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# Mental health services in southern countries of the European Region

Report on a WHO meeting

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## INTRODUCTION

A Working Group on Mental Health Services in Southern Countries of the European Region was convened in Madrid from 25 to 29 May 1986 by the WHO Regional Office for Europe in collaboration with the Government of Spain, which hosted the meeting at the Ministry of Health and Consumer Affairs in Madrid. The WHO collaborating centre for research and training in mental health, Paris, took an active part in the meeting and helped to plan and organize it.

The meeting was attended by 16 temporary advisers from the European and Eastern Mediterranean Regions, by eight observers, and by representatives of the Commission of the European Communities (CEC), the WHO collaborating centre for health, psychosocial and psychobiological factors, Bierbeek, Belgium, and the World Psychiatric Association.

Dr E. Luch Martin, Minister of Health and Consumer Affairs, Spain, welcomed the participants on behalf of the host country. Dr P.O. Petersson opened the meeting on behalf of the WHO Regional Director for Europe. Dr Isabel Alvarez Baleriola was elected Chairman. Dr H. Freeman and Dr J.G. Sampaio Faria were elected Co-Rapporteurs and Dr J.H. Henderson Secretary.

The Working Group's task was to review experience so far with the reformulation of mental health policies, methods of policy implementation, and evaluation of programmes, and to make general recommendations for future action. The review and the action proposed were to be based on the policies of health for all (HFA) by the year 2000, the regional strategies and targets, and the principles of the managerial process for national health development (MPNHD).

## BACKGROUND

Despite the not very impressive general progress achieved in Europe in terms of transition from a system of care provided mainly in mental

hospitals to one that should be comprehensive in scope and community-oriented, the Regional Office's long-term programme for 1970-1982 consistently promoted the principle of comprehensive community-based mental health services staffed by multidisciplinary teams. This had significant influence and brought about changes in many European countries.<sup>a</sup>

In 1984, the Regional Committee endorsed the 38 regional HFA targets. Mental health proposals were then incorporated in medium-term programmes of cooperation between WHO and several countries, including Greece, Portugal and Spain.

In 1984, the Council of Europe proposed a ministerial conference on mental health, which WHO helped some countries to prepare for. This Second Conference of European Health Ministers, held in Stockholm in April 1985, reaffirmed the importance of mental health promotion and the prevention of mental disorders as essential components of a comprehensive health policy. The European health ministers asserted that a modern mental health policy should be based mainly on the principles that (a) it is an integral part of health policy, and (b) it should be comprehensive, coordinated, coherent and based on the promotion of primary, secondary and tertiary preventive measures, as well as the development of primary health care services, whose role is crucial in all stages of prevention.

Both the participation of the southern European countries in the conference and the policy guidelines defined in the final text were expected to make a significant impact on mental health programming in those countries.<sup>b</sup>

The overall objective of WHO's global medium-term programme for protection and promotion of mental health is to reduce problems related to mental and neurological disorders and the abuse of alcohol and drugs, and to make it easier to incorporate mental health knowledge and understanding in general health care and social development. WHO aims to achieve this objective through four subprogrammes: mental health policy and programme formulation, coordination, evaluation and support; psychosocial factors in the promotion of mental health and human development; prevention and control of alcohol and drug abuse; and prevention and treatment of mental and neurological disorders.

Within these subprogrammes, special attention is given to problem assessment and policy formulation. For the first subprogramme, the

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<sup>a</sup> Freeman, H.L. et al. *Mental health services in Europe: 10 years on*. Copenhagen, WHO Regional Office for Europe, 1985 (Public Health in Europe, No. 25).

<sup>b</sup> *Second Conference of European Health Ministers*. Strasbourg, Council of Europe, 1985 (unpublished document MSN-2-7 revised).

targets to be achieved by 1989 are (a) the establishment of national and regional coordinating groups or equivalent mechanisms in all WHO regions, and (b) provision of coordinative and evaluative support to these groups, and other efforts directed to the development of mental health policies and programmes. Approaches will include the development of methods and materials that facilitate mental health policy formulation and programme evaluation, intercountry and interregional cooperation in these efforts, and technical support.

The report on *Prevention of mental, neurological and psychosocial disorders*, prepared by the Director-General for the Thirty-ninth World Health Assembly in 1986, was an important document for mental health policy formulation and implementation and resolution WHA39.25 urged Member States to implement the measures it proposed. The report stressed that mental, neurological and psychosocial disorders are an enormous public health burden for both developing and developed nations. At government level, it said, commitment to dealing with neurological and psychosocial disorders must be made visible by introducing a mental health component into national health and development policies. An intersectoral coordinating mechanism should be established to assist programme development.

Certain recent initiatives in other WHO regions have also proved relevant to the process of change in southern European countries, particularly those resulting from subregional groupings of countries. For example, the Region of the Americas organized a Caribbean Conference on Health/Mental Health Models in Jamaica in April 1985, in an attempt to provide an initial framework for a more comprehensive Caribbean mental health care plan of action, dealing particularly with the connection between physical and mental health. A major recommendation was that mental health should take high priority in the health systems of the area. The Eastern Mediterranean Region also held an intercountry meeting on national mental health programmes in Damascus in November 1985. The recommendations urged both WHO and the Member States to develop national mental health programmes as part of national health plans and national strategies for HFA.

The southern countries of the European Region have their own specific social, economic, cultural and demographic characteristics, and some of these countries — Greece, Portugal and Spain, for example — have undergone major and similar political changes during the last ten years or so. They are therefore formulating or reformulating their general health and mental health policies, and working hard to translate them into practice. Papers describing the main aspects of the planning process for national mental health policy and practice in the southern countries of the Region were presented to the Working Group.

## COUNTRY REPORTS

After the adoption in 1980 of the regional HFA strategy, the Regional Office started a round of discussions with Member States on their country programmes. This collaboration takes into account the countries' own reports, which identify needs and evaluate progress on the regional HFA targets.

At the time of the meeting, medium-term programmes had been drawn up or were planned with 21 countries in the Region. Such programmes specify the objectives and outputs of collaboration and list the activities required to reach them, indicating deadlines, financial implications and source(s) of funding, and the input required from both sides.

These country programmes are usually established (a) in priority health fields where there are marked variations between the countries of the Region and for which practicable solutions exist, (b) in countries where external resources need to be mobilized, and (c) in countries where a great deal of advocacy is needed to reorient national strategies and resources towards the priorities.

In every case, it is essential that the problems to be tackled should be clearly identified, that they should be of major national importance, and that the country should be able to sustain the programme financially and politically once it has started.

Greece, Portugal and Spain included mental health in their country cooperative programmes from 1984. Malta, Turkey and Yugoslavia are now preparing their programmes with a mental health component.

### **Greece, Portugal and Spain**

In each of these three countries, WHO mental health technical projects have been included in the country cooperative programmes.

#### *Greece*

In Greece, the aim of mental health policy is to scale down antiquated asylums and to replace them by effective, modern, community-based psychiatric services. This aim was embodied by Parliament in the National Health System Law of 1983, according to which psychiatric care will be provided through mental health centres, psychiatric units in general hospitals and special psychiatric hospitals for long-term care. The Law also establishes a series of health regions within which mental health regions and psychiatric sectors will be developed.

The Standing Mental Health Committee of the National Health Council was set up in May 1984 to examine the problems and to make

recommendations on the programming, organization and development of the mental health services. A five-year plan to reorganize the psychiatric services began that same year with support from the CEC.

This CEC support finances the creation of new psychiatric units in general hospitals, expansion and rearrangement of the existing buildings, provision of equipment for the psychiatric services, pilot programmes to find the most efficient ways of applying the permanent programmes, and the training of mental health professionals, especially nurses.

CEC support will continue until the end of the five-year plan in 1988. The plan was reviewed at a conference in Athens in 1985, while another conference held that same year covered the psychiatric unit in general hospitals.

The main features of this recent experience in Greece were therefore as follows:

- reorganization of the mental health services coincided with the beginning of a national health system;
- policy was derived from the National Health System Law;
- the policy was based on a non-custodial approach with the following main objectives and characteristics: a scaling down of psychiatric hospitals; the introduction of an alternative modern, effective and comprehensive community-based mental health service; the promotion of rapid recovery, thereby avoiding chronic disease and separation of the patient from local social networks; and the creation of mental health regions and psychiatric sectors;
- the process of programming, organizing and developing services was made the responsibility of the Standing Mental Health Committee of the newly created National Health Council;
- a five-year plan was developed;
- the contributions of intergovernmental agencies such as the CEC and WHO were decisive for policy formulation;
- the main constraints were identified as political, economic and cultural, with other problems resulting from lack of experience and inappropriate education; and
- the CEC's role as the major funding source was decisive in implementing the five-year plan.

As the CEC sees it, reform of the mental health care system in Greece should improve the lives of mentally ill and mentally handicapped people, mainly by means of modern methods of medical and vocational rehabilitation and care, reduced hospitalization, community-related psychiatry, and the construction, adaptation and equipment of buildings. In all these

efforts the principal aim is the integration of the mentally ill and the mentally handicapped into society.

This view is in accordance with the objective of the CEC European Social Fund, which concerns itself with all aspects of employment and vocational training. Therefore the granting of this exceptional support to Greece within the general context of vocational rehabilitation is in line with the European Communities' policy of integrating disabled people in social and working life. It has also enabled the CEC to increase Greece's share of the European Social Fund.

In 1984, the Greek Government asked for a study on a programme of reform of public mental health care, to be financed by the CEC. The study team's recommendations were accepted by the Government, which then applied to the CEC for financial support for a five-year programme for the development of mental health care. In the first three years of CEC assistance, 152 projects were put forward. The programme represents a total commitment of 61.5 million ECU, of which 34 million ECU will come from CEC sources.

### *Portugal*

A decisive shift occurred in Portugal in 1984 upon the abolition of the 26-year-old Institute of Psychiatric Assistance and the integration of mental health services, including mental hospitals, in the Ministry of Health as part of the Directorate-General of Primary Health Care.

This shift led to a greater consideration of community needs and to a better sharing of responsibilities with other health, social and community services concerned in the delivery of care.

Important organizational developments in various Portuguese health fields have also helped in the process of change, especially the progressive development of a comprehensive and integrated network of primary care services throughout the country.

Other important factors have been the introduction of a new national primary care general practitioner professional career structure integrated with the network of primary care services; the setting up of joint health and social services coordinating committees in all districts; new legislation defining the roles and responsibilities of the health and social services in the care of patients with stabilized chronic impairments, and of the mentally handicapped; the compulsory inclusion of psychiatric inpatient facilities in new district general hospitals; and the approval of a medium-term mental health programme proposal which aims to develop community-based mental health facilities, functionally integrated with the existing local primary care, hospital and social services.

The main objective of the programme is to make available to communities a minimum range of essential resources and services for the promotion

of mental health and for the primary, secondary and tertiary prevention of mental disorders. The emphasis is on gradual de-institutionalization, integrating mental health services with other health services without losing continuity of care, and developing and modernizing services to meet the needs of the community.

The programme's other objectives are:

- to integrate mental health care knowledge and technology in the daily practice of primary health care professionals;
- to integrate emergency services for mental disorders in the emergency services of general hospitals, with full access for the psychiatric services to the general hospitals' technical, human and physical resources;
- to set up day facilities in health centres, offering a minimum range of mental health services in the community;
- to support the development of postgraduate training programmes for professionals working in primary health care (general practitioners), district hospitals (emergency departments) and regional social services; and
- to bring about full coordination in all districts between the mental health and social security services.

As concerns policy formulation for mental health programming within the Directorate-General of Primary Health Care, recent developments of note have been the metropolitan areas' planning groups for mental health services; the Portugal/WHO medium-term cooperative programmes (1984/1985 and 1986/1987); and Portuguese participation in the Council of Europe's Second Conference of European Health Ministers in 1985.

The health and mental health planning process being implemented in Portugal is in line with the principles of WHO's managerial process for national health development. Portugal is making efforts to coordinate central health departments, to rationalize mental health management, and to establish a network of links between mental health services, general health services, and other central, regional, district and local organizations.

The main problems are considered to be political changes; the economic situation with its consequent organizational breakdowns; gaps in the entire health and mental health management processes; the lack of financial resources; and general management shortcomings. However, these problems are definitely exacerbated by the present lack of an efficient coordinating policy and structure between the central departments of the health ministry (planning, finance, human resources, hospitals, construction, etc.), the disconnected and inadequate legal provisions for mental health care, and the generalized lack of knowledge and awareness

among managers and other health professionals of mental health care and its organizational principles.

### *Spain*

In Spain, the 1986 General Law on Health (which includes provisions for mental health) established a national health system composed of all the health systems of the 17 Autonomous Communities. Mental health policy formulation had in fact begun some years earlier with discussion among health professionals, users and the population as a whole, and with an international conference on mental health organized by the Regional Office in 1983. This conference covered two main issues: an analysis of mental health services in Spain, and the roles of mental health care and primary health care. It also provided a framework for criteria on which to base a national plan. A Ministerial Commission for Psychiatric Reform was set up, which produced a report setting out the criteria for changes in mental health care in Spain.

The basic philosophy of the Commission's report was the promotion of mental health, with the following objectives:

- to enhance the promotion of both mental health and psychiatric care within the social environment of the population at risk;
- to integrate mental health with general health activities, while taking into account the unique features of this specialty;
- to develop rehabilitation programmes for the psychiatric patient, ensuring the provision of basic social and health care; and
- to protect the civil rights of psychiatric patients against measures that might restrict their freedom.

Therefore, the new model proposed for Spain is based on the principles of comprehensiveness (i.e. it must include primary, secondary and tertiary prevention in mental health); integration in the general health system through the primary health care and specialized hospital-based networks; participation (to allow for two-way interaction with the community); planned priorities for each stage of development; geographical bases in the different autonomous health zones; and functional bases in the primary and specialized levels of care.

The priorities of the reform are:

- integration of mental health services in the general health care system;
- reorganization of existing mental health services;

- increased and improved mental health resources, and an increase in the amount of attention paid to the mentally ill;
- clarification of administrative responsibilities in cases requiring not only health care but also social support;
- development of support measures for primary health care; and
- improved mental health curricula for all health personnel.

During the policy formulation stage, the WHO Regional Office and the Ministry of Health and Consumer Affairs organized a series of workshops at which representatives of the Autonomous Communities and the Ministry could discuss, with temporary advisers, various issues related to the reform such as psychiatric epidemiology, integration of mental health care in primary health care, and organization of mental health services.

In the Spanish experience, factors being given special consideration include a modest increase in financing; the pace of health changes, such as the implementation of the new primary health care model; the overcrowding of public hospitals, which in some cases does not permit either more beds or space for psychiatric units; the irregular pace at which psychiatric hospitals (both state and private) are undergoing change; the lack and inequitable distribution of staff, due in part to their concentration in the main cities and to variations in their qualifications; the lack of reliable data for proper planning and evaluation of the measures already taken; and the scarcity of community resources for the prevention of mental problems.

The main constraints to reform seem to be various cultural, legal, political, technical and administrative shortcomings, and a relative slowness in changing attitudes.

In Spain, the new policy has come about partly because of legal requirements arising from the constitutional right to health for all citizens, and partly as a result of the General Law on Health. The whole process of mental health policy formulation and implementation has coincided with the reform of health care in general. Promotion of mental health is the basic objective, including comprehensiveness, integration with general health care, community participation, division of the population into psychiatric sectors, decentralization of planning, and a functional basis in primary and specialized care. Technical discussions among professionals, and international participation and cooperation through WHO and the Council of Europe, were important components in the policy formulation process, which necessarily took account of mental health programme implementation in the context of the health responsibilities of both the central Government and the Autonomous Communities.

## **Other southern European countries**

### *Italy*

The Psychiatric Reform Act, passed in 1978 by the Italian Parliament, prohibits the construction of new psychiatric hospitals and both voluntary and compulsory admissions to them; makes it mandatory to use psychiatric units in general hospitals for compulsory or voluntary treatment; recognizes that community intervention through community facilities is central to the reform; and provides for the construction of facilities able to take in both patients discharged from psychiatric hospitals and those needing long-term treatment.

The reform has integrated mental health into the district general health structures (district health units), where facilities are coordinated and administered by each unit's presiding committee.

The Psychiatric Reform Act has also redefined compulsory psychiatric admission, which is now permitted only if the patient is affected by a serious mental illness; admission is to a general hospital at the recommendation of a general practitioner.

Between 1982 and 1985 the number of new psychotherapy centres grew considerably, the overall tendency being for community facilities to emerge (the law governing the setting up of mental health centres dates from 1968). The rate of growth seems to be similar in the various Italian regions, but in qualitative terms progress has apparently been very uneven. As regards psychiatric wards in general hospitals, there have been particular problems:

- too few psychiatric wards have been created in the general hospitals;
- the distribution of psychiatric wards in the various regions is uneven;
- trends in bed utilization and in the average length of stay in hospital are not the same in public and private psychiatry as they are in general medicine; and
- a conflict still persists between Italian psychiatry's two philosophies: the traditional one, biologically biased, which sees the general hospitals as a new, efficient location for the treatment of mental illness, and the reformist philosophy, which sees care in the community as the new frontier. The outcome of this conflict will be of the utmost importance for continuity of care, seen as the key to the clinical progress of the patient.

Other problems included the fact that the reform and the new organizational arrangements were introduced without previously preparing the

primary care and general hospital sectors to accept and integrate mental health care; the possibility of neglect of patients left in residence in psychiatric hospitals; the question of services for severely mentally ill patients; and the need for local and regional data both to throw light on differences between the regions and to help solve the more generalized problems of resource planning and distribution.

The National Research Council has undertaken epidemiological research on trends in suicide and attempted suicide, consumption of psychotropic drugs, and patients representing a danger to others, in order to investigate the possible effects of the Psychiatric Reform Act on the wellbeing of Italian society. The results of these studies suggest that the impact of the Psychiatric Reform Act on suicide and attempted suicide has been minimal; that overall consumption of psychotropic drugs obtained from public and private pharmacies, general practitioners and community psychiatric services has grown in recent years; but that the number of admissions of dangerous patients and the number of dangerous inpatients seem to have gone down between 1970 and 1984.

Proposals for improving the operational model of the Italian psychiatric reform are now being put forward, including the introduction of a mental health department in the present health administrative structures. Certain conditions seem to be of the utmost importance for future progress. For example, epidemiological evaluation techniques need to be improved and introduced into the psychiatric care services, which could then disseminate information to management bodies and professionals. The role of university clinics is also crucial in contributing to both research and the training of new professionals who will be able to cope with new problems and adapt to the new organization of services. And finally, a need exists for better coordination, increased financing, greater interest on the part of the Government and the Ministry of Health in the reform process and referral system, and public information and advice on the innovative process that is under way.

### *Malta*

During the last decade, Malta has made some progress in providing ambulatory facilities for psychiatric treatment in accordance with the community approach. The National Health Act of 1976 dealt with the admission of the patient; legal procedures and rights; the role of the psychiatric social worker; inpatient facilities at the St Luke's General Hospital; reorganization of outpatient psychiatric facilities; and half-way houses. In 1985, psychiatric clinics were set up in the area health centres or polyclinics, and new training courses and facilities were introduced for the various categories of specialized mental health personnel by then being recruited. More recently, coordinated intervention and

new facilities have been organized to cope with drug abusers and alcoholics.

With WHO help, Malta has drawn up a five-year plan for 1986-1990 according to the requirements of the regional HFA strategy. With the WHO regional targets on mental health in mind, the plan includes the following objectives:

- preventive mental health work will become more constructive, as a consequence of which professional education, guidance and instruction will be more varied and crisis and supportive therapy will be intensified;
- health services will be designed to help people cope with everyday situations and to form and maintain personal relationships, will secure support from the social environment, and will be developed in conjunction with other sectors and voluntary organizations;
- chronically ill, disabled, elderly and institutionalized people will be helped to form and maintain personal relationships; and
- mental health care will be intensified, with emphasis on preventive measures, primary health care and ambulatory care.

The long-term objective is to reduce the number of long-stay beds in the mental hospital by 50% over the next five years, and at the same time to strengthen community psychiatric services and introduce new concepts in mental health care, such as day units.

Priority in the proposed policies and plans will go to: half-way facilities and the re-accommodation of juvenile patients; the upgrading of psychiatric inpatient facilities; more intensive utilization of general hospital and mental health facilities based on primary care; day hospital facilities; and close collaboration with housing authorities and social services. Psycho-geriatric care, suicide prevention, and alcohol and drug abuse will all be areas of special programme concern.

### *Yugoslavia*

For two decades now, Yugoslavia has paid special attention to democratizing and humanizing mental hospitals, to establishing psychiatric departments in general hospitals, to progressively involving outpatient institutions and services in the provision of mental health care services, and to engaging other health services, social services and organizations in the provision of primary, secondary and tertiary preventive measures. Today, mental health services are provided by specialized independent institutions or by specialized mental health services in medical centres, general hospitals, primary care services, occupational health services, and so on.

Belgrade has developed an experimental model called "comprehensive mental health care in the community". This model has confirmed the importance of collaboration and coordination between mental health services, primary health care services and social organizations and institutions in the provision of care to both healthy and sick individuals and their families. This collaboration seems to be indispensable for the continuity of care to patients.

At federal level, a mental health commission has been set up to devise community programmes for mental health care that are acceptable to all parts of the country. The programmes are expected to take into account the actual situation, should include all structures of society, and should provide for simultaneous action by primary health care and all other health-related sectors.

The entry points for these activities should be the basic social entities: educational and health facilities, local communities and labour organizations, with full involvement of every member of the community. Community members, particularly children and young people, should receive education in self-care and a healthy lifestyle, so that they learn to take care of their own health.

In Yugoslavia all social services, including health services, are self-managing parts of the overall social system. The self-managing health bodies at communal, regional, provincial and republic levels consist of elected delegates from labour organizations, ordinary citizens and staff from health institutions. The highest governing body of the self-managing communities is the assembly of the community, consisting of two chambers, one of users and the other of providers of health services. Health and mental health policy decisions are taken in these communal assemblies, implementation being the responsibility of the assembly's executive board. Mental health and health programmes are integrated in the general plan of socioeconomic development. Regional and republic self-management interest groups are responsible for establishing and developing health services serving more than one commune (usually these would include highly specialized services such as mental hospitals).

Other kinds of decision-making operate at all levels, so that decisions on health matters in general and mental health in particular can be made even at the lowest level of the government administration.

Financial resources for health are generated by contributions from labour organizations in proportion to their income, from the individual incomes of workers, from the total income of agricultural workers, and from voluntary donations by labour organizations, individuals, and so on.

From experience over these 20 years, it is possible to list certain advantages and disadvantages of the decentralized health system and its responsibilities for mental health and general health care.

On the positive side, there is considerably greater involvement of the local authorities in mental health care activities and more effective multi-sectoral collaboration at commune level.

On the negative side, four disadvantages can be mentioned. First, the mental health information system is much harder to organize and use, and the flow of data outside the primary administrative unit is very difficult to effect and unreliable. Second, certain unresolved research problems need to be investigated on a broader level and in several communes. One particular problem is research funding, as funds have to be provided from several sources. Third, the introduction of new and improved technologies, whether they concern treatment or other aspects of the programme, is cumbersome and time-consuming. Fourth, there is an increasing probability that the gap between university training and actual practice will become greater in the years to come.

In summary, the federal structure gives rise to both opportunities and risks in the planning and management of mental health programmes. Points to be considered are:

- the importance of decentralization to commune level, which must be given special attention;
- in federal states, special provisions have to be made for collecting mental health information as a basis for financing relevant services and research;
- procedures must be specified for consultation between all concerned on matters such as the formulation of mental health legislation; and
- the exchange of experience between countries with a federal structure at a meeting specially organized for that purpose would be desirable.

Any discussion of problems of decentralization in health and mental health care policies and developments in a federal structure such as Yugoslavia's should take special account of the roles of the various administrative levels. Similar problems could be faced by other countries engaged in the process of administrative decentralization and regionalization of health services.

## **Countries of the WHO Eastern Mediterranean Region**

### *Cyprus*

Prior to Cyprus's independence in 1959, mental health services were rudimentary and primitive. Between 1959 and 1974, priority changes were made, including new hospital and clinic facilities and an increase in the

numbers of psychiatrists and nurses. The Cyprus Mental Health Association, founded in 1960, contributed to the promotion of mental health principles and programmes and the care of patients. Special attention was paid to the needs of mentally handicapped children and to child mental health. In 1972, with WHO technical assistance, comprehensive mental health plans and strategies began to be developed.

More recently, again with WHO help, the following goals have been set:

- to decentralize the services and promote a mental health system that is truly community-based and divided into psychiatric sectors, with emphasis on the principles of prevention and promotion of mental health;
- to upgrade the services offered at the only mental hospital in Cyprus and, through more dynamic rehabilitation programmes, to reduce its inpatient population;
- to reform the antiquated mental health law (a new law has been drafted and will be published soon as a White Paper);
- generally to redirect efforts towards the community by seeing to it that more mental health professionals work in the ever-increasing community facilities and at the periphery;
- to promote more intersectoral collaboration and integration of the mental health services in the general health system;
- to focus attention on the delivery of mental health care at the primary health level by various means: expanding district psychiatric clinics; encouraging more health professionals to work in the community, in general hospitals and other community centres and institutions; increasing the number of community psychiatric nurses; and training general practitioners and other primary health workers in psychiatry and mental health;
- to undertake epidemiological and other research studies on the prevalence of mental disorders, drug dependence, problems of geriatric and psychogeriatric patients, and similar subjects;
- to promote programmes whose objectives are to sensitize the public and important public figures to the problems and the needs of the mentally ill, and to help remove or reduce deep-seated prejudices and negative attitudes to these patients;
- to improve medical records and the data recording system.

Other points to be considered during the reorganization of mental health services in Cyprus will be urbanization, refugee housing, and the economic and psychosocial problems resulting from the political events of 1974.

In view of local realities, the resources available, and current social changes, it will be necessary over the next few years to focus on: a further extension of services to the community and within the community; more professional time for training, supervising and monitoring nonspecialized health workers; upgrading rehabilitation and other programmes in the inpatient facilities; diversifying services for geriatric patients, alcoholics and children with special problems; setting up a national coordinating committee for mental health to implement the programme and to guarantee an intersectoral approach; and research and epidemiological work.

### *Morocco*

In 1972, the Ministry of Public Health, assisted by WHO, prepared a long-term mental health programme with the aim of developing physical and human resources appropriate to a community-oriented modern mental health system.

The objectives of the programme are:

- to determine national mental health policy guidelines;
- on the basis of these general guidelines, to develop a rational and consistent mental health policy for the short, medium and long term;
- to set up a programme for medical and paramedical training of national staff to replace foreign professionals; and
- to modify negative attitudes towards psychiatry and break down resistance to change.

During the 1973–1977 five-year plan and the 1978–1980 three-year plan, significant progress was made, including postgraduate training of new psychiatrists, the inauguration of two psychiatric nursing schools, the opening of new mental health dispensaries throughout the country, the organization of small psychiatric inpatient facilities, the integration of psychiatric services in a new general hospital, training in mental health for general practitioners and nurses, and distribution of essential psychotropic drugs to the official public health services.

Nevertheless, the present pattern of care is still inadequate for the basic needs of the population at large and it has not proved possible to achieve fully the mental health policy objectives set by the Ministry of Public Health in 1972. For example, there are still shortcomings in the training of medical and paramedical personnel, and problems with the physical infrastructure. Progress has been slow in the area of intermediate and social resettlement facilities.

Some of the factors contributing to these problems seem to be: the organization of the Mental Health Directorate at the Ministry of Public

Health, which is not at present performing clear functions in the process of formulating, monitoring and evaluating mental health programmes; the lack of an effective coordinating policy between the mental health sub-system and the public health structures; a shortage of funds for the mental health sector; a lack of community participation and integration in the development of mental health policy; and inadequate coordination between ministries and at the central health department.

The next five-year mental health plans for 1987–1991 and 1991–1996 will attempt to integrate psychiatry into the system of basic general health services and will give priority to the training of psychiatrists and other specialized paramedical staff.

Like other countries of the Mediterranean basin, Morocco faces special problems due partly to the importance and extent of certain sociocultural aspects of its mixed traditional and occidental culture, and partly to the number of traditional healers (marabouts and fakirs) working in the country. The mental health services are increasingly being utilized by a population in cultural transition, who nevertheless still use the traditional healer as their first point of contact.

The coexistence of these two very different types of care raises several questions:

- Are modern mental health services adequate in Morocco's particular sociocultural environment?
- Should traditional healing systems be encouraged?
- If so, what kind of formal relationships should be developed between the two systems?
- Are there any other alternatives to specialist psychiatric care for Morocco?

As the existing mental health care facilities are still unable to meet the needs of the Moroccan population, the answers to these questions are of the utmost importance.

## SIGNIFICANT ISSUES FOR MENTAL HEALTH DEVELOPMENT IN SOUTHERN COUNTRIES OF THE EUROPEAN REGION

### **Protection and promotion of mental health**

The prevention and control of mental and neurological disorders is the major responsibility of the WHO mental health programme. Some idea of

the size of the problem can be gained from the fact that at least 40 million people around the world suffer from severe mental illness such as schizophrenia and severe depression, while at least twice as many are seriously disabled by drug dependence, alcohol-related problems, mental retardation, dementia and similar disorders of the nervous system. There is no known human community — whatever its level of development — that is free from severe mental disease. Estimates vary as to the number of people affected by less severe but nevertheless incapacitating mental disorders, but none of these estimates is less than 200 million. Mental disorders make up a substantial proportion of all adult and child morbidity seen in the general health services of both developing and developed countries.

Mental illnesses are among the most distressing and incapacitating conditions. Many of them tend to run a chronic or recurrent course and thereby place a severe burden on patients, their families and the community. In most societies, mental disorders are still regarded as a stigma, which aggravates the social problem and interferes with effective treatment. The number of mental patients is likely to grow in the years to come. Mortality from acute infectious diseases is declining, so more people survive throughout the entire risk period for mental illness.

Apart from this general demographic reason for the increase in mental morbidity, the incidence of specific disorders can rise or fall according to the rate of occurrence and spread of particular biological and environmental etiological factors in different parts of the world. Examples of this are increased alcohol consumption and the growing rate of accidents, which result in dramatic increases in toxic or traumatic organic brain syndromes, with accompanying behavioural disturbances. Where infectious and parasitic diseases are prevalent, the acute and chronic psychoses due to cerebral involvement can be expected. Stress occurs everywhere in its various forms, producing a range of dysfunctional behavioural responses such as anxiety states, depression, and psychosomatic disorders affecting millions of people. Suicide, according to recent estimates, causes as many as 100 000 deaths a year in Europe alone.

The social cost of mental morbidity is high and still rising; nevertheless, encouraging developments in the mental health and biobehavioural sciences make it possible to predict rapid progress in the coming decades in our ability to control and prevent many of these disorders. Already, methods and technologies are available which help to contain much of the problem, provided that the appropriate forms of organization and delivery of care exist, preferably at the level of primary health care.

Neurological disorders are a major cause of death and of long-term disability in all age groups everywhere in the world. Epilepsy affects 2–5 people per thousand in industrialized countries, although the figure in some developing countries may be 3–5 times higher. Cerebrovascular disorders are also a frequent cause of mental disability in all countries. Infectious

disorders of the nervous system, both viral and bacterial, are still very frequent and often have disabling neurological sequelae if not properly treated. Traumatic peripheral nerve diseases are increasing due to traffic and occupational accidents. Neurological disorders linked to aging increase with the increase in life expectancy. Several neurological disorders can be prevented, others can be treated and controlled, but there remain some whose management is still difficult and for which new knowledge has to be sought.

Of the world's 400 million disabled people, no fewer than two in every five are incapacitated by mental or neurological disease, or by the sequelae of alcohol abuse or drug dependence. The psychosocial dimension is also present in disability caused by physical illness or accidents, and this dimension is often crucial for the disabled person's rehabilitation and reintegration in the community.

Member States of WHO collaborate in the Organization's mental health programme with three aims:

- to prevent or reduce psychiatric, neurological and psychosocial problems (including those related to alcohol abuse and drug dependence);
- to increase the effectiveness of general health services through the appropriate utilization of mental health skills and knowledge; and
- to develop intervention strategies based on an increased awareness of the mental health aspects of social action and change.

The overall objective of the WHO mental health programme is to reduce problems related to mental and neurological disorders and alcohol and drug abuse, and to facilitate the incorporation of mental health knowledge and understanding in general health care and social development. The programme's specific objectives are as follows.

*Mental health policy and programme promotion, coordination, evaluation and support.* This concerns mainly the setting up of national and regional coordinating groups with similar mechanisms in all WHO regions, support to these groups, and efforts to develop mental health policies and programmes. Special attention is given to the formulation of national mental health programmes; advice on the methodology for setting up and operating mental health coordinating groups; the establishment of information systems to support managerial processes for national health development; and coordinated research on indicators of health and mental wellbeing, including reviews of psychiatric case registers.

*Psychosocial factors in the promotion of health and human development.* Here, the aim is to increase the effectiveness of general health care

in Member States by using mental health skills and knowledge, and to develop intervention strategies based on increased awareness of the psychosocial aspects of social action and change. The focus is on research and training in biobehavioural sciences and mental health; coordination of activities for the promotion of the mental health and psychosocial development of children; psychosocial aspects and quality of day care; the prevention of mental illness; assessment of the quality of life of patients with chronic diseases, with the appropriate interventions; the impact of television on behaviour; risk behaviour patterns for noncommunicable chronic diseases; and psychosocial problems associated with old age and mental disorders.

*Prevention and control of alcohol and drug abuse.* WHO cooperates with Member States in preventing and controlling problems related to alcohol and drug abuse, and in developing appropriate technologies for the treatment and management of problems when they do arise.

There are three priorities for the alcohol programme. The first is to arouse public interest, which has been done by new publications on community response to alcohol problems and on the public health implications of trends in alcohol production and trade. The second priority is to develop and review comprehensive national policies. The third is to develop techniques for the identification, prevention and management of alcohol-related problems in the primary health care setting.

As regards drug abuse, WHO has continued to assess the benefits and risks involved in the use of narcotic drugs and psychotropic substances liable to cause dependence, and the role of medical and other health care professionals in the rational use of psychoactive drugs. WHO also collaborates with countries on drug abuse policy analysis; the incorporation of drug abuse control in primary health care programmes; the role of various treatment approaches and prescribing practices; and assessment of the extent and magnitude of the problem of cocaine misuse.

*Prevention and treatment of mental and neurological disorders.* The purpose here is to plan programmes and develop appropriate technologies for use in primary health care. Activities have concerned mainly improved diagnostic tools and new classifications; the introduction of a mental health component into primary health care; crisis intervention and psychiatric emergency services; a review of knowledge in the area of mental retardation; coordinated studies on the incidence, manifestations and course of schizophrenia and related disorders; prevention of mental, neurological and psychosocial disorders; biological psychiatry and psychopharmacology; and neurological problems.

### *Implementation and coordination of programmes*

Implementation of mental health programmes requires multisectoral commitment, the wide application of available technologies, and research to develop new and better ones. Legislation, the incorporation of mental health components in national development programmes and in health care at all levels, and training are the essential prerequisites for success and for progress towards health and wellbeing. These activities need a technological and procedural infrastructure before they can be incorporated into national health programme development.

In recent years, WHO's mental health programme and those of many Member States have broadened in scope and now include not only the prevention and treatment of mental and neurological disorders and problems such as those related to the abuse of drugs and alcohol, but also other concerns such as the promotion of mental health and the psychosocial aspects of general health care and of socioeconomic development. Broader scope dictates the need for a sharp focus: this is also one of the reasons for the generally increased interest in the evaluation of mental health activities.

### *Problem assessment and policy formulation*

Valid assessment of mental health and psychosocial problems and issues is essential for effective policy formulation. WHO must be able to collaborate with countries in this assessment, which should result in the identification of specific needs in terms of technology development. Problem assessment will include epidemiological estimation of the size and nature of problems; exchange of information; development of mechanisms for monitoring changes in the mental health situation in the country; utilization of knowledge provided by agencies and institutions outside the health sector; and collaboration with decision-makers in sectors other than health.

Policy formulation starts by increasing the awareness of decision-makers, professionals, community leaders and the population about the nature of the problems and the means available for their solution. The development and maintenance of national coordinating groups is a possible and useful next step, serving also to facilitate agreement about policy options.

New approaches to mental health policy formulation are being developed in some regions. For example, in the African Region a Mental Health Action Group involving ten countries of south-east Africa formulates national mental health policies cooperatively; and in Europe, groups of centres are likely to play a particularly active role in policy formulation. Regional and global coordinating groups will continue to be used to

facilitate and guide WHO's input into national, regional and global programme development. Interregional support will be important to ensure the exchange of experience and technical information among regions and countries, and to evaluate the effectiveness of new approaches in policy formulation.

### *Research and adaptation of technology*

Technology development involves research, assessment, adaptation and effective information transfer. WHO can catalyse and coordinate such activities and help bridge the gap between scientific advance and population needs.

The social relevance of research efforts and national self-reliance in research are essential criteria in selecting areas for technology development. Emphasis is given to technology which can be used in primary care and which will facilitate the incorporation of mental health components into general health care. The latter is considered a crucially important approach to the provision of care in most regions.

Effective information transfer requires mechanisms for information processing, analysis and dissemination. A selective approach is used, with emphasis on transfer of knowledge concerning the extent and nature of problems, the development of services and manpower to cope with them, and psychosocial aspects of health care and of overall development.

The development of infrastructures for research and training is supported by a network of collaborating centres designated by WHO and contributing to national, regional and global programmes. WHO makes a special effort to establish these centres in areas which had few in the past. At the same time, new forms of research and training infrastructure will continue to be evaluated in order to offer Member States a variety of options for collaborative activities.

### *Promotion of the use of appropriate technology*

When collaborating with countries, WHO promotes the use of technology appropriate to their needs, priorities and objectives. Activities include organizing and disseminating evaluations of existing treatments, diagnostic methods, and training techniques and opportunities; maintaining up-to-date lists of essential drugs, training materials and techniques; and developing the capacity to recommend standards for care provision, training and research.

WHO also promotes collaboration intended to improve the training of various categories of personnel. It makes sure that both these cooperative activities and their evaluation help to identify critical gaps in knowledge, thereby orienting research to the development of technology needed in programme implementation.

## **Managerial process for national health development (MPNHD)**

The successful formulation, implementation, monitoring and evaluation of mental health policy depends heavily on use of the correct managerial methodology if the objectives and targets are to be achieved.

The progressive reorientation of health and mental health services in the southern European countries towards the primary health care approach makes this process even more complex. Primary health care must be an integral part of each country's social and economic development if HFA is to be achieved, and a managerial process should be applied by each country to formulate and implement the strategy in a manner consonant with the country's own health situation and resources, social and economic conditions, and political and administrative mechanisms.

Many southern European countries now have clear policy objectives, programmes to be implemented, political commitment at government level, and a minimum of resources and organization. A national managerial process is essential to formulate or reformulate strategies and to convert them into plans for action so that the health system becomes strong enough to deliver the best possible programmes and to monitor and evaluate performance and progress.

National planning and programming should be a systematic, continuous process, therefore. The WHO guiding principles for MPNHD would appear to be highly relevant for the southern countries of the Region, and could form the basis for more specific guidelines to be developed by the countries themselves.

The main components of MPNHD are:

(a) the formulation of national health policies (comprising goals, priorities and main directions towards priority goals) suited to the social needs and economic conditions of the country and forming part of national social and economic development policies;

(b) broad programming, which is the translation of these policies, through various planning stages, into strategies designed to achieve clearly stated objectives and, wherever possible, specific targets;

(c) programme budgeting, or the preferential allocation of health resources for the implementation of the strategies;

(d) the master plan of action, resulting from broad programming and programme budgeting and indicating the strategies to be followed and the main lines of action to be taken in the health and other sectors to implement the strategies;

(e) detailed programming, which is the conversion of strategies and plans of action into programmes that specify objectives, targets, and the technology, manpower, infrastructure, financial resources and time required for their implementation through a unified health system;

(f) implementation — the translation of detailed programmes into action so that they begin to function as integral parts of the health system, the day-to-day management of programmes and the services and institutions for delivering them, and the continuing follow-up of activities to ensure that they are proceeding as planned and on schedule;

(g) evaluation of developmental health strategies and operational programmes, in order progressively to improve their effectiveness and impact and increase their efficiency;

(h) reprogramming (as necessary) with a view to improving the master plan of action or some of its components, or preparing new ones as required; and

(i) support, in the form of relevant and sensitive information, for all these components at all stages.

Several mechanisms are essential for ensuring continuity in the managerial process. First, health ministries should form an integral part of the policy-making mechanism concerned with socioeconomic development at the highest governmental level, and maintain close contact with other ministries and government authorities dealing with socioeconomic development. Second, a multisectoral national health council or similar body should be established as an advisory group to the health ministry or the highest executive or legislative authority for health matters. Third, national centres for health development should provide technical support to health ministries and health councils and link technical and policy bodies. And fourth, the task of formulating a national health strategy and plan of action should be assigned to a core group or committee of an intersectoral nature. A committee of this kind must have permanent connections with decision-makers, national health councils, representatives of professional groups, community and health workers' associations, and so on.

### **Training for change in mental health**

Most of the southern European countries are short of all types of mental health personnel, whose quality largely determines the quality of mental health care, and they need extra training facilities. Expansion has been mainly in the number of psychiatrists, even in those countries already well provided with them.

Although most mentally ill people are cared for by nurses, there is still relatively little evidence of adequate professional training for psychiatric nurses. There continue to be very large numbers of untrained or auxiliary staff in mental health services in general and in psychiatric hospitals in

particular. However, traditional training programmes provided in traditional mental hospitals may well be inappropriate for staff who will be working in multidisciplinary teams in a community-based service.

The formulation and implementation of community-based mental health policies will imply generally less dependence on beds in mental hospitals and more emphasis on the delivery of care through day care, through primary health care and through general hospital services. This change will affect patients and their families, the community, individual mental and general health workers, the services and their administrators. Community mental health means more patients living in the community and more professionals working with other professionals and community agents outside hospitals. Those responsible for community care will need better information and preparation in areas such as:

- the role of the family and its expectations for patients;
- the development of programmes for instructing patients and their relatives about various aspects of mental illness;
- fostering community social support for patients and families;
- coping with a recurring crisis at any moment and in a different context from emergency facilities at the psychiatric hospitals;
- the side effects of long-term neuroleptic medication, the best way to follow up patients, and how to reduce the likelihood of relapse;
- the best ways to cooperate and link up with various categories of community agents, making them more aware of the specific needs and problems of mentally ill individuals living or spending most of their lives in the community;
- the management of unwilling patients during a crisis;
- home-visiting and domiciliary consultation;
- ways of strengthening cooperation and the functional integration of activities with general practitioners and other primary health care professionals;
- contacting community institutions and committees, both formally and informally, which implies considerable knowledge of civil legislation and social structure;
- working in multidisciplinary settings;
- defining responsibilities with others involved in the network of mental health services, to ensure continuity of care; and
- information, which is a crucial area requiring preparation and training, especially for those involved in administration; in the near future, many community services in the southern European

countries will be operating case registers providing information on the prevalence and incidence of disease, patterns of care, the effectiveness and efficiency of services, and the evaluation of services and programmes.

The following main issues emerged from questions raised by the country representatives at the meeting regarding human resources and training for change.

*Cyprus.* Cyprus will need to: redirect efforts towards the community by involving more mental health professionals working in the ever-increasing community facilities and at the periphery; train general practitioners and health workers in mental health and psychiatry; sensitize members of the public and key people in the community to the problems and needs of the mentally ill and help to remove or reduce prejudice and negative attitudes; organize short courses for primary health care professionals working at rural health centres; and devote a good portion of the time of the more experienced mental health professionals to the training, supervision and monitoring of nonspecialized health workers, and to the evaluation of mental health programmes.

*Greece.* Psychiatric units in general hospitals should carry out the training of doctors and especially psychiatric nurses; mental health centres should develop educational programmes for the population at large, for specific groups and for community agents.

*Italy.* University clinics should contribute to the training of new professionals able to face the new problems emerging in the area of mental health, and should adapt themselves to the new organization of public services.

*Malta.* Manpower development must include added emphasis on the community-oriented problems of the psychiatric patient, including training and recruitment of various paramedical staff in fields hitherto unexplored. Specialized personnel such as psychiatric social workers, occupational therapists and clinical psychologists should be trained in the country; training in primary care settings should be included. In-service training should be organized for medical practitioners, mainly in the early diagnosis of depression and its treatment and management. Public awareness needs to be increased through health education programmes in schools, youth clubs and universities.

*Morocco.* Morocco will need to set up a new organization of mental health services taking into account, among other points, the services' physical capacity for training activities; and should give priority to the training of psychiatrists, nurses, psychologists and social workers.

*Portugal.* Portugal will need to: develop postgraduate training programmes for professionals working in primary health care (general practitioners), emergency departments in district general hospitals and therapeutic social centres; organize mental health educational programmes for general practitioners, including preventive interventions for special groups (mother/child, schoolchildren, the elderly, etc.); provide training courses for mental health professionals in mental health administration and community psychiatry; and introduce mental health components into the postgraduate courses for public health doctors and nurses, occupational physicians and hospital administrators.

*Spain.* Spain will need to: counteract the scarcity of human resources, which at present is due mainly to the concentration of staff in the main towns and in the hospitals; deal with differences in professional qualifications within the same professional categories of health worker; improve knowledge of mental problems among primary health care personnel as part of the introduction of mental health programmes in primary health care services; reduce the numbers of hospital beds and make available professional staff who can be oriented towards extra-hospital care; as a priority, introduce programmes whereby mental health teams support, advise and supervise primary health care teams; gradually introduce accreditation in areas such as the mental health of children, adolescents and the elderly, alcohol and drug abuse, and mental health planning and management (some Autonomous Communities have started pilot experiments in the postgraduate training of psychologists); reorganize obsolete structures; and make better use of health professionals.

*Turkey.* Turkey will need to: meet the need for increased numbers of mental health personnel and for increased training facilities; ensure that psychiatric nurses are trained mainly in university hospitals and that the university offers training in clinical psychology; and improve communications between the Ministry of Health (the provider of mental health services) and the universities (the training institutions for doctors and nurses).

Other points raised were:

- given mental health budget limitations, as well as the proportion of this budget devoted to employing psychiatrists, careful attention should be given to the number of psychiatrists trained, since large increases in this group could prevent the development of other professional categories, especially nurses;
- the shortage of nurses, especially in the field of community psychiatric nursing, is a severe problem in the southern European countries

and will be a major constraint on the desired development of community-based mental health services;

- other categories of mental health professional, such as psychologists, suffer from inadequate training and inadequate facilities for clinical work in mental health services;
- similar difficulties confront occupational therapists and social workers, mainly as concerns the need for training programmes provided by and within the mental health services;
- in many cases it is difficult to develop adequate and effective in-service training programmes in mental health because opportunities are still scarce for trainees to participate in community mental health services or to undergo advanced training;
- WHO collaborating centres should play a part in this important field of training; and
- the progressive development of psychiatric facilities within the general hospitals will require the specific training of mental health professionals to work in this new context.

### **Mental health problems of migrants**

According to the United Nations, about 5.5 million immigrants from southern European countries were living in the northern and western parts of Europe in 1974. Since then, because of the economic recession, aging of the earlier migrant population, high unemployment and stricter immigration controls, labour migration has fallen sharply and a reverse trend of migration back towards the countries of origin has appeared.

The health consequences of migration have long been a subject of interest: social psychiatrists as well as epidemiologists working in the mental health field have tried to find out to what extent it could be held responsible for the occurrence of mental disturbances. In these studies, the highest rates of mental disorders have been found among groups such as refugees and displaced persons, whose emigration could hardly be considered to be voluntary. Today, however, the relationship between mental disorders and migration has become more questionable and migration seems less often to be considered as a risk factor in itself.

Little is known about the mental health of those relations and family members who are left behind, especially children. A few epidemiological studies have been made of mental health problems of immigrants from southern to northern countries of the Region; but national and international statistics on the subject, even when available, are largely inconclusive.

The southern European participants in the Working Group believed that problems related to the increasing number of migrant workers

returning home was an important health and mental health issue. For example, some studies have shown that more than 60% of the total number of emigrants who have returned to Yugoslavia now had either a reduced work capacity or total incapacity to work. Finding high rates of unemployment in their home countries and lower standards of living, and with problems of family adaptation after many years abroad, some returning migrants are re-emigrating back to their host countries.

An important contribution of mental health services in southern European countries could be the improvement of epidemiological research and the collection of epidemiological data that could be used to identify needs and plan services for migrants and their families. Caution must be exercised, however, to prevent the medicalization of migrants' adjustment problems.

WHO and other international organizations have an important role to play in supporting coordinated studies and promoting the exchange of programmes and information on migration and health. The European Regional Office has published a special report on this subject.<sup>a</sup>

The Working Group considered that there was an urgent need for short-term initiatives to be taken in the field of mental health problems of migrants from the southern countries of the Region.

## CONCLUSIONS AND RECOMMENDATIONS

### Conclusions

1. Mental health policies and strategies have been formulated and implemented in various ways in the Member States represented in the Working Group, and are at present at different stages of development. Nevertheless, the Working Group felt that these different experiences could be used to advantage by those countries either intending to start or already involved in the reorientation of their mental health policies and practices.
2. Technical collaboration between and among Member States is highly desirable, given the circumstances of rapid change in the reformulation of policy and the development of national programmes of mental health care. In particular, the Working Group believed it would be useful to exchange experience and information on managerial methods for formulating, planning, implementing and evaluating mental health policies and strategies.

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<sup>a</sup> Colledge, M. et al., ed. *Migration and health: towards an understanding of the health care needs of ethnic minorities*. Copenhagen, WHO Regional Office for Europe, 1986.

3. Although all were agreed on the decentralization and regionalization of the managerial process for implementing change and development, there was some concern about the need to ensure intersectoral collaboration and coordination between central government departments and ministries, which is so essential for good mental health promotion.

4. An administrative post should be established in each country at the highest level of the government ministry or department concerned, as a focal point for coordination, and to permit the integration of mental health skills and knowledge in the general health services and in governmental and nongovernmental organizations.

5. The mental health problems of migrants should be a matter of concern for Member States, especially the issue of providing adequate and accessible care for migrants and/or members of their families with mental health problems.

### **Recommendations**

1. Ways should be explored of strengthening and supporting technical cooperation in the field of mental health among southern European countries and other countries of the Mediterranean basin, including the possibility of setting up a permanent action group composed of these countries. Special attention should be given to migration-related problems.

2. WHO should facilitate the exchange of experience and information about managerial processes in the development of community-based mental health programmes that conform to the objective of HFA. Special attention should be paid to the particular circumstances of countries with a federal structure.

3. The experience gained in national programme development by countries represented at this meeting should be brought to the attention of other countries in the European and other regions, using publications or other appropriate means and stressing the results of systematic evaluation constructed on a credible data base.

4. To facilitate the planning, budgeting, implementation and evaluation of national mental health programmes, a coordinating group on mental health should be established as appropriate at national, state and regional levels. The group should be composed of representatives of different sectors of government, e.g. welfare, education and health, and of nongovernmental organizations. Its terms of reference and its existence should be formalized by means of a governmental decision, and ways of implementing its decisions should be specified.

5. Under the responsibility of a senior officer in the health ministry, a department should be designated as being responsible for the implementation of the national mental health programme, and any country that has not yet adopted such a programme should do so as soon as possible. The programme should include fostering intersectoral cooperation between different government departments with responsibilities in the mental health field.

6. In every country, further efforts should be made to improve the professional training of all staff engaged in mental health activities, whether they provide primary health care or specialist services. Those workers who equip themselves with a high level of knowledge and skills should be encouraged to take leadership roles in developing mental health services.

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## RESUME

Le groupe de travail a été convoqué par le Bureau régional de l'OMS pour l'Europe en collaboration avec le gouvernement espagnol qui a accueilli la réunion au Ministère de la santé et de la consommation à Madrid. Le centre collaborateur de Paris (France) pour la recherche et la formation en santé mentale a participé activement à la préparation comme au déroulement de la réunion.

A cette réunion ont assisté 16 conseillers temporaires des Régions de l'Europe et de la Méditerranée orientale, huit observateurs, et des représentants de la Commission des Communautés européennes (CCE), du centre collaborateur de l'OMS pour la santé et les facteurs psychosociaux et psychobiologiques, à Bierbeek (Belgique), et de l'Association mondiale de psychiatrie.

La réunion du groupe de travail s'inscrivait dans le cadre du programme OMS interpays à moyen terme pour la santé mentale et de programmes coopératifs à moyen terme entre des pays de la Région et le Bureau régional.

### **Le point sur l'état des services de santé mentale et leur évolution**

Le groupe de travail a fait le bilan de l'expérience acquise par trois pays qui ont entrepris de reformuler leur politique de santé mentale à l'occasion de la révision de la politique sanitaire générale avec l'aide de l'OMS dans le cadre d'un programme coopératif à moyen terme. Les participants ont également décrit l'évolution des services de santé mentale dans leur pays sans l'appui de l'OMS et ont étudié dans quelle mesure il serait possible d'inclure les activités de santé mentale dans leur programme coopératif.

Les participants ont étudié et échangé des informations sur les méthodes de planification, d'exécution, d'évaluation et de reprogrammation de la politique de santé mentale dans leurs pays respectifs. Ils ont pris connaissance des principes directeurs de l'OMS applicables au processus gestionnaire pour le développement sanitaire national et à l'évaluation des programmes de santé et ont fait part de l'expérience acquise dans leur pays.

## Questions présentant un intérêt particulier

Parmi les questions présentant un intérêt particulier examinées lors de la réunion figuraient les problèmes de santé mentale des migrants vers les pays d'Europe du Sud et en provenance de ces pays.

Le directeur du Fonds social de la Commission des Communautés européennes a présenté en détail l'appui financier exceptionnel fourni par la Communauté européenne à la Grèce afin de permettre à ce pays de revoir son système de santé mentale.

Le directeur de la Division de la santé mentale du Siège de l'OMS a présenté le programme mondial à moyen terme de protection et de promotion de la santé mentale ainsi que le rapport du directeur général à la Trente-neuvième assemblée mondiale de la santé, tenue en mai, sur la prévention des troubles mentaux, neurologiques et psychologiques.

## Conclusions

Les Etats Membres dont l'expérience a été étudiée n'ont pas abordé de la même façon le processus de formulation et de mise en oeuvre des politiques et stratégies de santé mentale, qui est donc plus ou moins avancé selon les cas. Les informations présentées constituent une source importante et variée de données d'expériences qui doivent être partagées avec les pays qui envisagent de réorienter leurs politiques et méthodes de santé mentale ou qui ont déjà commencé à le faire.

Les participants ont reconnu que la collaboration technique entre les Etats Membres était très importante en raison de la rapidité des changements observés au cours de la reformulation ou de l'élaboration de programmes nationaux de santé mentale. Ils ont notamment étudié les mérites de la mise en commun de données d'expériences et de l'échange d'informations sur leurs méthodes respectives de formulation, planification, mise en oeuvre et évaluation des politiques et stratégies de santé mentale. Tous les participants étaient convaincus que l'évolution de leurs systèmes de santé mentale passait par la décentralisation et la régionalisation du processus gestionnaire, mais certains se demandaient comment assurer au niveau des ministères et des départements la collaboration et la coordination intersectorielles indispensables à la promotion de la santé mentale et aux activités de prévention. Ils sont parvenus à la conclusion qu'il faudrait créer au plus haut niveau au sein d'un ministère ou d'un département un poste dont le titulaire serait chargé de coordonner et d'intégrer les compétences et savoir-faire en matière de santé mentale dont disposent les services généraux de santé ainsi que les organisations gouvernementales et non gouvernementales.

Les problèmes de santé mentale des migrants et/ou de leurs familles, et en particulier la possibilité de leur offrir des soins appropriés et accessibles, sont un sujet de préoccupation.

## Recommandations

1. Il faudrait renforcer et appuyer la coopération technique dans le domaine de la santé mentale entre les pays du sud de l'Europe et d'autres pays du bassin méditerranéen, éventuellement en créant un groupe d'action permanent entre ces pays. Il faudrait accorder une attention particulière aux problèmes liés aux migrations.

2. L'OMS devrait faciliter l'échange de données d'expérience et d'informations sur les processus gestionnaires pour l'élaboration de programmes communautaires de santé mentale conformes à l'objectif de la Santé pour tous. Il faudrait accorder une attention particulière à la situation spécifique des pays fédérés.

3. L'expérience acquise lors de la mise en oeuvre des programmes nationaux étudiés à l'occasion de la réunion devrait être communiquée aux autres pays de la Région européenne et d'autres Régions sous forme d'une publication et par d'autres moyens. Des résultats d'évaluation systématique, établis à partir d'une base de données crédibles, seraient particulièrement utiles.

4. Afin de faciliter la planification, la budgétisation, la mise en oeuvre et l'évaluation des programmes nationaux de santé mentale il faudrait établir, selon les besoins, un groupe de coordination aux niveaux national et régional. Ce groupe devrait être composé de représentants des différents secteurs de l'administration (par exemple action sociale, administration, santé, etc.) et d'organisations non gouvernementales. Son mandat et sa création devraient faire l'objet d'une mesure officielle et il faudrait préciser par quels moyens ses décisions seront mises en oeuvre.

5. Un service, dirigé par un haut fonctionnaire du Ministère de la santé, devrait être chargé de l'application du programme national de santé mentale, et les pays qui n'ont pas encore adopté un tel programme devraient le faire aussi rapidement que possible. Ce programme devrait notamment favoriser la coopération intersectorielle entre les différents services concernés.

6. Il faudrait dans tous les pays faire davantage d'efforts pour améliorer la formation professionnelle de tout le personnel s'occupant de questions de santé mentale, aussi bien au niveau des soins de santé primaires que des services spécialisés. Il faudrait encourager ceux qui ont acquis des connaissances et compétences particulièrement importantes à prendre l'initiative dans la mise en place des services de santé mentale.

## ZUSAMMENFASSUNG

Diese Arbeitsgruppentagung, die vom WGO-Regionalbüro für Europa in Zusammenarbeit mit der spanischen Regierung veranstaltet wurde, fand auf Einladung des Gastgeberlandes im Ministerium für Gesundheit und Verbraucherangelegenheiten in Madrid statt. An der Planung und Durchführung dieser Tagung war auch das in Paris, Frankreich, angesiedelte WGO-Kollaborationszentrum für Forschung und Ausbildung im Bereich geistig-psychische Gesundheit aktiv beteiligt.

Anwesend waren 16 Berater auf Zeit aus der Europäischen Region und der Region Östliches Mittelmeergebiet, 8 Beobachter sowie Vertreter der Kommission der Europäischen Gemeinschaften (KEG), des WHO-Kooperationszentrums für Gesundheit, psychosoziale und psychobiologische Faktoren in Bierbeek, Belgien, und des Weltverbandes für Psychiatrie.

Die Tagung der Arbeitsgruppe wurde im Rahmen des mittelfristigen Mehrländerprogramms der WGO für geistig-psychische Gesundheit und der mittelfristigen Kooperationsprogramme des WGO-Regionalbüros für Europa mit einzelnen Ländern durchgeführt.

### **Analyse der Dienste und Entwicklungen**

Die Arbeitsgruppe informierte sich über die bisherigen Erfahrungen dreier Länder, in denen das Konzept der geistig-psychischen Gesundheitsbetreuung im Zusammenhang mit weitreichenden gesundheitspolitischen Entwicklungen und Veränderungen und unterstützt durch ein mittelfristiges WGO-Kooperationsprojekt einen grundlegenden Wandel erfahren hat. Von den Teilnehmern wurden dabei auch Veränderungen und Entwicklungen beschrieben, die sich in ihren Ländern ohne Unterstützung durch ein WGO-Kooperationsprogramm im Bereich der geistig-psychischen Gesundheitsversorgung vollzogen hatten. In diesem Zusammenhang wurde auch die Möglichkeit in Erwägung gezogen, Aktivitäten auf dem Gebiet der geistig-psychischen Gesundheitsbetreuung in das jeweilige Kooperationsprogramm eines Landes mit der WGO einzugliedern.

Im Rahmen eines Informationsaustausches befaßten sich die Teilnehmer mit den in den verschiedenen Ländern praktizierten Verfahren zur Planung, Durchführung, Beurteilung und Abänderung von Projekten im Bereich der geistig-psychischen Gesundheitsversorgung. Außerdem wurden die Grundzüge des Management-Prozesses zur Verbesserung der Gesundheitslage in den Ländern (MPNHD) und der Gesundheitsprogrammevaluierung (HPE) vorgestellt und diesbezügliche Erfahrungen einzelner Länder ausgetauscht.

### **Sonderthemen**

Zu den Fragen, denen besondere Aufmerksamkeit gewidmet wurde, gehörten geistig-psychische Probleme von Wanderarbeitnehmern, die entweder aus den südlichen Ländern der Europäischen Region stammen oder dort einer Beschäftigung nachgehen.

Der Direktor des Sozialfonds der Kommission der Europäischen Gemeinschaften erörterte die außerordentlichen finanziellen Hilfsmaßnahmen, mit denen die Europäische Gemeinschaft die Reform der geistig-psychischen Betreuung in Griechenland unterstützt hat.

Vom Direktor der Abteilung Geistig-psychische Gesundheit der WGO-Hauptverwaltung wurde das globale mittelfristige Programm der WGO für den Schutz und die Förderung der geistig-psychischen Gesundheit sowie der Bericht des Generaldirektors an die neununddreißigste Weltgesundheitsversammlung im Mai zum Thema Verhütung geistig-psychischer, neurologischer und psychologischer Störungen vorgestellt.

### **Schlußfolgerungen**

Wie die besprochenen Fallbeispiele zeigten, wurden in den betroffenen Mitgliedsländern bei der Ausarbeitung und Umsetzung eines Konzepts und entsprechender Strategien auf dem Gebiet der geistig-psychischen Gesundheitsbetreuung verschiedene Ansätze verfolgt, die sich z.Z. in unterschiedlichen Entwicklungsstadien befinden. Die diesbezüglichen Erfahrungen, über die in Vorträgen berichtet wurde, waren gerade für diejenigen Länder sehr aufschlußreich, die eine Umorientierung ihrer Konzepte und Praktiken im Bereich der geistig-psychischen Gesundheitsversorgung planen oder bereits in Angriff genommen haben.

Die Teilnehmer waren sich darin einig, daß eine bi- und multilaterale fachliche Zusammenarbeit zwischen den Mitgliedsländern angesichts des raschen Wandels bei der Umorientierung bzw. Entwicklung einzelstaatlicher Programme auf dem Gebiet der geistig-psychischen Gesundheitsversorgung sehr wichtig und angebracht erschien. Als besonders nützlich erachteten sie den Informations- und Erfahrungsaustausch über die in den einzelnen Ländern angewandten Verfahren zur Ausarbeitung, Planung,

Durchführung und Beurteilung von Konzepten und Strategien für eine geistig-psychische Gesundheitsbetreuung. Es bestand zwar Einvernehmen darüber, daß die mit diesem Wandel und den sich daraus ergebenden Entwicklungen verbundenen Probleme am ehesten durch eine Dezentralisierung und Regionalisierung zu lösen seien; einige Teilnehmer stellten allerdings besorgt die Frage, wie die erforderliche Kooperation und Koordination zwischen einzelnen Behörden und Ministerien sichergestellt werden könne, die für die Förderung der geistig-psychischen Gesundheit und die Verhütung psychischer Störungen so wichtig ist. Es wurde beschlossen, daß in jedem Land auf oberster ministerieller Verwaltungsebene ein Posten geschaffen werden solle, von dem aus die Koordination und Integration der erforderlichen Sach- und Fachkenntnisse aus dem öffentlichen Gesundheitswesen sowie aus staatlichen und nichtstaatlichen Organisationen zentral gesteuert werden solle.

Besondere Bedeutung kommt den geistig-psychischen Problemen von Wanderarbeitnehmern zu, insbesondere der Schaffung einer angemessenen und leicht zugänglichen Versorgung für Wanderarbeitnehmer und/oder deren Familienangehörige, die unter geistig-psychischen Problemen leiden.

## **Empfehlungen**

1. Die fachliche Zusammenarbeit zwischen den Ländern Südeuropas und anderen Mittelmeeranrainerstaaten auf dem Gebiet der geistig-psychischen Gesundheitsversorgung sollte gestärkt und gefördert werden, eventuell durch die Schaffung eines mit Vertretern dieser Länder besetzten Ständigen Ausschusses. Besondere Aufmerksamkeit ist in diesem Zusammenhang auch den Problemen von Wanderarbeitnehmern zu widmen.

2. Die WGO sollte den Informations- und Erfahrungsaustausch über praktische Verfahren zur Entwicklung gemeindenaher geistig-psychischer Gesundheitsbetreuungsmaßnahmen erleichtern, die den Zielen der GFA-Strategie entsprechen. Besondere Beachtung verdienen in diesem Zusammenhang die spezifischen Verhältnisse, die in Ländern mit einer föderativen Struktur herrschen.

3. Die auf der Tagung vorgestellten Erfahrungen einzelner Länder bei der Entwicklung geistig-psychischer Gesundheitsdienste sollten auch anderen Ländern Europas und anderen Regionen durch Veröffentlichungen und andere zweckdienliche Mittel zugänglich gemacht werden.

4. Zur Erleichterung der Planung, Kosteneinschätzung, Umsetzung und Evaluierung einzelstaatlicher Programme auf dem Gebiet der geistig-psychischen Gesundheitsversorgung sollte entsprechend den nationalen

Gegebenheiten auf Bundes-, Landes- oder regionaler Ebene ein Koordinationsausschuß geschaffen werden. Dieser Ausschuß sollte sich aus Vertretern staatlicher Stellen (z.B. der Sozialfürsorge, sowie dem Bildungs- und Gesundheitswesen, etc.) und nichtstaatlicher Organisationen zusammensetzen. Die Aufgaben und die Existenz dieses Ausschusses sollten durch einen entsprechenden Beschluß der jeweiligen Regierung formalisiert werden, und es sollte auch festgelegt werden, mit welchen Mitteln die Entscheidungen des Ausschusses umgesetzt werden können.

5. Für die Durchführung der jeweiligen nationalen Programme im Bereich der geistig-psychischen Gesundheitsbetreuung sollte eine unter der Leitung eines hochrangigen Beamten stehende Abteilung im Gesundheitsministerium zuständig sein. In den Ländern, in denen noch keine derartigen Programme existieren, sollten sie so bald wie möglich geschaffen werden. In diesem Zusammenhang sollte die Zusammenarbeit zwischen den einzelnen Behörden und Ministerien, die für Fragen der geistig-psychischen Gesundheitsbetreuung zuständig sind, gefördert werden.

6. In jedem Land sollten weitere Anstrengungen zur Verbesserung der beruflichen Ausbildung aller auf dem Gebiet der geistig-psychischen Gesundheitsbetreuung tätigen Fachkräfte unternommen werden, und zwar sowohl im Bereich der primären Gesundheitsversorgung als auch im fachärztlichen Bereich. Diese hochqualifizierten und spezialisierten Fachkräfte sollten dazu ermutigt werden, bei der Entwicklung geistig-psychischer Gesundheitsdienste eine führende Rolle zu übernehmen.

## КРАТКИЙ ОТЧЕТ

Совещание рабочей группы было созвано Европейским региональным бюро ВОЗ в сотрудничестве с правительством Испании, организовавшем проведение совещания в Мадриде при Министерстве здравоохранения и по делам потребителей. Сотрудничающий центр ВОЗ по научным исследованиям и подготовке специалистов в области охраны психического здоровья, Париж, Франция, принял активное участие и внес определенный вклад в дело планирования и проведения совещания.

В работе совещания приняли участие 16 временных советников из государств - членов Европейского и Восточномедиземноморского регионов, восемь наблюдателей, а также представители Комиссии европейских сообществ (КЕС), Сотрудничающего центра ВОЗ по воздействию психосоциальных и психобиологических факторов на здоровье, Бирбэк (Бельгия) и Всемирной психиатрической ассоциации.

Рабочая группа была создана в контексте межнациональной среднесрочной программы ВОЗ по охране психического здоровья и среднесрочных программ сотрудничества между странами и Европейским региональным бюро.

### Обзор служб и положение дел

Рабочая группа рассмотрела положение на сегодняшний день и опыт в трех странах, в которых политика в области обеспечения психического здоровья была пересмотрена в контексте общих процессов и

изменений политики в области здравоохранения, осуществляемых в соответствии со среднесрочной программой сотрудничества ВОЗ со странами. Участники также рассказали об изменениях и развитии служб охраны психического здоровья в своих странах безотносительно к программе сотрудничества ВОЗ со странами и рассмотрели перспективы включения мероприятий по охране психического здоровья в соответствующую программу сотрудничества у себя в странах.

Участники рассмотрели информацию и обменялись информацией по методам планирования, претворения в жизнь, оценки и пересмотра программ в рамках политики охраны психического здоровья в своих странах. Были представлены руководящие принципы ВОЗ по процессу управления развитием национального здравоохранения (ПУРНЗ) и по оценке программ здравоохранения (ОПЗ) и был осуществлен обмен опытом отдельных стран.

### Особые темы

К числу тем, которым было уделено особое внимание, относились проблемы охраны психического здоровья лиц, мигрирующих в южные страны Европейского региона и эмигрирующих из них.

Директор Социального фонда Комиссии европейских сообществ остановился на вопросе чрезвычайной финансовой помощи, предоставленной Греции Европейским сообществом на проведение реформы в области охраны психического здоровья.

Директор отдела охраны психического здоровья при штаб-квартире ВОЗ рассказал о глобальной среднесрочной программе по охране и укреплению психического здоровья, а также представил доклад Генерального директора Тридцать девятой сессии Всемирной ассамблеи здравоохранения, состоявшейся в мае, о профилактике психических, неврологических и психологических отклонений.

## Выводы

В государствах-членах, о которых говорилось выше, процесс формулирования и претворения в жизнь политики и стратегий охраны психического здоровья осуществлялся неодинаковым образом и в настоящее время находится на различных стадиях своего развития. В представленных материалах нашел свое отражение весьма многогранный ценный опыт, который можно было бы использовать в тех странах, которые или намереваются приступить или уже приступили к решению задач по переориентации своей политики и практической деятельности в области охраны психического здоровья.

Участники согласились с тем, что техническое сотрудничество между государствами-членами весьма актуально и необходимо, учитывая быстрые изменения, происходящие в деле переработки или разработки национальных программ охраны психического здоровья. В частности, они рассмотрели положительные стороны обмена опытом и информацией относительно своих управленческих методов формулирования, планирования, осуществления и оценки политики и стратегии охраны психического здоровья. Все согласились с тем, что децентрализация и регионализация управленческого процесса является способом обеспечения необходимых изменений и развития, однако отдельные выступавшие высказали озабоченность по вопросу о том, каким образом следует обеспечивать необходимое межсекторальное сотрудничество и координацию между ведомствами и министерствами центрального правительства – условия, существенные для обеспечения надлежащего развития служб охраны психического здоровья и работы профилактического характера. Было решено, что в каждой стране необходимо учредить административную должность на самом высоком уровне правительственного министерства или ведомства в качестве центра координации и интеграции знаний, навыков и умений в области охраны психического здоровья в рамках обычных служб охраны здоровья, а также в правительственных и неправительственных организациях.

Озабоченность вызывают проблемы психического здоровья мигрантов, в частности, вопрос об обеспечении надлежащей доступной помощи мигрантам и/или их семьям в отношении проблем охраны психического здоровья.

## Рекомендации

1. Необходимо усилить техническое сотрудничество и обеспечить содействие ему в области охраны психического здоровья в странах юга Европы и других странах Средиземноморского бассейна, возможно, путем учреждения постоянной группы для проведения в жизнь практических мер сотрудничества между этими странами. При этом следует уделить особое внимание проблемам, связанным с миграционными процессами.
2. ВОЗ надлежит активизировать обмен опытом и информацией об управленческих процессах, имеющих место при разработке программ охраны психического здоровья на коммунально-общинном уровне, что соответствует целям обеспечения здоровья для всех. Особое внимание следует уделить конкретным особенностям стран, представляющим собой федерацию.
3. Опыт по разработке национальных программ в странах, ставший примером обсуждения на совещании, следует довести до сведения других стран данного и иных регионов путем издания соответствующей публикации и с помощью других средств. Особенно полезными могут быть результаты систематической оценки, полученные с использованием надежной и достоверной базы данных.
4. Для содействия планированию, составлению бюджетов, осуществлению и оценке национальных программ психического здоровья следует учредить соответствующую группу по координации действий в области охраны психического здоровья на национальном, государственном и региональном уровнях. Эта группа должна объединять представителей различных секторов правительственных (например, социальное обеспечение, образование, здравоохранение и т.д.) и неправительственных организаций. Их круг ведения и фактический статус

можно было бы соответствующим образом определить путем принятия надлежащего правительственного решения с конкретизацией путей и способов выполнения данных решений.

5. Следует выделить специальное ведомство под началом одного из старших сотрудников министерства здравоохранения, которое бы отвечало за реализацию национальных программ охраны психического здоровья, тогда как в странах, где такая программа еще не принята, это следует сделать как можно быстрее. Сюда должно относиться, в том числе, укрепление межсекторального сотрудничества между различными правительственными ведомствами и учреждениями, на которые возложены обязанности в области охраны психического здоровья.

6. Во всех странах следует приложить дальнейшие усилия с тем, чтобы усовершенствовать дело профессионального обучения всего персонала, работающего в области охраны психического здоровья как на уровне первичной медикосанитарной помощи, так и на уровне специализированных служб. Работников, добившихся высокого уровня квалификации, знаний и умений, следовало бы поощрять, предоставляя им возможность выполнять руководящие функции в деле развития служб охраны психического здоровья.