

areas of 100 000 inhabitants and offer community services for severe mental illnesses (SMI). An MHC multidisciplinary team should be staffed by nine psychiatric nurses, nine social workers, two psychiatrists and one psychologist. It should provide mobile case management services, crisis interventions, day care services, and out-patient psychiatric and psychological care. The Centres must be continuously accessible by telephone and available 12 h per day for out-patient visits. Moreover, they should be equipped with 2–10 beds for short-term emergency stays. During 2017, a pilot operation will be launched in 30 Centres; this will be financed from EU funds during the first 18 months, then subsequently by the public health insurance system and local social funds. The guarantor of the Reform is the Czech Psychiatric Association, which is preparing for the individual activities of the Reform in close cooperation with the Ministry of Health (see [Table 1](#)).

Future tasks

Although the first plans for the transformation of hospitals are already included in the current Reform, more effort will be needed for deinstitutionalisation of large hospitals in future, in order to prevent parallel care and to recruit the necessary staff for new services. Regarding community services, more attention should also be paid to target groups other than SMI, e.g. children and adolescents with mental health problems, and elderly people with dementia.

Another point is that there seems to be insufficient legislation for mental healthcare, promotion and prevention. Amendments to legislation which would cover these issues seem to be necessary for the future.

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SPECIAL
PAPER

Reform of mental health services in Eastern Europe and former Soviet republics: progress and challenges since 2005

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For over a decade, concerted efforts have been made in Europe to reform mental health services and move away from institutions to community-based models of care, supported

by international policy statements, good practice examples and research evidence. Progress has been uneven. So what is the status of mental healthcare across the World

Health Organization European Region, and what factors support, or detract from, such progress?

The policy environment

A Europe-wide consensus on mental health policy was reached at the World Health Organization (WHO) Ministerial Conference in Helsinki in 2005, when a declaration and Action Plan was endorsed by all the European Member States on the direction of mental healthcare – balancing promotion and prevention with the provision of effective, accessible and affordable community-based services – inspired by successful transitions away from institutions in some Western countries. This model was reinforced by the European Mental Health Action Plan in 2013 which strengthened the focus on the rights of patients and families (WHO, 2015a). The European Commission (2016) has also been very active in the field, working in close partnership with WHO. The European Commission launched the Pact for Mental Health and Wellbeing in 2008, and in 2016 completed the European Framework on Mental Health and Wellbeing. This included a work package on ‘transition to community-based and social inclusive mental healthcare’. The objectives and goals of the WHO and European Commission policy documents were closely aligned.

The messages about the need for accessible and acceptable mental health services were acted on by many of the ministries across Europe. Most countries have now drafted comprehensive mental health policies, inspired by the content of the WHO Action Plans. In many cases, national policies are remarkably similar, partly because they have a similar ideological origin following the adoption of the Action Plans, but also because countries use each other’s policies as templates. A trail can be followed from Serbia to Azerbaijan, Turkey to Turkmenistan, and across the Central Asian Republics. Obviously, language as well as culture play an important role.

Infrastructure

All European countries have some psychiatric infrastructure in place, however basic. In most former East European and Soviet countries, mental health systems still comprise large mental hospitals and rudimentary psychiatric out-patient clinics only, with very little involvement from primary care or social services. Psychosocial services are unavailable apart from a small private or independent sector. These countries have very limited numbers of clinical psychologists and many have no social workers active in mental health. The implementation of community care is therefore not equated simply to the closure of hospital beds and expansion of clinics, but requires the establishment of new community resources.

The development of national strategies

In principle, commitment to mental health reform is genuine and strong in many countries. A typical example is Turkmenistan, where services are still based on the old Soviet model, providing traditional and stigmatized psychiatric treatments in clinical settings. In the course of several visits requested by the Ministry of Health, and after many long meetings with the mental health working group, alternatives were initially explored with a significant degree of scepticism, but then with gradual acceptance. Examples are the expansion of the role of family doctors and the idea of small outreach services based in community settings. Very recently, a new modern mental health policy was adopted.

It would be unfair and simplistic either to equate the adoption of a national strategy with an improvement of mental healthcare, or to dismiss the process as symbolic or a gesture to international agencies to demonstrate commitment. Drafting and adoption of strategies always involves the engagement of the main stakeholders, many of whom are passionately committed. Adoption implies a scrutiny process and approval by the ministry, government or even parliament. Still, undeniably many reforms stall or do not proceed beyond the strategy stage, creating a sense of cynicism about the realism of intent and process. But realism should not be confused with commitment.

Who succeeds and why?

The key question is why some countries succeed with reform, whereas so many struggle. Comparing countries that have made the transition to community-based services with those that still provide traditional hospital care offers some insights. The former include the Netherlands, the UK, Scandinavian countries and Italy. A transitional group include France, Germany, Switzerland, Luxembourg, Austria and perhaps Belgium and Israel. These latter countries typically provide good quality services that rely heavily on private practice and modern hospital care, with some community support. But some isolated examples of good practice can also be found in many former Eastern European countries such as Albania, Bosnia and Slovenia, which are often supported by Western funding bodies and run by inspiring local non-governmental organisations. The challenge is to achieve national adoption of such model services in the face of poor available infrastructure and funding.

Finance

The graph (Fig. 1) demonstrates powerfully, for those countries with available information, that all countries that provide modern and/or good quality mental health services invest relatively heavily in mental healthcare (WHO, 2015b). Countries with basic and traditional services do

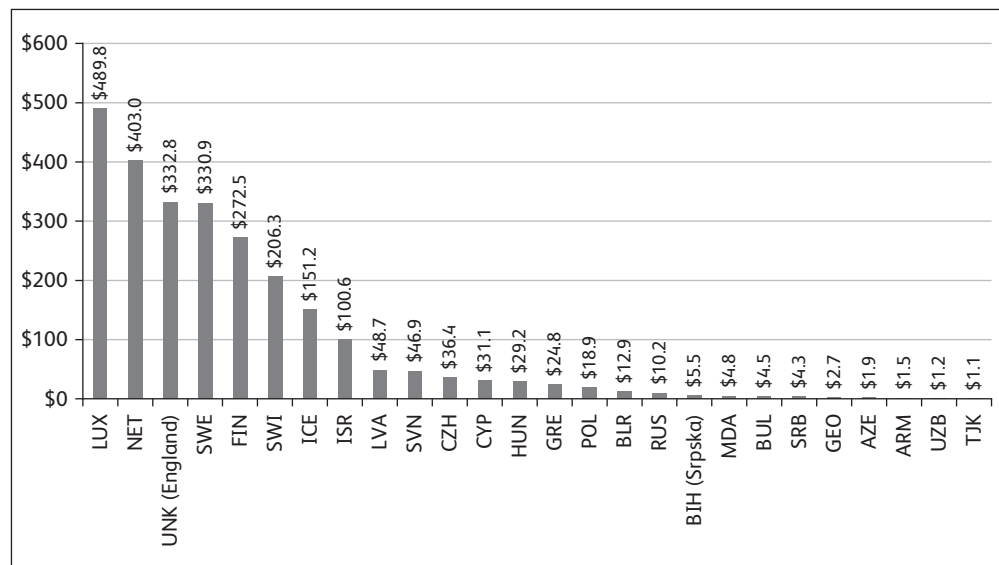


Fig. 1
Mental health expenditure per capita (\$USD). Data from WHO (2015b).

not. It is concerning that mental health spending inversely correlates with the percentage of gross domestic product spent on health. The lowest-income countries allocate a lower proportion of their resources to health, and of that an even lower percentage is spent on mental health. The highest-income countries allocate about 10% of their health budget to mental health, whereas the lowest-income countries allocate perhaps 1%. This results in a range of spending of \$1–\$500 per capita.

On their own, crude health spending figures only offer very limited insight since they do not take into account differences in salary levels, capital investment or quantity of supply, nor municipal budgets available for social care services. Graphs demonstrating numbers of psychiatrists or nurses, however, do show a strong association with spending. Numbers of beds are less correlated with spending, although the highest-income countries typically have more than the lowest-income countries, especially when care homes are included.

Rightly, the case is often made for transitional money to fund the reform of mental healthcare. Transitional cash enables a gradual transfer of mental hospital resources such as ward staff and capital costs to community services, such as accessible clinics and new small-scale residential homes by the temporary provision of double funding. For EU members or EU-accession countries, structural funds or accession money can be made available as is the case in, for example, Czechia, Poland and Turkey. Non-EU countries have the double disadvantage of lower health budgets and the lack of international resources to support the transition. An old and dilapidated hospital with a psychiatrist and 2 nurses for some 50 patients is a poor basis for building a modern mental health service.

It is not just money

It can be argued that such middle-income countries should increase their investment in mental health services, and that the low investment is due to neglect of the most vulnerable people and stigma. This is true, and the gap in quality between conditions of general and mental hospitals is distressing.

But it is not simply a case of investment. There is also a gap in academic expertise and training capacity. A striking example is Tajikistan (the only low-income country in the European Region), which lacks an academic department for psychiatry, since it used to rely on Moscow. In many countries the ability to train new recruits in modern mental health practice is lacking, and they rely on external support of varying quality and consistency. Moreover, once trained, many will leave to countries offering better salaries and quality of life.

It is becoming increasingly clear why countries struggle with implementation of their transformation strategies. Most successful are countries such as Turkey where a new policy is supported across government, bringing together health and social care, and backed up by funding and sustained international support. This is rare, and was possible at a time of strong economic growth which is, as always, cyclical. More typical is Ukraine, where short-term external emergency funding has enabled the creation of a few exciting new pilot services that have been quickly put at risk because of the lack of continuity, and a country bereft of funds. The resulting demoralization is inevitable.

Conclusion

If the international community is committed to improving the human rights and the conditions

of, and care for, people with mental disorders, a strong case needs to be made not to ignore middle-income countries, where relatively low levels of investment have the potential to achieve great change. For example, Central Asian countries are keen to jointly develop a mental health workforce training institute. Expertise developed in Turkey, Ukraine or Georgia could be shared and accelerate progress elsewhere. It is frustrating how difficult it is to find support because of a combination of the misleading label of 'middle income', the requirement of sustained funding, and the difficulty to construct and sustain initiatives that cross borders. A strategic perspective focusing on potential benefits, rather than

geography and superficial categories, might lift the quality of life of many of the most vulnerable people, their families and communities.

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SPECIAL
PAPER

Supporting community-based care and deinstitutionalisation of mental health services in Eastern Europe: good practices from Bosnia and Herzegovina

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In Eastern Europe, the Swiss Agency for Development and Cooperation is supporting various post-communist states in reforming their mental health systems to ensure equal access to high-quality services in community-based settings. The approach and new care models introduced have proven successful in most of these countries, one of which is Bosnia and Herzegovina.

Bosnia and Herzegovina has experienced a sharp increase in mental disorders over the past 20 years. Much of the population is still suffering from the consequences of the war that ravaged the Balkans in the 1990s (Priebe *et al.*, 2010). The most common mental disorders are depression, anxiety and disorders related to stress or domestic violence, as well as some more serious pathologies such as acute psychotic conditions and dementia. Of particular concern is alcohol and substance misuse among young adults suffering from transgenerational trauma in relation to the conflict. (On intergenerational transmission of trauma in general, see also Bowers & Yehuda (2016), Devakumar *et al.* (2014) and Jordanova (2012).) These disorders are exacerbated by high unemployment and widespread impoverishment. An ageing population and increased life expectancy have led to an upsurge

in mental health problems that tend to affect the elderly, in particular, dementia.

Prompted by a wave of deinstitutionalisation in mental health services across Europe since the 1970s, Bosnia and Herzegovina launched a comprehensive reform of its mental health services around 10 years ago, with a view to finding a balance between out-patient or in-patient care and the development of community-based services. Efforts to phase out mental asylums as an intervention model and to reduce the rate of hospital admission pose a real challenge in a context where public attitudes to those experiencing mental illness still result in stigmatisation and social exclusion. The Swiss Agency for Development and Cooperation has supported this reform since 2010 in the country's two political entities (Federation of Bosnia and Herzegovina and Republika Srpska), in partnership with the Swiss cantons of Jura, Fribourg, Bern and Geneva.

An integrated approach with high-quality care

As in Moldova and, more recently, in Ukraine, Swiss support in Bosnia and Herzegovina aims to promote equal access to health services and to improve the health and well-being of people living with a mental illness or those at risk of developing a mental disorder. Seeking a comprehensive