manager in Montenegro

Capital city: Podgorica
Population: 650,575
Area: 13,812 km2
CMHC: Kotor
Catchment: 60,000

PROCESS MILESTONES

The institutional framework for mental health promotion in Montenegro has been established.

The National Mental Health Strategy and Action Plan were adopted in 2004.

The Law on Protection and Exercise of Rights of the Mentally Ill was passed in 2005.

The pilot community mental health centre in Kotor, Montenegro, was officially opened on the 18th of May, 2005.

Both public and private mental health facilities have been mapped and their resources catalogued. Non-governmental organizations active in the mental health system have been registered.

Dr Aleksandar Mačić, Coordinator of the Kotor CMHC

"The opening of the pilot CMHC in Kotor has marked the beginning of community mental health care in Montenegro. This work concept, if successfully carried out, would result in much greater satisfaction of professionals and consumers alike, compared to the classic mental health dispensaries."

A programme to integrate unemployed mental health service users into projects to support the elderly, after appropriate training is under development.

Mental health remains a neglected area of public health in Montenegro and there are few clearly measurable indicators. This is because the reforms faced underdeveloped capacity and an outmoded concept of mental health and illness. The main strength of the mental health system at the beginning of the process was the relatively good availability of professional help to all categories of the mentally ill, in places where relevant institutions existed. Where such institutions did not exist, it was a different story, however. Problems included insufficient and poorly trained staff, a lack of continuing education in mental health care for specialists and general practitioners, poor collaboration between the various levels of the mental health services, and the absence of specialist consultation services, research into mental health, a common database for treatment monitoring, specialist services for vulnerable groups, or capacity for specialist diagnostics. A further issue was outdated mental health legislation.

In some areas, the situation has already significantly improved:

- The activities implemented through the SEE Mental Health Project have taken the first concrete steps towards de-institutionalization and the development of community-based mental health care.
- The pilot CMHC in Kotor is the first centre of this kind in Montenegro.
- The SEE Mental Health Project has carried out significant workforce training programmes.
- The Montenegrin Parliament adopted the new Law on Mental Health in May 2005. The law is based on the Strategy for Mental Health Improvement and proclaims the principle of providing mental health care in the community, with the full engagement of all formal and informal resources.

Reform of the country's mental health system has proven a more difficult and demanding process than initially anticipated and its progress depends in large measure on the degree to which the other segments of the health system embrace the process and provide strong and unequivocal institutional support. While individual enthusiasm is valuable and most welcome, it is crucial to put mental health on the agenda of the responsible officials and institutions. The clear and widely shared understanding among mental health professionals that it is high time for a radical change in mental health service provision that has resulted from the project is an important step on the road to reform.

CMHC PROCESS

The Community Mental Health Centre in Kotor was established on the 18th of May, 2005. The two main reasons for selecting Kotor were that it is the main urban centre for the relevant catchment area and that the largest psychiatric hospital in Montenegro (Dobrota Special Psychiatric Hospital) is located there. This means that the population in the area is more aware of mental health issues and levels of stigma and discrimination are lower than in other parts of the country.

The Centre is part of the Kotor Health Centre. It provides a range of services, including individual therapeutic sessions, group therapy, medication and depot therapy, and work with families. The CMHC enjoys excellent co-operation with community institutions, both health and social, as well as educational, judicial, media, police and NGOs. The staff includes a psychiatrist, a psychologist, a social worker, two nurses, and one medical technician who work two shifts, from 7 am to 7 pm. Clients come to the CMHC of their own initiative or are referred by general practitioners. The patient is normally assessed by each team member on their first visit. This allows the team to make a base evaluation and proceed with developing a treatment plan.

EXPERIENCE AND LESSONS LEARNED

The most significant problems are the discrepancies between the public health care reform and mental health system reform. The more general health care reforms imply that the CMHCs are to be treated as support units to a given physician, which strips them of their autonomy. There is also duplication, as the public health care reform plan includes in its basic package of services certain types of service the CMHC should provide. It will therefore be necessary to work together to find a solution and ensure the development of an appropriate model of community mental health centres.

COUNTRY PROFILE

REPUBLIC OF MOLDOVA

Adapted from material contributed by Dr Larisa Boderskova, Country Project Manager in Republic of Moldova

Capital city: Chisinau
Population: 3,606,800
Area: 33,800 km2
CMHC: Chisinau
Catchment: 110,000

PROCESS MILESTONES

The pilot community mental health centre in Chisinau was officially opened on the 14th of April, 2005.

The Ministry of Health selected Mental Health as a priority.

The National Health Policy was approved, with a chapter on mental health (Ch. XII. *Ensuring conditions for mental health promotion).*

A National Mental Health Programme was approved for 2007-2011.

The new Mental Health Law was adopted in February 2008.

CMHC PROCESS

Although mental health reform in the Republic of Moldova began in 1988, it was the last country in the region to join the SEE Mental Health project (in 2003). The regional process has been particularly important in redirecting and re-energizing mental health as a national priority. Due to these circumstances, the process in the Republic of Moldova followed a different dynamic, with the creation of the CMHC preceding the process of consultation and policy and legislative review and development. The entire process has enjoyed the particularly close support of the Ministry of Health.

The first significant result was therefore the opening of the Community Mental Health Centre in Chisinau. As a new model service, the Chisinau CMHC received financial support from the National Medical Insurance Company, on condition that the required documents are provided to prove the effectiveness and need for community services. By 2007, there were three CMHC in the Republic of Moldova – Chisinau, Ungheni, and Balti. Up to that point, the CMHCs were classified as specialized mental health services within the primary health care system. This classification had positive and negative aspects. The positive aspect of being incorporated into primary care was counterbalanced by the lack of a legal framework for the CMHCs, making clear their position in the structure of the mental health services.

Regulations and a ministerial order were issued in February 2007, but failed to address the Centre's finances. An inter-ministerial memo (between the Ministry of Health and the Ministry of Social Protection) has therefore

been prepared to make clear types of services and payment mechanisms, with the technical assistance of the WHO. The National Insurance Company has earmarked the sum required for the three existing CHMCs.

During this process, the criteria and requirements for the CMHCs, their catchment areas, and the regulatory documentation for both rural and urban CMHCs were refined, as were admission and release criteria, job descriptions, and the list of professionals and system of references between the CMHCs and traditional mental health services. Ongoing public administration reform caused a four month delay, while the process revealed a need for other document sets (e.g. standards of care and minimum quality standards, accreditation criteria). These documents required preparation as a matter of urgency, if the services were to be stable and sustainable. The existence of the documentation means that a network of community mental health services can now be developed without further difficulty (as a Ministry of Health order to this effect stipulates).

The documentation is also very important for the mental health professionals, as it describes in detail the required and optional activities that may be performed by a community service, as well as their terms of references and job descriptions. The managers of the traditional mental health services opposed the development of community services, because they were afraid it would affect the financing of the mental hospitals. A frank exchange of opinion, however, has removed any acute conflict of interests.

The universities have developed postgraduate modules to support mental health care reforms in social assistance, psychology, medicine (GPs, psychiatrists), and nursing. They will be introduced countrywide as of the next academic year.

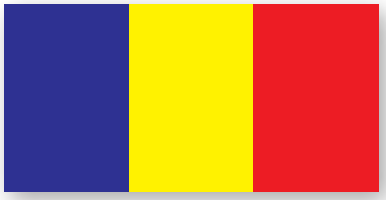
The CMHC clients have benefited most, due to better access to integrated services delivered locally by a multidisciplinary community team. Some relatives and families have resisted the services, however, preferring residential or hospital services, as they relieve them of their responsibilities and duties regarding their relatives suffering from mental health problems. The fact that the patients' needs (medication) are not all covered by the medical insurance fund in out-patient services also plays an important role.

COUNTRY PROFILE

ROMANIA

Adapted from material contributed by Ms Raluca Nica, Country Project Manager in Romania

Capital city: Bucharest
Population: 22,355,551
Area: 238,000 km2
CMHC: Bucharest
Catchment: 120,000



PROCESS MILESTONES

The first mental health care assessment in Romania by the WHO experts was conducted in 2000.

The Mental Health Law was passed in 2002.

The first Romanian Mental Health strategy was elaborated and adopted by the Ministry of Health in 2005.

An Action Plan for the Implementation of the Mental Health Policy of the Romanian Ministry of Health was elaborated (within the framework of the Twinning Light Project/partnership with Dutch Ministry of Health) in 2005.

Norms for the implementation of the mental health legislation were adopted in 2006.

The National Mental Health Centre was established in April 2006, while a ministerial order from the same month sets out the conditions for setting up Mental Health Centres in Romania. Some 15 million Euro were allocated in 2006 and 2007 for the development of community mental health centres.

The Titan Psychiatric Unit in Bucharest was selected as the pilot site for the community mental health centre, which opened on the 1st of October, 2005. It was officially inaugurated by Dr Matthijs Muijen of the WHO Regional Office for Europe in March 2006.

In 2007, the Centre staff underwent a six-month training programme in community care and case management.

CMHC PROCESS

After a slow start, due to lack of expertise and understanding as to the role and responsibilities of a multidisciplinary team and of community care more generally, the Titan Community Mental Health Centre is now operating in line with the standards established. It has a daily program for psychotic patients that consists of group therapy, individual therapy, art therapy (painting), music therapy, psycho-education for patients and families, and physical activities. The Centre also offers group therapy and psycho-education for patients with depression.

EXPERIENCE AND LESSONS LEARNED

The SEE Mental Health Project has been crucially important for mental health reform in Romania. It helped us to take the first steps towards the new philosophy of community care and provide the tools. The success of the SEE Mental Health Project in Romania is evident: what seemed at first very ambitious and difficult, because of our lack of experience, bureaucratic obstacles, and resistance to change, has indeed happened. In a fortunate match, the EU was applying pressure to improve mental health care at just the time that the project was producing results. Mental health reform in Romania would have been much more difficult without the SEE Mental Health Project. There are still many difficulties to be overcome and we are aware of the long road that lies ahead of us, but we are confident that our efforts, combined with the support of the network created in the SEE region, will give us the necessary background to succeed.

Priorities for the next phase of reform include:

- an anti-stigma programme,
- the development of community mental health centres,
- quality improvement of hospital services,
- training and education,
- implementation of the Law on Mental Health and Protection of People with Mental Disorders, and
- user involvement.

COUNTRY PROFILE

SERBIA

Adapted from material contributed by Dr Vladimir Jović, Country Project Manager in Serbia

Capital city: Belgrade
Population: 10,159,046
Area: 88,361 km2
CMHC: Niš
Catchment: 70,000

PROCESS MILESTONES

Mental health care reforms in Serbia began with the project.

The National Mental Health Policy and the Draft Mental Health Law have been prepared.

The National Committee for Mental Health was established in 2003, tasked with preparing the strategy for mental health care reform.

The transformation of mental health services has started, with the accent on community care, anti-stigma campaigns, and continuous education.

CMHC PROCESS

The pilot community mental health centre in Niš, Serbia, was officially inaugurated on the 2nd of October, 2005.

At the beginning of the mental health care reform, the Serbian mental health care system had the advantage of even territorial coverage by inpatient psychiatric services and a well-educated staff. An additional advantage was the relatively small percentage of institutionalized patients. A major disadvantage was that some of the large psychiatric hospitals were effectively asylums for chronic psychiatric and mentally retarded patients. The hospitals were overcrowded and understaffed and treatment did not follow the principles of contemporary psychiatry. There were lapses with regard to the human rights of mental patients. Cooperation between psychiatric and social welfare institutions, which is necessary to ensure adequate accommodation, treatment, and continued care of the mentally ill once reintroduced into society, was poor. There were no community mental health centres or other outpatient psychiatric services providing mental health care in the community.

According to the Republic Institute of Public Health, the number of registered mental disorders has increased by 13.5% (from 271,944 in 1999 to 309,281 in 2002). The prevalence of stress disorders is high and depression, suicide rate, alcohol and substance abuse, and psychosomatic disorders are on the rise. The number of drug addicts has been growing continuously since 1997. Serbia is also witnessing an alarming increase of aggression and violence, especially among young people, which is caused by complex biological, psychological and social reasons.

The development of community-based mental health services was recognized as a priority in the national mental health policy, which states that CMHCs may be established within existing health institutions, but with complete

independence and a separate administration, plan, and organization. They should be organized on the territorial principle (one centre for every 40,000 to 100,000 inhabitants) and provide care and promote the mental health of the entire population of their catchment area, not just persons with chronic mental disorders. In short, all services related to the mental health care of the population should be developed in the centres.

The National Policy, Action Plan, and the Law are entirely in accordance with the Helsinki Declaration and incorporate the SEE Mental Health Project's Joint Statement on Mental Health.

EXPERIENCE AND LESSONS LEARNED

The Project has created additional value of benefit to the further development of community mental health care:

1. Contacts and partnership with other governments in the region have created a solid basis for political support to overall reforms.
2. National teams have established deep mutual relationships that extend over a variety of professional activities and can work together as a solid creative force.
3. Thanks to their public activities and commitment to the reforms, the national teams, and, in some countries, the national mental health committees are perceived as the leading bodies and initiators of reforms.
4. Although not a primary goal of the Project, sharing information and building a knowledge base regarding community psychiatry, especially in the form of interactive discussions during technical workshops, has proven to be one of the major benefits.
5. The development of an informal network of professionals working in community mental health from different countries outside SEE is a significant benefit of the Project.

"There are no precise epidemiological data on the mental health status of the nation. However, it is certain that disastrous events and countless challenges in the last fifteen years have affected mental condition of the population. In Serbia, the United Nations sanctions lasted three and a half years and were followed by 78 days of bombing, a strong acute stressor, superposed to the existing chronic stress. We are witnessing prolonged political turmoil and painful social transition – about one million people are unemployed and the average salary is degradingly low. All the stressors mentioned above, both acute and chronic have led to social deprivation, apathy, dehumanization, and a culture of poverty.

We believe that the reform of psychiatry means restoring the dignity of our noble discipline. Reform implies deep transformation, transformation that should start within ourselves, not from outside. Although most psychiatrists support the multidimensional approach, many remain reluctant to accept treatment of man-as-a-whole and take recourse to schools, classifying themselves as biological psychiatrists, psychotherapists within a specific orientation, or even experts in a single category of mental disorders. An eclectic, holistic approach requires vast knowledge and tolerance of cognitive dissonance. Few of us are prepared for that, which is why it is easier to hide behind individual schools and orientations. Psychiatrists often assume an attitude of omnipotence, acting as if they have the answers to all questions, even the ultimate ones. To avoid the narcissistic omnipotence and dangerous paternalistic playing God psychiatrists are prone to, we believe it is necessary to develop the modesty of the general psychiatrist, a profession on the verge of extinction, psychiatrists in the service of their patients, regardless of their orientation or the topic of their doctoral theses. Integrative treatment, good clinical practice based on values and not only on evidence, as demanded by modern science, is essential. Psychiatrists should treat the person and not the disease."

Adapted from *Mental Health Care in Serbia – Challenges and Solutions*, a report by the National Committee for Mental Health of the Ministry of Health of the Republic of Serbia.

COUNTRY PROFILE

THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA

Adapted from material contributed by Dr Vladimir Ortakov,
Country Project Manager in
The former Yugoslav Republic of Macedonia

Capital city: Skopje
Population: 2,022,547
Area: 25,333 km2
CMHC: Strumica
Catchment: 120,000

PROCESS MILESTONES

Reform of mental health care has been ongoing since 2000.

Six community mental health centres have been established, while two protected homes provide lodging of up to one year, and one permanent protected home and several houses for supported living have been established.

More than 100 people with mental illnesses are employed in four publicly-owned companies.

The National Mental Health Policy and Mental Health Law have been endorsed.

A pilot community mental health centre was established under the SEE Mental Health Project in the town of Strumica. It opened its doors on the 4th of March, 2005.

There have been programmes of professional education in Case Management and Leadership and Management. There have also been courses for primary care practitioners from Strumica and the region.

CHMC PROCESS

Strumica is one of the largest towns in the eastern part of The former Yugoslav Republic of Macedonia. The fact that none of the existing six CMHCs in the country was located in the eastern part of the country (east of the Vardar River) was a decisive reason for selecting Strumica as the site for the pilot CMHC.

Good cooperation was established with the local authorities from the beginning.

As the Strumica CMHC team would put it, ongoing education of mental health professionals ensures increasing levels of information, which can be conveyed to the users' families and the local community. It is very important that the public be familiar with the problems of the mentally ill and the types of solution that can be found for their problems, with the help of the people from their local communities.

One of the results of this cooperation was the construction of a house funded by the Mayor for one of the users of the CMHC Strumica, who was practically homeless.

EXPERIENCE AND LESSONS LEARNED

1. Maintaining the **regional network** – the significance of maintaining cooperation and the exchange of experiences between the countries of the region is enormous.
2. **Raising awareness -** advocate with decision makers for consistent and comprehensive reforms of the mental health system.
3. **Establishing legally binding instruments** – legislation is required to allow full implementation of reforms (with particular stress on deinstitutionalization and full involvement of the Social Sector etc.). Even extremely meticulous and detailed action plans are useless without legislation.
4. **Family involvement** - Permanent mobilization of the families is the best bulwark against exclusion and resistance to reform.
5. **Formal education** - Formal training for work in community mental health must be available at the institutions of higher education in the countries of SEE.

Impressions and Reflections of the CMHC Strumica team members on their new way of working and treating patients

Lora Geteva, Nurse:
I have been employed in the CMHC Strumica for one and a half years now. Before I worked as a nurse in the children's outpatient department. At the CMHC, we organize courses, give lectures every day, and do home visits. Our work is team work and it requires an individual approach to the patients. Depending on their personal capabilities, wishes, skills, and mental condition, we include the patients in different activities. In the past there was very little mention of people with mental disorders. I think that with steady hard work we can attract public attention to their problems. Our task is to help, support, and train them to manage their own lives. To achieve this, we too need more support, training, and experience regarding the everyday needs and problems of people with mental health problems.

Evgenija Ananieva, Nurse:
Before coming to Strumica, I was working at the gynaecology outpatient department. My opinion is generally positive and I think our work meets our users needs reasonably successfully. There is a lot of room for improvement, however, and our work in the CMHC could be made easier. It would be very useful to include the social welfare services more and in a more appropriate way, as most mental health clients are very low on the social scale. Not just the users, but the community services need much more funds too. Secondly, cooperation with the public sector, the media, the private health sector, NGOs etc, should be increased and improved. Above all, our team needs education and training and the exchange of experiences with experts and professionals from abroad.

Marija Januševa, Nurse:
I came to work in Strumica one and a half years ago. It wasn't my first job as a nurse, but it was totally new experience for me and I found it very difficult to work with users of mental health services at first. After a while, I began to like the work here and I find it much easier now. We need much better funding, if we are going to meet the needs of the users and we need to develop our activities, both in the centre and the field.

Violeta Manuševa, Nurse:
Before I came to Strumica, I worked as a nurse at an outpatient department with a very high turnover. Working with people with mental health problems was a big change. Patients feel safer here and they get what they re

cont.

ally need. Above all, they get company, which is the most important thing. We need to develop our mobile services – we need vehicles and more staff. I think it is crucial to develop home visits, because our users are very often reluctant to come to the Centre, even though coming to the Centre makes them better in every sense.

Olga Toševa, Nurse:
After beginning to work here at Strumica, I became aware of the difference in approach to patients. Before, I worked in gynaecology. Now, I can see that people with mental health problems require a very different way of relating to them. At the beginning, it was difficult for me to adapt to the new circumstances, but I got used gradually to working well with the users, and the team of course. Team coherence makes cooperation with the users much better. But we need better material conditions for our work, and most of all, we need much more equipment. We have not visited any other CMHC so far, to compare our work with theirs. It seems to me that our CMHC works well, but I think it would be much better if conditions could be improved. I am in charge of pottery and we have a lot of talented participants. I think that we could make more progress than any other CMHC in Macedonia, if we had the necessary equipment for our handicrafts programme.

Tanja Bedzovska, Nurse:
I have been at Strumica since it opened. When I first worked at this sort of establishment – the CMHC in Skopje – I was a little afraid and unsure whether, as a nurse trained in gynaecology, I could manage the 'switch' to mental health. It was my first encounter with people with mental health problems. Then, I became acquainted with their problems and the stigma coming from the 'mentally healthy' population, and saw the energy and devotion of the nurses and other members of the CMHC team. It taught me a lot. Thanks to the cooperation of the teams from the other CMHCs and the various training courses we have had here at Strumica, we have succeeded in creating an atmosphere that encourages and motivates users to visit the centre and develop their potential. I would like to mention one limiting factor: the lack of resources and of the technical equipment.

Ljubica Miteva, Psychologist:
My experience as a psychologist, employed at Strumica since it opened, leads me to conclude that we have contributed to improving the psychological status of all our users, helping them build relationships, develop basic living skills, adjusting their behavior and reality management, and generally improving their quality of life. The quality of our work at the Strumica Centre would benefit from more frequent educational workshops and group psycho-educational training that included the users.

Andrijana Donkova, Social Worker:
My experience with this type of work began with my employment at Strumica two years ago. My visits and contacts with experienced community mental health professionals helped me approach my work. I am now involved in the social assessment of the users, preparation of their social histories, maintaining contacts between users and their home and working environment, motivating them and their families regarding treatment, and establishing contacts with the relevant institutions to secure their legal and social rights. The training provided by the SEE Mental Health Project's excellent experts helped me in my professional development. I strongly urge greater involvement by the social sector, which is one of the weakest points in the development of community mental health services and mental health reforms generally.

CONCLUDING REMARKS

The Mental Health Project for South-eastern Europe stands as an expression of progress made under the aegis of the Stability Pact for SEE towards regional co-operation and integration with wider European organizations and structures.

The reforms carried out under the Mental Health Project for South-eastern Europe are an excellent example of translating commitment to reform into strategy and action. The process involved a number of clearly demarcated phases, divided for purposes of planning and implementation into three components. First was the hammering out of a common vision of how best to serve users of mental health services and what such service provision might look like, viz. the model of community-based care to be applied given local and regional circumstances. This was accompanied by determination of the political and institutional changes and innovations that would be required to make the vision a reality, as well as of the room for variation to be allowed each of the countries involved. Then came the actual development of consistent and harmonized national mental health policies, strategies, and legislation and the delicate process of putting them in place and ensuring implementation. The first pilot phase of reform was brought to a successful close with the creation of at least one community mental health centre in each of the participating countries and the development of training programmes for mental health professionals and general practitioners. In some cases, the reforms have progressed to the point of revising university and medical school curricula, so that the reforms will take root not just in a few institutions but in the approach and practice of doctors, nurses, psychologists, and related professionals throughout the health services.

Those involved in the process are rightly proud of what they have accomplished. They have seen their shared vision of humane treatment and care pass from aspiration to reality, not merely in one or two countries, but in all nine countries of the South-eastern European region. It is of crucial importance to the providers and users of mental health services, but also to the well-being of society more generally, that this remarkable progress be recognized and built upon.

A powerful indication of the impact of the process has been the response of the political sponsors, the ministries of health of the participating countries, who have expressed their commitment to continue and disseminate the reforms of the mental health services in the region. This will involve the transformation of the SEE Mental Health Project's network of regional and country offices into a Regional Health Development Centre for Mental Health in South-eastern Europe, based in Sarajevo, Bosnia and Herzegovina, and a network of national institutions for the coordination and promotion of mental health-related issues. This commitment has been formally expressed in a *Declaration on a long-term programme for regional cooperation and development on mental health*, prepared for signature by the ministers of health of the participating countries. A copy of the Declaration is appended to this report (see Annex 3).

The Declaration must not be interpreted as capping a process, but as ushering in a second and expanded phase of activities that not merely sustain but build on the foundations laid by the SEE Mental Health Project and carry out the full transition to community-based care promised under the Dubrovnik Pledge.

The Dubrovnik Pledge

Meeting the health needs of vulnerable populations in South East Europe

WORLD HEALTH ORGANIZATION
EUROPE

COUNCIL OF EUROPE CONSEIL DE L'EUROPE

ANNEX 1

This Pledge was endorsed at the Health Ministers Forum on meeting health needs of vulnerable populations in South East Europe (Dubrovnik, 31 August – 2 September 2001) – an event which was co-sponsored by the Council of Europe and the World Health Organization, and hosted by the Ministry of Health of Croatia.

The Dubrovnik Pledge

Meeting the Health Needs of Vulnerable Populations in South East Europe

We the Ministers of Health of South East Europe (SEE), gathered here today at the Health Ministers' Forum for Regional Health Development Action in South East Europe recognize the damaging effects on health of recent wars, continuing unrest and conflict, as well as the economic hardships faced by the populations of SEE during their countries' transition to market economies. We accept the challenge to play a key role in strengthening the fundamental human rights of our societies and of vulnerable populations and individuals within them to effective health care, social wellbeing and human development, in line with the principles of the World Health Organization and the Council of Europe.

Focus on specific strategies

We, the Ministers of Health of: Albania; Bosnia and Herzegovina; Bulgaria; Croatia; Romania and the former Yugoslav Republic of Macedonia; and the Federal Secretary for Labour, Health and Social Welfare of Yugoslavia commit ourselves through government action to the following goals.

WE WILL WORK IN PARTNERSHIP with relevant national and international bodies and organizations: to ensure equity, health gain and a better quality of life and health care (including reduced inequalities in its infrastructure and balanced primary and secondary services and public health interventions for the populations of SEE); and to collaborate on issues of common concern, including the harmonization of policies, legislation and information systems, institutional capacity building and networking to build an infrastructure to pursue regional goals and future European integration.

WE WILL MEET THE HEALTH NEEDS OF VULNERABLE POPULATIONS IN SEE, mobilizing human and financial resources to the extent possible to:

- increase citizens' access to appropriate, affordable and high-quality health care services;
- intensify social cohesion by strengthening community mental health services;
- increase the quality of and regional self-sufficiency in the provision of safe blood and blood products;
- develop integrated emergency health care services that are offered free of charge to the user;
- strengthen the surveillance and control of communicable diseases;
- strengthen institutional capacity and intersectoral collaboration for access to affordable and safe food products; and
- establish regional networks and systems for the collection and exchange of social and health information.

Plea to international stakeholders

The Health Ministers' Forum for Regional Health Development Action in South East Europe recognizes the need for assistance from international stakeholders to achieve the goals of this Pledge.

WE LOOK TO the Council of Europe and the World Health Organization for strategic guidance in developing mechanisms to coordinate partnership with national and international agencies in the fulfilment of this Pledge and request their support in organizing a first meeting to monitor and evaluate the progress achieved by such partnership.

WE ASK THAT the international community assist, within the framework of the Stability Pact for South East Europe, by providing resources to support the implementation of the above-mentioned urgent action areas for health reconstruction and development. In so doing, we commit ourselves to transparency and dedication in the implementation and reporting of all project activities and their results.

WE REQUEST that the World Health Organization Regional Office for Europe and the Council of Europe report to their governing bodies about this Pledge and the progress achieved towards its goals.

SIGNATORIES

Albania	**Romania**
Ms Ruki Kondaj Secretary General of the Ministry of Health for The Minister of Health of Albania	Dr Daniela Bartos Minister of Health of Romania
Bosnia and Herzegovina	**The former Yugoslav Republic of Macedonia**
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Bulgaria	**Yugoslavia**
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Croatia	**For the Secretariat of the Meeting**
Dr Ana Stavljenic Rukavina Minister of Health of Croatia	Mrs Gabriella Battaini-Dragoni Director General for Social Cohesion Council of Europe Dr Marc Danzon Regional Director for Europe World Health Organization

Dubrovnik, 2 September 2001

COUNCIL OF EUROPE CONSEIL DE L'EUROPE

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WORLD HEALTH ORGANIZATION
EUROPE

Second Health Ministers' Forum
With the special participation of ministers of finance

Health and Economic Development in South-Eastern Europe in the 21st Century
Skopje, The former Yugoslav Republic of Macedonia, 25–26 November 2005

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Original English

The Skopje Pledge

STABILITY PACT
FOR SOUTH EASTERN EUROPE

SOUTH-EASTERN EUROPE HEALTH NETWORK

ANNEX 2

We, the Ministers of Health of Albania, Bosnia and Herzegovina, Bulgaria, Croatia, the Republic of Moldova, Romania, Serbia and Montenegro, and The former Yugoslav Republic of Macedonia, have gathered for the Second Health Ministers' Forum for health and economic development in South-eastern Europe in Skopje, The former Yugoslav Republic of Macedonia on 25 and 26 November 2005 with the purpose of discussing progress achieved towards the goals of the Dubrovnik Pledge.

Current situation

We acknowledge the importance of the role of the South-eastern Europe (SEE) Health Network - in partnership with the World Health Organization (WHO) Regional Office for Europe and the Council of Europe, supported by the Council of Europe Development Bank and in the framework of the Social Cohesion Initiative of the Stability Pact – in meeting the challenges related to the health needs of vulnerable populations in the SEE region.

We:

- recognize that health, as an integral determinant of social cohesion, and an investment and a major factor in development, is essential to lasting peace, stability and economic progress;
- recognize that regional cooperation in the field of health is a vital part of the European Union (EU) integration process;
- recognize that health and the health systems in the SEE region are facing important challenges;
- recognize that there is a need to continue to develop, strengthen and support work being carried out in this area in general and, in particular, to improve the access of vulnerable populations in society to the health services of the region;
- recognize that there is a need to promote the exchange of experiences within the area of health systems and health system reform, at international, regional and national levels;
- express our gratitude for the support received from international and bilateral institutions and governments, and particularly the important analytical and policy development work of the Council of Europe, the Council of Europe Development Bank and the WHO Regional Office for Europe.

Looking forward

Having reviewed the concerted action taken over the last five years in health development as a bridge to reconciliation, peace and development, we accept the challenge of reforming the health systems in the region and thus contributing to its economic development in the twenty-first century.

WE UNANIMOUSLY AGREE:

- to continue to cooperate beyond 2005 on the initiative: "Health development action for south-eastern Europe: the South-Eastern Europe Health Network" (hereinafter referred to as the SEE Health Network);
- to further consolidate the SEE Health Network alliance at regional level, according to its agreed Statutes, which form an integral part of this Pledge (Annex);

- to assume full responsibility for regional cooperation on health and health-related projects;
- to continue regional cooperation and concerted efforts to improve the health systems of the countries in the SEE region in order to secure universal access to high-quality public health services for the populations of the region, based on sustainable financing;
- to confirm our commitment to implement action in the thematic areas identified in the Dubrovnik Pledge and, in doing so, to develop and apply the common criteria and procedures outlined in the Statutes;
- to demonstrate the economic potential of health as a means to increase productivity and decrease public expenditure on illness: a healthy population works better and produces more;
- to strengthen regional collaboration and coordination on preparedness planning for emerging priorities and to put this forward as a priority for action within the SEE Health Network;
- to advocate that national governments should put health higher on the political agenda and ensure that health is reflected in the policies and strategies of other sectors;
- to empower health professionals to ensure a sustainable long-term improvement in public health.

WE COMMIT OURSELVES to transparency and dedication in the implementation and reporting of all project activities and their results.

Plea to international stakeholders

The Second Health Ministers' Forum on Health and Economic Development in South-Eastern Europe recognizes the need for assistance from international stakeholders to achieve the goals of this Pledge.

WE LOOK TO the Council of Europe and the WHO Regional Office for Europe for strategic guidance in further consolidating regional cooperation through concerted action to improve the health systems in the region and provide its populations with universal access to high quality health services. We also request their support in the further implementation of action related to the thematic areas outlined in the Dubrovnik Pledge and in fulfilling the commitments of this Pledge.

WE ASK THAT the international community assist by providing resources to support the implementation of urgent action for health and economic development in the above-mentioned areas. In doing so, we commit ourselves to transparency and dedication in the implementation and reporting of all project activities and their results, in accordance with the Statutes of the SEE Health Network.

WE REQUEST THAT the WHO Regional Office for Europe and the Council of Europe report to their governing bodies on this Pledge and the progress achieved towards its goals.

SIGNATORIES

Ministers of Health of the SEE Member States

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Minister of Health

BOSNIA AND HERZEGOVINA
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BULGARIA
Professor Radoslav Gaydarski
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CROATIA
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REPUBLIC OF MOLDOVA
Professor Ion Ababii
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ROMANIA
Mr Vasile Loca, Charge d'Affaires a.i., Embassy of Romania to The former Yugoslav Republic of Macedonia

SERBIA and MONTENEGRO
Professor Miodrag Pavlicic
Minister of Health of the Republic of Montenegro

THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA
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Witnessed in the presence of:

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GREECE
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NORWAY
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SLOVENIA
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SWITZERLAND
Mr Romain Darbellay,
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Council of Europe Development Bank
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Social Cohesion Initiative of the Stability Pact for South Eastern Europe
Mr Laurent Guye, Director of Working Table II-Economy

WHO Regional Office for Europe
Dr Marc Danzon
Regional Director for Europe

Skopje, The former Yugoslav Republic of Macedonia, 26 November 2005

South-eastern Europe Health Network
"Health development action for South-eastern Europe"

Declaration

on a Long-term Programme for Regional Collaboration and Development on Mental Health

by

the ministers of health of the member countries of the South-eastern Europe Health Network

DRAFT

Seventeenth Meeting of the South-eastern Europe Health Network

Original: English

Zagreb, Croatia, 7-8 December 2007

Paper no 14

ANNEX 3

We, the Ministers of Health of the countries of south-eastern Europe (SEE), (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Montenegro, the Republic of Moldova, Romania, Serbia and The former Yugoslav Republic of Macedonia), met with the Council of Europe and the WHO Regional Office for Europe, in the framework of the Stability Pact Initiative for Social Cohesion, in Sofia, Bulgaria from 21 to 23 June 2007, for the Sixteenth Meeting of the SEE Health Network.

RECOGNIZING that the recent enlargement of the European Union has reinforced the importance of public mental health for the region, and that the European Commission (EC) is preparing a mental health strategy, thus demonstrating that mental health is one of the priorities of EC public health policy;

RECALLING that the WHO Mental Health Declaration for Europe, Facing Challenges, Building Solutions (2005), expressed concern that the disease burden from mental disorders is not diminishing and that many people with mental health problems do not receive the treatment and care they need;

COGNIZANT of the very substantial mental health needs of the population in our countries, particularly related to problems such as stress, depression and post-traumatic stress disorder, and the specific needs of vulnerable populations, and also aware of the challenges that must be met in order to provide decent and effective care for people suffering from severe and long-term mental health problems, many of whom are still living in mental institutions;

LOOKING BACK with satisfaction on the achievements of the Mental Health Project for South-eastern Europe, which has contributed considerably to addressing some of these needs by developing modern national mental health policies and legislative frameworks, establishing a pilot community mental health centre in each of the nine countries, and designing and delivering training for human resources in mental health;

HIGHLY COMMITTED to consolidating current achievements, with a view to establishing comparable systems for collecting and processing mental health information in each country of the Network;

WARMLY WELCOMING the achievements in mental health that have served as a vehicle for peace-building and reconciliation, and have contributed to improving the well-being of the population of south-eastern Europe;

CONCERNED that these gains and opportunities should not be lost, and that countries should build on the successes achieved and unite their efforts in the mental health field in order to move into an era of sustainability, international cooperation, self–determination and growth;

HOPING that the European Union's public health policy for SEE countries will offer opportunities for the development of coordinated initiatives in mental health in the region;

RECOGNIZING the need to transform the Mental Health Project into a long-term programme for regional collaboration in order to maintain mental health as a priority on the public policy agenda;

HIGHLY APPRECIATING and strongly supporting the initiative of Bosnia and Herzegovina to bring about the establishment of a regional centre for collaboration on mental health;

GRATEFULLY ACKNOWLEDGING the fact that all the countries in south-eastern Europe and the intergovernmental organizations so far involved in the Mental Health Project support the establishment of such a regional centre for collaboration on mental health;

CONFIRMING our full commitment to the implementation of the WHO Mental Health Declaration for Europe, which was endorsed by the Ministers of Health of all our countries in Helsinki on 15 January 2005, the recommendations and conclusions of the Second Health Ministers' Forum that was held in Skopje in November 2005, and Recommendation R(2004) 10 of the Council of Europe on the protection of the human rights and dignity of persons with mental disorder;

We, the Ministers, adopt the following:

DECLARATION
on a
Long-term programme for regional collaboration and development on mental health.

We support the transformation of the Mental Health Project for south-eastern Europe into a long-term programme for regional collaboration and development on mental health, under the conditions laid out in the Proposal of the SEE Regional Cooperation Process.

We support the establishment of a regional centre for collaboration on mental health, to be based in Bosnia and Herzegovina, the role of the centre being to plan, coordinate and evaluate activities contributing to the development of mental health promotion, prevention, service delivery and social inclusion by:

- collecting information and disseminating evidence and regional experience;
- identifying, lobbying and applying for resources for new projects in mental health;
- facilitating sustainable reform in mental health and, in particular, developing integrative community mental health services;
- promoting the development of an adequate and competent workforce;
- evaluating and reporting on achievements;
- identifying and building up partnerships and collaboration with the European Commission and international organizations working in this field.

To this end, we recommend that the following measures be taken:

- the establishment by the authorities of Bosnia and Herzegovina of a legislative framework for the Regional Centre for Collaboration on Mental Health;
- the establishment of mechanisms to ensure country ownership of the Regional Programme;
- the introduction over a period of three years of mechanisms to ensure sustainability;
- country participation in mental health programmes, in accordance with national priorities;
- the maintenance of a spirit of transparency and accountability.

We confirm our commitment to the introduction of sustainable reform in mental health for south-eastern Europe.

That we request the Council of Europe, the Council of Europe Development Bank and WHO Regional Office for Europe to provide us with continuous guidance and technical support in implementing our national and regional commitments;

We extend our appreciation and thanks to those who have contributed to the achievements of the last four years as members of the Steering Committee and the Executive Committee, donors and partner organizations, as well as individual experts who supported the work.

Finally, we invite the donors and partner organizations to consider supporting the transformation of the successful Mental Health Project initiative into a long-term programme through the establishment of the Regional Centre for Collaboration on Mental Health; in this regard, we welcome the interest expressed by the International Organization for Migration in collaboration in the area of mental health.

SIGNATURES:

ALBANIA:

BOSNIA AND HERZEGOVINA
Federation of Bosnia and Herzegovina:

Republika Srpska:

BULGARIA:

CROATIA:

MONTENEGRO:

REPUBLIC OF MOLDOVA:

ROMANIA:

SERBIA:

THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA:

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WHO REGIONAL OFFICE FOR EUROPE:

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Date

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