BULGARIA

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

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

Table 1: Psychiatric Disability Rates:
Age-group Percentage of Disabled Who Are “Psychiatric”

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 – 19</td>
<td>31.3%</td>
</tr>
<tr>
<td>20 – 29</td>
<td>18.8% (11.7% due to schizophrenia)</td>
</tr>
<tr>
<td>30 – 39</td>
<td>15.3%</td>
</tr>
<tr>
<td>40 – 49</td>
<td>6.6%</td>
</tr>
<tr>
<td>50 – 59</td>
<td>3.8%</td>
</tr>
<tr>
<td>Over 60</td>
<td>2.3%</td>
</tr>
</tbody>
</table>

Rates of Mental Illness

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

Table 2: Rates of Mental Illness

<table>
<thead>
<tr>
<th></th>
<th>1991</th>
<th>1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence of mental disorders:</td>
<td>26.4 per 1000</td>
<td>28.3 per 1000</td>
</tr>
<tr>
<td>Incidence of mental disorders:</td>
<td>3.1 per 1000</td>
<td>1.0 per 1000</td>
</tr>
<tr>
<td>Mortality among psychiatric patients:</td>
<td>8.4 per 1000</td>
<td>10.4 per 1000</td>
</tr>
</tbody>
</table>

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

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Mental Health Services in Bulgaria

Outpatient psychiatric care in Bulgaria is provided by; small outpatient units, which are very few; outpatient clinics (dispensaries) which are either autonomous facilities or attached to general hospitals; and ambulatory units at general polyclinics and hospitals. The latter provide predominantly consultation and referral to psychiatric clinics and hospitals. Inpatient psychiatric care is provided by large psychiatric hospitals and university clinics and also by psychiatric wards in general hospitals. The overall number of beds is shown in Table 3.

<table>
<thead>
<tr>
<th></th>
<th>1992</th>
<th>1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>General psychiatry</td>
<td>6843</td>
<td>6242</td>
</tr>
<tr>
<td>Child psychiatry</td>
<td>90</td>
<td>80</td>
</tr>
<tr>
<td>Drug addiction and alcohol</td>
<td>1037</td>
<td>361</td>
</tr>
<tr>
<td>Old age psychiatry</td>
<td>180</td>
<td>187</td>
</tr>
<tr>
<td>Total</td>
<td>8150</td>
<td>6870</td>
</tr>
</tbody>
</table>

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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Beds for adults</td>
<td>4945</td>
</tr>
<tr>
<td>Beds for children and teenagers</td>
<td>2230</td>
</tr>
<tr>
<td>Total</td>
<td>7175</td>
</tr>
</tbody>
</table>

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

Table 5: Mental Health Personnel

<table>
<thead>
<tr>
<th></th>
<th>1992</th>
<th>1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>678</td>
<td>692</td>
</tr>
<tr>
<td>Nurses</td>
<td>1316</td>
<td>1210</td>
</tr>
<tr>
<td>Social workers</td>
<td>30</td>
<td>29</td>
</tr>
<tr>
<td>Psychologists</td>
<td>62</td>
<td>77</td>
</tr>
</tbody>
</table>

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

Mental Health Care Reform

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

Principles of the Reformed Services

Public Health Approach

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

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

System Approach

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

Human Rights

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

Mental Health Priorities

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

Multidisciplinary Teamwork and Community-Based Psychiatry

Community-orientated health services in Croatia are provided by 120 primary health care centers, with more than 1,500 general practitioners and 21 public health facilities. These cooperate with local centers for social work and with educational institutions. Some 222 psychiatrists are employed in the national health institutions, providing out- and inpatient services for a population of 4.7 million. In addition, about 50 percent of 160 neuropsychiatrists (who completed their specialty training prior to the splitting of the two disciplines) are also dealing with psychiatric disorders.

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

Reports from 1998 show that there were 0.22 psychiatric beds per 1,000 population in general hospitals with the average length of stay being 17.5 days. In addition to this, there were 0.74 hospital beds per 1,000 in hospitals providing services for chronic psychiatric patients, where the average length of stay was 70.1 days. Bed utilization in psychiatric wards was among the highest of all hospital units, reaching the 100 percent level.

In Croatia, there was a decrease of 21.3 percent in the total number of hospital beds between 1990 and 1996. The decrease in psychiatric beds was even higher, amounting to 25.3 percent. The national Public Health Institute maintains a Register of Psychoses. In 1995, there were 7,759 admissions of 5,396 schizophrenic patients. Out of this number, 572 patients were in hospital care during the whole year and their share of hospital days represents 36.8 percent of the total days of hospital treatment for schizophrenic patients.

Intersectoral Cooperation

Several government bodies have been formed, some of them permanent and others temporary, to improve a particular service or activity for those with mental disorders. Recently, a Commission has been established to monitor the care of persons with mental disorders. It includes representatives of different government bodies, including the health and social welfare authorities, legal experts, and other professionals dealing with ethics and public relations. One of the tasks of this Commission is to encourage the implementation of mental health promotion programmes. In 1999, the Ministry of Health formed a special body to develop improvements in the already-existing community-based psychiatry. The Croatian Association of Psychiatrists has also elaborated a draft version of a framework for this.

Several mental health programmes have been considered for further development:

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

The Commission for Narcotics is a permanent government body, comprising representatives of all authorities responsible for drug abuse, including the health, education, and social welfare authorities. A strategy on prevention of drug abuse has been accepted by the Croatian Parliament and is currently being implemented. Several other commissions, with more global tasks, have been formed to examine the possibilities of improvement in the quality of life of particular population groups, such as children and the elderly. These commissions include representatives of various government bodies concerned with the target groups. In view of the high incidence of war-related psychological trauma, a Council of Experts was formed to propose, elaborate, and implement psychosocial programmes for war victims.

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

Mental Health Legislation

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

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

Psychiatry and Recent Changes in Society

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

Professionals and the Network of Treatment Facilities

In 1999 there were 1,184 psychiatrists, 3,581 psychiatric nurses and numerous psychologists, social workers, lay therapists and other professionals serving mentally ill patients. The overall number of psychiatric beds was 11,605 and most of these were in psychiatric hospitals (10,007). The total number of beds in residential facilities has decreased markedly within the last ten years (by approximately 3,500 beds) although the number of psychiatric hospitals (21) and the number of psychiatric departments in general hospitals (26) remained the same. There is now about one psychiatric bed per 1,000 of population. The average duration of hospitalization decreased during the last ten years from 109 days to 82 days in psychiatric hospitals and from 34 to 25 days in psychiatric departments of general hospitals.

The number of outpatient services increased correspondingly, with less than 400 psychiatrists in outpatient services in 1989, to 525 in 1997. (Information provided by the Institute for Health Information and Statistics, Prague.)

Deinstitutionalization, De-stigmatization, Reintegration: Dreams and Reality

There is no doubt that the trends in psychiatric care in the Czech Republic are similar to those in other European countries, which means less and shorter treatment in hospitals and more intervention in the patient’s natural social and familial environment. The data presented above confirm this tendency and it should be added that the changes have substantially improved the quality of treatment provided in hospitals as well as the living conditions of patients. Despite these positive changes, much remains to be done with regard to rehabilitation and social reintegration of mentally ill patients. The current
shortcomings are partly due to limited financial resources. The costs of treatment are covered by the health insurance fund, but for other interventions, which are considered to be rather social support than treatment, such wide coverage does not exist. The other obstacle is that the traditional psychiatric treatment facilities are not appropriate to fulfill these tasks. The majority of work in this field was done by various nongovernmental organizations. Despite this new sector growing rapidly, it is still not able to provide for the demand. It should be added however, that there are a number of very promising initiatives in sheltered housing, sheltered work and reintegration into the community.
Over 920,000 people (over 2% of the whole population) are treated annually in psychiatric outpatient facilities (including substance abuse facilities). Over 160,000 patients are hospitalized in a year. The numbers of those admitted to hospital on account of a psychosis was 63 per 100,000 population. Over the years 1990–1996, the numbers with non-psychotic disorders in outpatient care increased by 45 percent (from 275 per 100,000 population in 1990 to 395 in 1998), whilst those with alcohol-related disorders increased by 25 percent (from 90 to 115 per 100,000 population) and with drug-related disorders by 100 percent (3.5 to 7.6). While the number of those with non-psychotic disorders in inpatient care did not change in the years 1990–1996, the numbers of new cases of alcohol- and drug-related disorders rose (by 42 and 117%, respectively). The estimated level of alcohol consumption increased in the 1990s by about 40–50 percent, but was declining again towards the end of that decade. The actual number of people in the country with alcohol dependence is estimated to range between 700,000 and one million. The number of those dependent on drugs in 1996–1998 was estimated to be between 25,000 and 45,000.

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

**Mental Health Legislation**

The following legal acts regulate mental health issues:

- The Mental Health Act adopted with amendments by the Polish Parliament in 1994. It provides legal protection to persons with mental disorder and defines legal principles concerning the relations between patients and staff.
- The Act on Social Assistance of 1990, with subsequent changes.

Medical faculties exist in 11 universities in Poland. After six years of medical studies and 18 months’ internship, trainee specialists have a five-year programme with an additional two years for child and adolescent psychiatry. In 1998, there were 2,480 psychiatrists, equivalent to 0.064 per thousand general population. There are also 1,483 psychologists working in the psychiatric services, mainly engaged in psychotherapy or psychosocial and rehabilitation programmes. In 1998, 7,326 registered nurses were employed in psychiatric inpatient services. The number of psychiatric beds in 1998 was 30,455, with 155,189 admissions during the year. Of all psychiatric beds, 80 percent were still in mental hospitals; people addicted to alcohol account for 30 percent of patients in
psychiatric wards and hospitals.

Intersectoral Cooperation

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

About 2,000 clinical psychologists, 450 social workers (only a few with a university degree), and almost 800 therapists are working in psychiatric units. According to the Mental Health Act of 1994, the Minister of Health and Social Welfare is responsible for the organization of responsibilities for the whole psychiatric care system, but the question of mental health is considered an intersectoral one, and many ministries are collaborating in the organization of the various services needed by those with mental health problems. According to the Mental Health Act, the local authorities should establish and operate mental health care facilities, as well as organize services and nursing homes to provide for the specific needs of mentally disordered persons. Coordinating teams have been created at the level of the county, consisting of representatives of those services providing health care to the mentally disordered. The team acts also as an advisory body in matters of social policy concerning mental health issues and the needs of psychiatric care including the allocation of financial resources. A voluntary Coalition for Mental Health was set up in 1993 as a national organization including many self-help and related associations and groups.

Deinstitutionalization

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

The main forms of psychiatric care and delivery of alcohol or drug abuse treatment are outpatient clinics and various forms of intermediate care – day hospitals, mobile community teams, crisis intervention centres and rehabilitation facilities. In 1998, there were 603 outpatient mental health clinics, 419 outpatient alcohol treatment facilities and 34 outpatient clinics for those dependent on drugs.
For intermediate care, in 1998 there were 112 day centres (56 in 1985 and 100 in 1995), with a total of 2,464 places. This form of care was provided to 8,691 patients. The number of day clinics is expected to increase to 430 by the year 2005. Though the network of outpatient clinics is quite well developed, only 71 percent had a full-time psychiatrist and were open every day.

Community-Based Psychiatry

The first community-based teams were set up in the 1970s, but the lack of financial resources for training professionals was the main reason for the slow progress in this field. The situation changed rapidly in 1995, when psychiatrists from Holland offered technical assistance to Polish community-based psychiatry. Mobile community teams were first organized in six centres and are now functioning in 19 centres. In 1999, they provided treatment to 2,262 patients (i.e. to 17% more than in 1997). Teams work mostly in large cities, but recently more attention has been focused on the population in the countryside. It is expected that 141 mobile community teams will have been established by the year 2005.

Alcoholism

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

National Mental Health Programme

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

- The main form of psychiatric care will be outpatient facilities, with greater involvement of general practitioners, social services, case managers, and multidisciplinary therapeutic teams.
- Intermediate care facilities are to be developed in the local communities, including day hospitals, mobile community teams, emergency services, rehabilitation facilities and sheltered housing.
- Hospital care is to be provided mostly in psychiatric wards of general hospitals. Large psychiatric hospitals are to be dismantled or transformed for some other purpose.
- The number of psychiatric beds is to decline by about 20 percent, i.e. to the level of 0.53 per thousand population by the year 2005. The number of beds per
hospital is to be reduced to no more than 350.

- Communal coordinating teams should be created at the level of county areas, consisting of representatives of services providing health care to the mentally disordered. The team should also serve as an advisory body in matters of social policy concerning mental health issues and the needs of psychiatric care (including allotment of financial resources).

- The quality of care in psychiatric facilities will be improved by introducing a system of quality monitoring. In addition, a programme of postgraduate training for general practitioners is now under development and an internship in psychiatry for medical school graduates was introduced from the beginning of 2000.

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

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

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

- Deinstitutionalization and improvement of the quality of care;
- Development of community-based psychiatry;
- Mental health promotion.

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

Mental Health Care

Mental health care in Romania is concentrated in the psychiatric hospitals and wards although the number of psychiatric beds is not high (76.1 beds per 100,000 habitants). The total number of beds is 16,895, with 13,374 in mental hospitals, 3,521 in general hospitals, 605 in other settings. Psychiatric beds represent 11 percent of all hospital beds in Romania. There are 861 adult psychiatrists and 240 child psychiatrists. Some of the care outside the hospitals is provided by “Mental Health Laboratories”, which are organized on an autonomous basis or within polyclinics. These should be centres for community care, but in reality, they are not, with probably only 10 percent of these “laboratories” having an activity approaching this. Many consist simply of a psychiatrist, with no therapeutic team, providing basic outpatient care. Some therapeutic units do have nurses (who do not have a specific training) and psychologists working with the psychiatrists. Social workers are a rarity, however, and the number of nurses and psychologists is insufficient. A few units have work therapists, but these are insufficiently qualified.

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

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

Ideology of the Care Process

Mental health is not officially considered a priority matter of public health. There is a tendency (frequently undeclared) to stigmatize psychiatric patients and unfortunately the mass media sustain this. The principles of community psychiatry (which include putting the patient as the therapist’s partner) are only put into practice in isolated cases. Paternalism is prevalent; but it must be admitted that in the last 5–6 years, there has been increasing acceptance and respect for both the patient’s rights and psychiatric ethics. The international documents that set out patient’s rights have not yet been officially included in any normative documents in Romania.
The following are a list of shortcomings which need to be addressed:

- Lack of up-to-date comprehensive studies on morbidity or studies evaluating population needs within a definite area or with certain risk factors;
- Lack of (or only a rudimentary level of) multidisciplinary teams for outpatients, due to the reduced number (or even the absence) of persons and/or necessary positions (psychologists, social workers, vocational therapists, legal advisors); the development of social protection and non-medical ways of helping some categories of mentally ill patients and some populations with a high risk for mental illness;
- There are insufficient day centres and counseling services (of various types);
- There is a lack of effective coordination of the care services at the national level;
- Postgraduate specialist training is still based on an excessively biological and reductionism model, which seems to promote pharmacotherapy as the only really effective and credible therapeutic approach. Continuing education is inadequate;
- The liaison psychiatry, forensic psychiatry, community psychiatry and psychotherapy are not officially recognized;
- The general practitioners and other specialists lack basic psychiatric knowledge and have little capacity to provide psychiatric help or make referrals to psychiatrists.

**Mental Health Needs**

Priorities should include:

- The elaboration and implementation of a Mental Health Law. [In December 1999, a Project of the Law concerning the promotion of mental health and the protection of rights of the persons suffering of mental disorders was elaborated by a work group consisting of representatives of the Romanian Psychiatric Association and Romanian League for Mental Health, with consultant help from WHO Geneva and WHO Romania.]

- This Law stipulates the elaboration of the National Plan of Mental Health which will include the necessary elements for the planning and implementation of the mental health reform in Romania.

- The National Plan of Mental Health will be based on an analysis of a mental health assessment (morbidity and mortality figures) in Romania and will include items such as, prevention, deinstitutionalization, community care, multidisciplinary teamwork, training and intersectoral cooperation.

**Mental Health Promotion**

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

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

**Equity and Human Rights**

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

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

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

**Mental Health Audit**

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

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

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

Compiled by Martin B. Tracy, Ph.D.
ILO External Consultant

October 10, 2004