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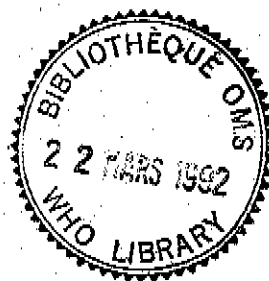
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PRIORITIES FOR COLLABORATION WITH COUNTRIES OF CENTRAL AND EASTERN EUROPE IN THE FIELD OF MENTAL HEALTH

Report on a WHO Meeting



Amsterdam
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EUR/HFA TARGET 4

This activity was organized by the WHO Regional Office for Europe to promote work aimed at achieving the following target in the health for all strategy.^a

TARGET 4

REDUCING CHRONIC DISEASE

By the year 2000, there should be a sustained and continuing reduction in morbidity and disability due to chronic disease in the Region

Index terms

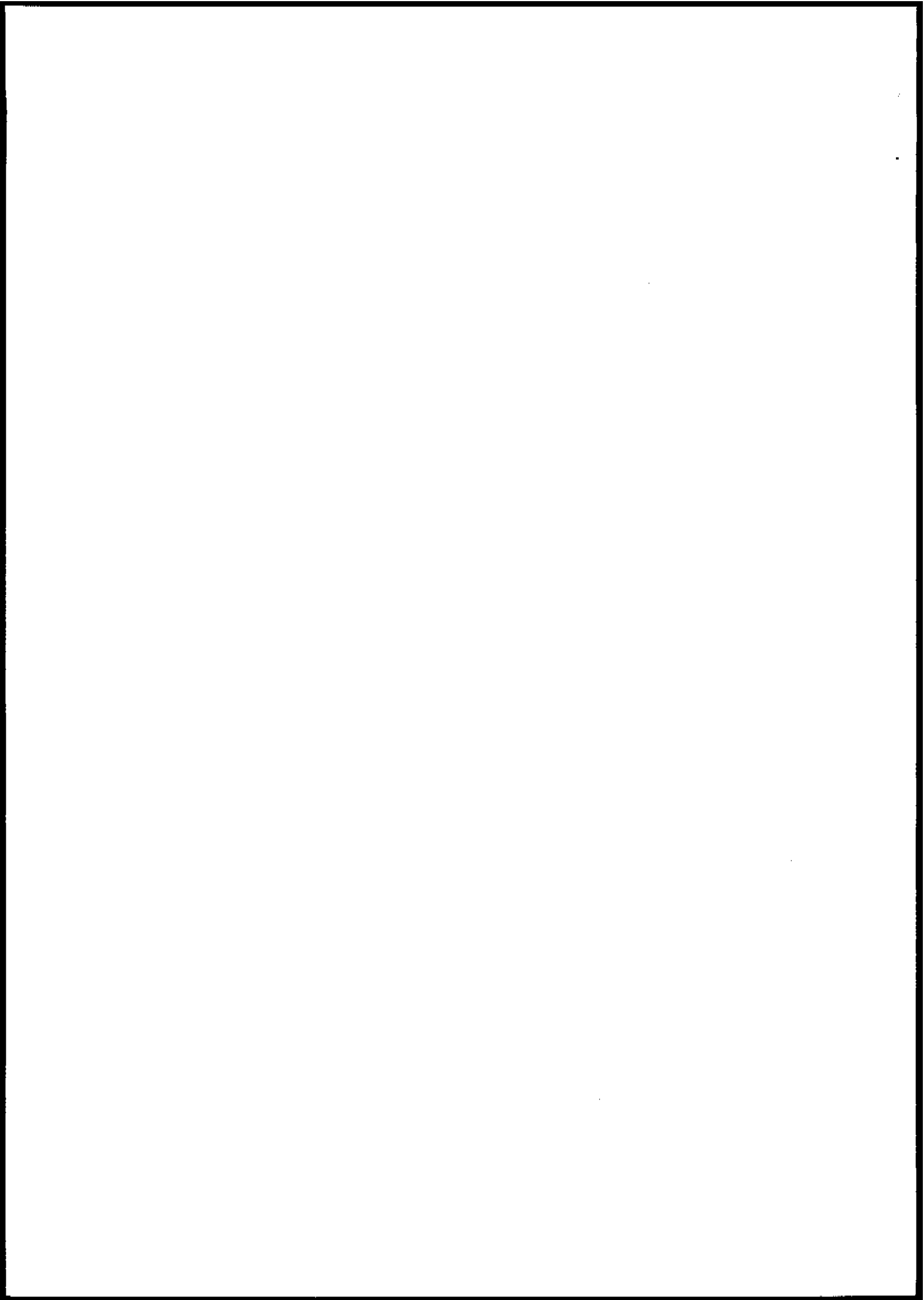
**MENTAL HEALTH
MENTAL HEALTH SERVICES
INTERNATIONAL COOPERATION
CCEE
CZECHOSLOVAKIA
HUNGARY
YUGOSLAVIA
ROMANIA
POLAND
GREECE**

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^a Updating of the European HFA targets. Copenhagen, WHO Regional Office Europe, 1991 (document EUR/RC41/Inf.Doc./1 Rev.1).

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Introduction

The participants at the meeting on the exchange of information with mental health advisers and experts from countries of central and eastern Europe met in Amsterdam on 9 April 1991 to share information on mental health care developments and discuss the priorities for collaboration in the field of mental health. The participants comprised eight mental health advisers and experts from countries of central and eastern Europe (CCEE), eight from other European countries and two WHO staff members, one from the WHO Regional Office for Europe and one from WHO headquarters.

Ms Ada Wildekamp, Alderman, Health and Social Affairs, City of Amsterdam, welcomed the participants and conveyed her best wishes for the success of the meeting, and reminded everyone that progress in the political process was usually slow, and needed considerable determination. Dr J.G. Sampaio Faria, Regional Adviser for Mental Health, WHO Regional Office for Europe, explained the context of the meeting and outlined the main initiatives being developed by the Regional Office in the field of mental health within the intensified programme of cooperation with CCEE which had been established in 1989.

Detailed reports on the present situation and characteristics of the mental health systems in CCEE were introduced by the mental health advisers and experts attending the meeting. A comprehensive discussion on the major priorities to contemplate in the collaboration to be fostered followed the presentation of the country reports.

Reports from participants

Professor Assen Jablensky began by saying that the problems in the mental health field being faced by Bulgaria are to a large extent similar to those of many other CCEE, although significant differences can also be identified as a result of the dissimilarities in the historical background of each country.

One common problem inherited has been the ideological control by the State and the low priority in many instances that responsible authorities place on mental health care. During the 1950s a Pavlovian model was predominant, there were considerable staff purges, and a marked isolation of psychiatry from western ideas. Linked with this isolation there was backwardness in clinical and research methods. Nevertheless, there were cycles of growth and positive developments in many countries of central and eastern Europe, which were mainly linked to individuals and to small groups. In some countries the so-called dispensary system was introduced with the idea of providing comprehensive mental health care to long-term care patients and should be seen as an example of a positive step forward in the direction of community care.

The following issues are predominant at present: (1) continuing paternalistic attitudes by medical staff towards patients and to the population; (2) a persisting marked stigma towards psychiatric patients against which practically no measures have been taken for the last 40 years; (3) insensitivity to patients' rights, which have not been seen as a top priority issue, which resulted in the proliferation of administrative regulations at different levels and in the restriction of patients' rights and the rights of people who have been in contact with psychiatric services. Examples of this are, for instance, the ease with which a driver's licence can

be withdrawn from a psychiatric patient, or the restriction to education in people who have been diagnosed as psychotic; (4) a persisting outdated mental health legislation; and (5) a very serious underfunding of mental health care, which has very often been at the bottom of the ladder of priorities of health ministries.

Professor Jablensky identified the following emerging trends: the presence of a number of younger and critical psychiatrists; the influence of reform movements from outside official psychiatry; an increasing emergence of nongovernmental organizational self-help and mutual aid groups; and a recent developing interest in psychotherapeutic, behavioural and sociotherapeutic forms of treatment. In conclusion, he indicated that the eminent reform process should take a bottom-up rather than top-down approach, and would form around coalitions cutting across traditional strata, and forming alliances between patients, relatives, professionals and citizens who are interested for the first time in mental health as an individual right.

In his introduction, Dr Skoda reminded participants of the deep historical and cultural differences within Czechoslovakia between the formerly Austrian part (now Bohemia) and the formerly Hungarian part (now Slovakia). In the former, large psychiatric institutions were established, usually outside towns, while in the latter psychiatric beds were far more often located within general hospitals. Czech services have benefited over the last 30 years from a sophisticated information infrastructure which was established according to advice from the World Health Organization and from Dr Morton Kramer.

Dr Skoda passed to the Chairperson and some of the participants a booklet with about 30 figures of the most important parameters of health care availability and consumption in the field of mental health. An extract of it (Table 1) is attached as Annex 1.

Up to the present there are no private beds within the psychiatric system. Thus the psychiatric information system (PIS) has so far covered the full extent of mental health care provision. The inpatient service utilization data shown in Table 1 indicate that in recent years, half of all first-time admissions of males aged from 30 to 59 years in the Czech Republic and two thirds of all such admissions in the Slovak republic were for alcohol and drug-related conditions. In the group aged 60 years and over, organic psychosyndrome constitutes the main cause of increasing incidence rates of inpatient treatment.

Up to the present there are no private beds within the psychiatric system, and service utilization data indicate that about a third of all admissions in the age group 30 to 59 years are for alcohol and drug-related conditions. In the age group 60 years and above, organic psychosyndromes constitute the main cause of admission.

Particular concern exists also with the legal and training aspects of substance abusers with psychopathological personality. In Czechoslovakia, there has been no significant criticism against clinical psychology as has happened in other CCEE. Psychology has therefore positively contributed to the development of psychotherapy, psychodiagnostic and psychosocial rehabilitation. As a result of the low standards of care existing in some inpatient facilities, a large movement of psychiatric reform attempt was initiated in the 1960s. In this period, psychiatric care became one high priority within the health care priorities leading to the conspicuous

development of outpatient care in the country which is at present evenly distributed throughout the country. However, the treatment offered in these outpatient facilities was almost exclusively biological with a generalized trend for medicalizing disorders related to social problems. Hospital care is largely undifferentiated, and it is hoped that within the framework of the new proposal for health policies and legislation the present pattern of services could evolve in the direction of a more differentiated community-based system of mental health care.

Lay and voluntary organizations active in the field of mental health are emerging in Czechoslovakia. This bottom-up movement is expected to have a precipitative impact on the overall development of mental health care.

Dr Buda contrasted the previous organization of services in Hungary, which were centralized and monolithic, with more recent regionalist developments, with the former arrangements characterized by control and neglect. Nationally there are now 13 000 beds for a population of 10.5 million. A total of 1200 medical doctors are specialists in psychiatry and 800 of these, in addition to 1000 psychologists, are working in the mental health field. Dr Buda identified three stages in the development of Hungarian psychiatry over the last 30 years. First, up to 1960 the period was characterized by total neglect of psychiatry as the prevailing assumption was that the social system will reduce psychiatric afflictions. The total number of beds available in the country was 5000. Second, after 1960, the service developed slowly, with an addition of 5000 acute and 2000 long-term beds. During this period, new young doctors specialized in psychiatry and became critical to the existing situation. Some changes resulted from this movement, such as full scale and practical developments of rehabilitative care, resocialization services and psychotherapeutic treatment. Third, there has been a period of transition since 1990: private practice is now possible, a health insurance model is being developed to allow the participation of the private sectors, and local administrative committees to decentralize services is being encouraged. At present, Hungary has the highest ratio of psychoanalysts per population among CCEE and a large number of young professionals are now being trained as psychoanalysts, including family therapy and behaviour therapy. All these treatment modalities have been adopted by a growing private practice as the structure of psychiatric care is still rather unofficial and hospital based.

Approximately half of psychiatric hospital beds are occupied by patients with alcohol-related conditions, and Dr Buda added that there are high prevalence rates of depression and suicide in Hungary but few crisis services. Moreover, there are very severe economic problems in funding proper services. Mental health and psychiatry do not constitute a top priority in Hungary, and there is a generalized belief among psychiatrists that progress is only possible if based on the contribution of self-help organizations and mental health professionals. In 1980 a large group of psychiatrists founded a new national association of psychiatrists. This new association has at present 2000 members, including psychologists and general practitioners with psychosocial interests. There is also a trend to separate neurology from psychiatry.

Dr Kalicanin reported that in Yugoslavia, in 1960, there were 22 000 psychiatric beds distributed by 17 hospitals for a population of 22 million. Outpatient services were not developed. The Mental Health Institute in Belgrade was founded in the 1960s as well as some other institutions with a social psychiatric orientation. These initiatives hastened the development of

outpatient services, dispensaries and differentiation of mental health care services. In 1972 a move was made in Belgrade and Serbia to link psychiatric services to primary health centres for sectors of between 50 and 100 000 inhabitants. The services were provided with one psychiatrist and one nurse per 20 000 inhabitants, and one psychologist, one social worker and one "social pedagogue" per 40 000 population. These workers would contact patients in health centres, social centres, schools and factories. Also during this period psychiatric departments were opened in general hospitals in Serbia. At present, about half of all psychiatric beds are in general hospitals and the remainder are in specialized psychiatric hospitals. Of all inpatients, about 33% are diagnosed as schizophrenic, 25% have alcohol-related conditions, and 30% have been in hospital for over one year. Mental health care is highly medicalized and training of mental health professionals and general practitioners are thus biologically oriented. As a major factor for the improvement of mental health care, Professor Kalicanin mentioned the need for comprehensive education of professionals and participation of other social sectors in the process of reform.

Professor Wald emphasized the very severe economic difficulties present in Poland. Apart from Turkey, Poland has the lowest proportion of national wealth spent in Europe on health service provision, with 3.7% of gross national product (range for EC countries is 5.2-11.3%). Several factors appear important in the recent development of psychiatric services in Poland: the perception of the patient as an individual in his or her own right, the predominance of a biomedical model, a scarcity of public education on mental health needs, concern with the number and quality of psychiatric personnel who are not sufficiently differentiated and trained in modern treatment techniques, and very uneven distribution of services within the community, along with an outdated mental health law from 1952. There are a few community-oriented types of service as well as scarce rehabilitation units. The mental health law is from 1952 and requires updating and revision. Psychiatric services are separated from primary health centres, as well as from other medical specialties, and social sector psychiatrists are accorded low prestige and priority. Apart from some developments for drug and alcohol-related conditions, there is no self-help movement in Poland. Notably the recently appointed Minister of Health and Welfare in Poland is a psychiatrist. Dr Wald concluded by indicating that a thorough review of the situation is required to modernize services.

Dr Bomba stressed the present great heterogeneity of apparatus and service development throughout Poland. He did, however, indicate a number of positive trends, for example slowly developing community services (particularly in Cracow, Gdansk and Warsaw). These include home care programmes for the seriously mentally ill and crisis intervention services. In Gdansk there is also a comprehensive child mental health care system. An association for family members has recently been established and is planning to open its own work centre. Dr Bomba's service in Cracow had, however, recently encountered difficulties in opening sheltered accommodation for the mentally ill, when local residents feared a fall in the value of their own apartments. Loans for developing services are possible. However, under the present economic crisis, its repayment is difficult.

Dr Oancea reported that, until 1989, Romania experienced a long dark period of fortuitous isolation which had severe consequences for mental health professionals. The country is now in a period of transition as it strives towards regaining its place in the European community. Romania finds itself in an unusual situation with unusual needs, greater than those of other

countries. The Romanian return to Europe is more difficult than that of other countries owing to two main obstacles: lack of funds and lack of international connections.

Dr Oancea emphasized the essential technical support offered by WHO in Romania over the past two years. Other international organizations such as UNICEF, Handicap International and Red Cross, as well as national and voluntary groups, have also offered substantial help. Now it is necessary to harmonize all those efforts, which have been isolated and fragmented, in order to support the Romanian national, regional and local development programmes.

Part of this effort was the funding of documentary visits on general topics in countries such as Denmark, France, Ireland, Netherlands and the United Kingdom for psychiatrists, psychologists and other professionals. However, visits of one to two months should also be arranged on more specific topics. The length of the visit would depend on the complexity of the topic.

So far, twinning has had rather limited results except in the Netherlands and Sweden (a multicentre study with Professor Ferris).

According to Dr Oancea, a significant step for many countries would be the organization of a system of fellowships in psychiatry and related disciplines which would give priority to people from underdeveloped areas of CCEE. Romania is interested in psychotherapy, rehabilitation, community psychiatry, psychiatric nursing and assessment techniques.

WHO would play an important role in such an effort, for example by printing a booklet with information about universities and centres with expertise and responsibilities in areas such as the conditions for access. One good example is the booklet on mental retardation centres prepared by WHO.

Another way to increase cooperation is to facilitate the dissemination of official documents, especially laws concerning mental health care between countries. Probably in the near future a movement will start to harmonize concepts and create similar laws in the CCEE, as a means towards achieving a common European house in the field of mental health.

At present in Romania, the following needs are essential:

- technical and material support in the organization of workshops, consultations and seminars in Romania on topics related to the various subprogrammes proposed by the national task force;
- a workshop on a curriculum for special education programmes for mentally retarded children and adults;
- a workshop on remedial services in normal schools (structure curriculum, staff, legislation; Romania only has experience in speech therapy);
- a workshop on community psychiatry, especially crisis intervention and emergency services;
- support in finding short-term fellowships on, for example, alcoholism, suicide, crisis intervention, SOS telephone, mental health education, family interventions for psychiatrists, psychologists and, perhaps, social workers;

- the systematic inclusion of Romanian representatives in international meetings organized by WHO, possibly through WHO funding or local funding;
- the inclusion of Romanian specialists in various working groups and associations, for example on substance abuse;
- provision for systematic dissemination of WHO publications in Romania through representatives such as the APR (Romanian psychiatric association), to be paid in lei or free currency in one or two bookshops in Bucharest (similar information could be offered to international publishing houses);
- support for mental health projects such as the establishment of community-based mental health care (which might also be an occasion to provide Romanian specialists with documentation, as well as to provide training for personnel at the main university clinics in occupational therapy, remedial teaching and psychotherapy; these clinics are also of primary importance in the training of future specialists).

It would be useful to receive collaboration for the establishment of a group to assist the national task force on mental health and the local and national professional and nonprofessional organizations in order to increase contacts with the general public, colleagues and the local authorities so that the resource base can be broadened.

Dr Rumyantseva said that a network of services is available in the USSR. There were a number of recent initiatives, including a reorganization of the network of dispensaries, and the establishment of a new service for "borderline" patients. A particular service is now being established in the Chernobyl area. Current developments include increasing psychotherapeutic services, improving education for physicians, psychiatrists, nurses and social workers, and increasing links with other countries. The resources for financing mental health care are scarce. Attempts to attract financial support from large industrial enterprises have been successful in some cases. Progressive decentralization of administrative, legislative and financial responsibilities to republics is being attempted. Local authorities are taking the initiative and several new emerging services are developing across the USSR.

Professor Schnabel reported on a recent tour of central and eastern European countries (Czechoslovakia, Hungary and Poland) to establish potential beneficial links with western European countries. He indicated a number of impressions from this visit. Many countries seemed to be in the forefront of service development until the Second World War and have remained largely stationary since. Psychiatry is marginalized within medicine and is very frequently biologically and neurologically influenced. There is a distinct lack of scientific and teaching material. Better education for psychiatric nursing is urgent. Services are extremely underresourced. There continued to be many "total institutions". Legislation on patient's rights needs updating in several instances. There are insufficient outpatient services, and where these exist they are not well integrated with inpatient services. The blueprint for the current service did seem to be very useful, in that it indicated the need for regionalized and comprehensive services (although using a top-down model). The different needs of the country, alcohol abuse and its complications, and suicide were important areas. There was a distinct lack of managerial expertise to develop services. Finally, Professor Schnabel

indicated that doctors had developed more into bureaucrats and had lost much of their professional identity and autonomy. In his opinion, the restoration of the professional's role and confidence is imperative.

Mr Verberne reported on his work during the last two years in establishing a foundation for exchange of psychiatric expertise between the Netherlands and the USSR. During the coming year a series of six exchange visits are planned with particular institutions for training purposes. In the longer term he wished to establish an international psychiatric centre in Moscow. He did, however, indicate that communication problems, especially from east to west, are very serious, both by phone and by post.

Dr Bertolote spoke about a meeting convened during the World Health Assembly in 1990 with representatives of the ministries of health in eastern and central Europe. He reported that none of the countries saw mental health as a priority. He also proposed four areas for current focus. First, the formulation of mental health legislation, which is seriously outdated in these countries, may be facilitated by a forthcoming United Nations' Declaration of Rights for the Mentally Ill, to be voted on in December 1991. Second, increased training in direct care, management and planning of services. Third, the development of a national plan or framework within each country which can allow decentralization of services. Fourth, as WHO continued to develop its role on matching individual offers of assistance, particularly from expatriates of central and eastern European countries, with requests for assistance from these countries.

Discussion on priorities for cooperation

The identification of the major factors to be considered in the short term for collaboration in mental health as well as the appropriate approaches to operationalizing this collaboration were comprehensively discussed by the Group.

According to Dr Oancea there is a need for information on the international resources available for cooperative efforts. This information should particularly identify and describe centres, experts and programmes in Member States developing relevant activities in all areas of mental health and psychiatry, as it would assist CCEE in establishing the necessary contacts. In addition, a system of international fellowships for students from CCEE needs to be established. Another initiative mentioned by Dr Oancea was the development of a framework for preparing mental health legislation which could provide common general principles and internationally accepted minimum standards as the basis for modern mental health legislation. Regarding visits of experts abroad he suggested that preference should be given to more prolonged contacts with one institution rather than visits at many places and centres. This will allow personnel to acquire technical expertise in one given field instead of general ideas that would be difficult for them to integrate properly in their future work.

Dr Gleser raised the issue of the appropriateness of the solutions to be proposed in relation to the realities of the countries adopting the innovations. He mentioned the experience of Israel as example of what could have been avoided if appropriate advice had been given in the 1960s when the mental health system in Israel was being developed. Hospitals were being built when the process of deinstitutionalization was already spreading in many countries. On the other hand, professionals are learning about deinstitutionalization and have started to:

- work in the community, providing alternatives to hospitalization through community treatment, prevention and rehabilitation of chronic patients by means of intensive, continuous outreach programmes and use of rehabilitation techniques and approaches;
- ensure that care is regionalized through work in catchment areas and the transfer of hospitalized and clinic patients to their home areas;
- develop interrelated services between the hospital and liaison services in medical, social and educational institutions so as to ensure continuity of service;
- reduce hospital beds by systematically closing down hospitals and hospital beds giving low quality service and supporting the opening of community services and residences instead;
- screen for a better selection of patients with mental disorders who are likely to benefit from hospitalization;
- use the multidisciplinary model for care:
- transfer from the medical pharmacological model to a multidisciplinary team model (the new biopsychosocial approach allowed professionals other than psychiatrists to be actively involved in the treatments);
- transfer from individual to group therapy to allow for the treatment of more patients with the same number of staff;
- use more appropriate designs of treatment and rehabilitation frameworks and progressive gradients to fit individual needs and potentials better, i.e. follow-up groups for patients using Lithium or long-acting antipsychotic medications;
- undertake group psychotherapy (family, Holocaust survivors, psychogeriatrics);
- allow the older analytical psychotherapy model to yield to the more operative "here and now" problem-solving therapies;
- develop special services for certain groups of patient, e.g. drug abusers, in which self-help groups become active partners in providing care;
- collaborate with families, and relatives of patients in the development of facilities and resources in the community.

All these items represent a great savings in therapeutic hours, work and professional staffing, especially of psychiatrists.

According to Dr Gleser, all these developments could be fostered with relatively low budgetary provisions as most of the efforts and contributions are made by community organizations and with the support of community-based partners and institutions. Dr Gleser also agrees that mental health legislation should be based on a minimum set of agreed international criteria and should be comprehensive and innovative. For example, compulsory hospitalization for mental patients who are dangerous to themselves or others should perhaps also be applied to people with severe personality disorders. A

second example would be the efforts that are being made in Israel for allowing schizophrenic patients to obtain a driver's licence. He added that recommendations on the basic services that should be provided to the population could be of great use to international cooperation.

Dr Ballas, after describing the progress being achieved in psychiatric reform in Greece, pointed out the main alternatives being developed for patients admitted to the large and isolated psychiatric hospitals on the island of Leros. He mentioned in particular the role and assistance given in this process by the Commission for the European Communities as well as institutions and centres from Italy and the Netherlands. Twelve new hostels, as well as protected apartments and foster families for receiving patients who have transferred from the psychiatric hospitals on Leros, have been developed. Thirty new mental health centres are being created in Greece for meeting the needs of their respective catchment areas. These centres are going to be built in the more deprived areas of Athens and other parts of Greece. Mobile teams for working in mountainous, remote areas on small islands are being created. The training of psychiatric nurses is being given top priority. The new mental health law divides the country into 13 areas and establishes a mental health authority in each of them. Sectorization is another important development taking place. Dr Ballas also mentioned the need for collaboration with regard to refugees and migrant groups arriving to Greece from, especially, Albania and the USSR. Greece would be happy to give eastern European countries any necessary assistance, especially in the fields of personnel training, deinstitutionalization of large hospitals and the rehabilitation of chronically ill mental patients.

Dr Skoda drew attention to the need for improving communication between experts from different countries as the lack of such communication could hinder effective collaboration. He stressed that in the CCEE there is no second common language that could facilitate communication between experts from these countries, and that experts from abroad also hardly understand and communicate with the majority of mental health workers in these countries as they are not able to speak their language. Dr Skoda proposed that expatriates from CCEE should be systematically used in collaboration when appropriate, and that a new information dissemination system inside the CCEE should be created as soon as possible. These proposals were endorsed other participants and considered very important for the effectiveness of the desired collaboration.

Dr Bertolote stressed the need for organizing national workshops to define the policies and priorities for mental health care development and organization. He considered this a fundamental step as it will function as a guide for international collaboration and support. It would also limit the possibilities of expanding such collaboration to fields where the technical contribution of other countries does not constitute a real priority or where its feasibility is moot.

The problem of collaboration in the training of managers for mental health services was raised in the general discussion and corroborated by several participants. Professor Schnabel pointed out that priority should be given to the improvement of essential care for the general population rather than focusing cooperation on the development of high technology.

According to Professor Jablensky any collaboration has to take into consideration the role of the alliances being established in CCEE between lay groups, consumer groups and professionals to further mental health reform. In his opinion this reformation process needs only the informal consent of

ministries, and he therefore suggested that WHO establish new mechanisms for reaching these new partners in endeavours to reform the existing mental health systems. Professor Jablensky thinks that WHO must not only consider ways of becoming more flexible in the formalization of contacts inside Member States, particularly with nongovernmental organizations, but also be able to say no to some requests that are particularly a responsibility of international and national professional organizations (e.g. training in psychoanalysis). Alternatively, WHO should concentrate on its specific role as an intergovernmental organization and give particular attention to providing technical expertise in matters such as HFA approaches to mental health policy, training issues, quality assurance, consumer and self-care groups, psychosocial support, professional standards, psychotropic drugs, etc.

In conclusion, Professor Jablensky proposed that WHO should:

- establish a task force of experts for answering country requests;
- provide assistance in improving and reviving communication between the countries of central and eastern Europe themselves;
- support the development of local demonstration projects, e.g. a district comprehensive mental health service that offers continuity of care, a multidisciplinary team approach and can produce identifiable results.

Conclusions and recommendations

In general, the reports presented showed remarkable similarities, with only quantitative differences. In each of these countries, rapid changes are going on in the mental health services in close connection with the political changes. A centralized system of mental health care is being transformed to a decentralized, service-oriented system, where local, i.e. regional, needs are increasingly taken into consideration. The process seems to be isomorphic with the transition from a planned economy to a market economy. The former system tried to conform with the ideal of a socialist health care where everybody is entitled to free and high standard health services. Planning has been done at top levels and deployment of services followed instructions from above. According to the participants, the system worked bureaucratically, and established rather monolithic and uniform modalities of care. Little attention was paid to prevention, psychotherapeutic services were underdeveloped, and alcohol and drug treatment facilities were scarce. With a few exceptions, mental health has been regarded officially everywhere as a low priority issue and was, according to some views, controlled from an ideological point of view. Treatment followed the medical model, the burden of care fell to hospitals (generally large mental hospitals built still in the last century), outpatient care was not well developed and seldom in contact with hospitals. Psychiatric care worked separated from primary care. Mental health personnel consisted mainly of doctors and nurses.

Changes have begun over the last two years and the idea of central coordination is being slowly abandoned. Regional needs are manifesting themselves and demanding facilities. Communities and churches as well as voluntary organizations are participating in mental health care and rehabilitation, and non-hospital treatment and care facilities are being progressively organized. Self-help and mutual aid groups are being formed, both in respect of patients and their relatives. Mental health professions are beginning to be differentiated, clinical psychologists, social workers and

occupational therapists are being employed at an increased rate. There is an increasing interest in methods of psychotherapy and sociotherapy, and a growing number of professionals want training in them. Consideration is being given to putting health care on a health insurance basis with an increasing participation of the private sector (private practice, nonprofit enterprises, etc.). Mental health professionals are abandoning the former paternalistic attitudes towards patients and becoming increasingly sensitive to human rights issues concerning the treatment of mental patients.

Political tensions and economic crises make transformation difficult, and almost none of these countries are able at present to invest the necessary amount of money into the mental health field. The infrastructure of services is insufficient everywhere. Prestige is low in the field of psychiatry and public interest in the field is not great.

Spontaneous, grassroots developments are expected to grow, and differentiated forms of helping and caring organizations are hopefully filling in the gaps between the existing structures.

Some of the experts at the meeting have visited CCEE and agree in general with what had been said by participants; Professor P. Schnabel has toured Hungary, Czechoslovakia and Poland, and Mr A. Verberne visits the USSR regularly in order to coordinate help from the Netherlands to improve mental health services in the USSR. They showed their concern with the characteristics of the infrastructures existing in these countries, and mentioned the almost total institutional character of mental hospitals and the lack of adequate flexibility of bureaucracy in these countries. They missed the proper management of mental health facilities, the professional self-esteem of the different mental health professionals, and they stressed the lack of initiative, the need to update training, and the discrepancy between the demands of professionals, e.g. in training and in equipment, with the immediate needs of care.

In each country, new mental health legislation is in the process of being formulated. The importance of proper laws, regulation of treatment, prevention and rehabilitation was also emphasized in the discussions.

The following recommendations emerged from the presentations and ensuing discussion.

1. WHO should support initiatives particularly attuned to assist CCEE in the fields of policy formulation, legislation, financing, human resource development, quality assurance, consumer groups, supply of psychotropic drugs, training in mental health management and social psychiatry.
2. A task force of experts able to meet the demands of CCEE for technical advice and consultancy should be established.
3. Support should be given to the development of local demonstration projects, e.g. a district comprehensive mental health service that offers continuity of care, a multidisciplinary team approach and ability to produce identifiable results in the short term.
4. Assistance should be given to improving the communication between CCEE themselves.

5. WHO should envisage the setting up of a more flexible procedure for communicating and reaching out more efficiently to several nongovernmental organizations and other active partners in CCEE.

6. The system of communication and dissemination of technical information within CCEE should be improved, mainly through the establishment of translating and information centres in CCEE with the aim of disseminating information to the local and institutional levels, utilizing advisers and experts that speak the country's language (expatriates or experts working abroad), and preparing translated written and videotaped material for training and educational purposes.

7. A comprehensive list should be prepared of leading centres and experts in Europe in all main fields of mental health services development, research, training and education.

8. A special fellowship programme should be offered to experts from CCEE so that they can acquire technical expertise in selected centres. These fellowships should support prolonged visits to selected centres rather than shorter visits to many centres and places.

9. Priority in collaboration efforts should be given to developing essential care rather than highly sophisticated forms of care and expertise (in this context it was recommended that a list of basic needs and services to be fulfilled by the mental health system should be prepared as a tool for priority-setting in the process of collaboration).

Annex 1

Table Ia. Various descriptors of the availability of mental health services in the Czech (CR) and Slovak (SR) national republics and in the Czechoslovakian Federal Republic (CSFR)

	CR		SR		CSFR	
	1960	1989	1960	1989	1960	1989
All rates given per 100 000 inhabitants; the differences given in percentage of 1960 value						
<u>Psychiatric beds</u>						
Total	155.5	146.9	90.0	86.9	133.4	126.1
in mental hospitals	146.3	130.2	49.2	58.0	117.9	105.9
in psychiatric departments of general hospitals	9.2	16.7	30.8	27.5	15.5	20.3
Percentage of total in psychiatric departments of general hospitals	5.9	11.3	38.5	32.2	11.6	16.1
			Difference	Difference	Difference	Difference
			-5.3	-3.4	-3.4	-5.5
			-11.0	+17.9	+17.9	-10.2
			+81.5	-10.7	-10.7	+31.0
			+91.5	-16.4	-16.4	+38.8
<u>Psychiatrists' posts</u>						
Serving all beds	2.8	4.8	1.8	3.6	2.5	4.4
in general hospitals	2.5	3.7	.7	1.8	2.0	3.1
in psychiatric departments of general hospitals	.4	1.1	1.1	1.8	.6	1.4
in outpatient psychiatric services	.87	3.88	.54	3.47	.78	3.74
in outpatient anti-addiction services	.03	.18	.01	.39	.15	.45
Total in health care service	3.20	8.87	2.33	7.27	3.32	8.33
			+71.4	+100.0	+100.0	+76.0
			+48.0	+157.1	+157.1	+55.0
			+175.0	+63.3	+63.3	+133.3
			+346.0	+542.6	+542.6	+379.5
			+500.0	+3800.0	+3800.0	+200.0
			+177.2	+212.1	+212.1	+150.9

Table 1b. Various descriptors of the consumption of mental health services in the Czech (CR) and Slovak (SR) national republics and in the Czechoslovakian Federal Republic (CSFR)

	CR		SR		100 SR/CR (%) ^a			
	1960	1988 Difference ^a	1960	1988 Difference ^a	1960	1988		
Inpatient treatment incidence per 100 000 civilian population								
MALE								
<u>Age group 15-29</u>								
Brain syndrome	11.9	2.4	-79.7	8.9	4.6	-48.2	75.3	190.0
Functional psychosis	30.2	25.1	-16.9	30.4	33.2	+9.3	100.6	132.3
Neurosis and other nonpsychotic disorder	67.7	79.5	+17.4	38.0	58.0	+52.4	56.2	73.0
Substance abuse, dependence and their psychotic complications	41.0	70.3	+71.6	35.3	87.2	+147.3	86.0	124.0
All mental disorders	211.0	240.6	+14.0	155.1	232.0	+49.6	73.5	96.4
<u>Age group 30-59</u>								
Brain syndrome	22.0	11.4	-47.9	13.5	12.9	-5.0	61.8	112.7
Functional psychosis	42.0	24.3	-42.0	47.3	40.1	-15.4	112.9	169.9
Neurosis and other nonpsychotic disorder	83.1	49.0	-41.0	68.9	43.8	-36.4	83.0	89.5
Substance abuse, dependence and their psychotic complications	71.1	116.0	+63.2	110.4	255.4	+131.0	155.4	220.2
All mental disorders	248.2	228.0	-8.1	270.5	372.0	+37.5	109.0	163.1
<u>Age group 60+</u>								
Brain syndrome	135.2	198.4	+46.7	57.1	140.5	+146.1	42.2	70.8
Functional psychosis	28.3	20.7	+26.7	33.0	33.2	+0.5	116.6	159.9
Neurosis and other nonpsychotic disorder	26.8	32.4	+20.9	20.1	31.6	+57.4	75.0	97.7
Substance abuse, dependence and their psychotic complications	11.9	18.0	+51.7	13.4	53.8	+302.2	112.9	299.4
All mental disorders	214.5	290.7	+35.5	139.2	262.5	+88.6	64.9	90.3

Inpatient treatment incidence per 100 000 civilian population

	CR		SR		100 SR/CR (%) ^a			
	1960	1988	Difference ^a	1960	1988	Difference ^a	1960	1988
FEMALE								
<u>Age group 15-29</u>								
Brain syndrome	7.1	3.0	-57.3	4.3	2.6	-40.4	61.2	85.4
Functional psychosis	32.0	34.9	+12.3	32.2	39.5	+22.4	100.7	113.2
Neurosis and other nonpsychotic disorder	98.2	80.1	-18.0	68.4	63.1	-7.8	69.6	78.3
Substance abuse, dependence and their psychotic complications	2.0	11.5	+484.8	2.4	10.9	+356.0	121.2	94.5
All mental disorders	173.4	160.2	-7.1	138.2	135.1	-2.3	79.7	84.3
<u>Age group 30-59</u>								
Brain syndrome	13.7	6.2	-54.5	9.6	6.9	-28.2	70.5	111.3
Functional psychosis	55.6	43.7	-21.3	56.5	58.4	+3.5	101.5	133.6
Neurosis and other nonpsychotic disorder	103.8	74.1	-28.6	102.0	76.2	-25.3	98.3	102.8
Substance abuse, dependence and their psychotic complications	3.4	27.4	+706.3	6.0	49.8	+732.0	176.0	181.5
All mental disorders	191.3	169.6	-11.3	191.4	205.2	+7.3	100.0	121.0
<u>Age group 60+</u>								
Brain syndrome	135.7	230.3	+69.6	40.6	134.0	+230.5	29.9	58.2
Functional psychosis	40.0	43.6	+9.2	30.0	57.4	+91.4	75.0	131.5
Neurosis and other nonpsychotic disorder	31.5	44.0	+39.8	22.2	40.2	+80.6	70.6	91.2
Substance abuse, dependence and their psychotic complications	0.5	3.8	+754.9	1.4	8.7	+519.5	315.0	228.2
All mental disorders	213.6	338.6	+58.5	99.1	246.8	+149.0	46.4	72.9

^a All differences and percentages are calculated from unrounded values.

Annex 2

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