Original Articles

Mental health system and services in Albania

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SUMMARY. **Aims** — To describe the mental health system in Albania. **Methods** — Data were gathered in 2003 and in 2004 using a new WHO instrument, *World Health Organization Assessment Instrument for Mental health Systems* (WHO-AIMS), designed for collecting essential information on the mental health system of low and middle income countries. It consists of 6 domains, 28 facets and 156 items. **Results** — The information collected through WHO AIMS covered the key aspects of mental health system in Albania: the mental health policy and the legislative framework, the network of mental health services and the characteristics of the users, the role of the primary health care, the human resources, the public education and the links with other governmental sectors, monitoring and research. **Conclusions** — The data collection through WHO AIMS represented a needed step for a better in-depth knowledge of the system and for implementing actions to strengthen the system. Examples of planned actions were the improvement of the mental health component in primary care, a clear shift of resources from mental hospitals to community facilities, an increase of the outpatient care and an expansion of the mental health information system.

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INTRODUCTION

The World Health Organization (WHO) in the *World Health Report 2001. Mental Health: New Understanding, New Hope* (World Health Organization, 2001a) has put forward ten broad recommendations with specific minimum actions to be taken by countries in the area of mental health support for people with mental disorders. Recommended actions cover varying areas, including mental health policy, public education, and the organization of mental health services. One recommendation calls for monitoring. Monitoring systems and services is important to achieve informed decision making and accountability (World Health Organization, 2000).

The WHO Atlas study (World Health Organization, 2005a) reports that in 2005 more than 24% of countries do not have any system for collecting and reporting mental health information. Many other countries have information systems but these systems often are of limited scope and quality. Problems caused by a lack of information include a lack of rational planning, impeded accountability, incapacity to monitor the change promoted by mental health reforms, and the potential for developing ad-hoc solutions before understanding the situation.

Responding to this information gap, the World Health Organization has recently developed the *WHO Assessment Instrument for Mental Health Systems* (WHO-AIMS), a comprehensive mental health systems assessment, designed with the needs of middle and low-income countries in mind (World Health Organization, 2005b).

As in some Eastern Europe countries (Saraceno & Saxena, 2005), also in Albania in the last years many efforts have been done by the Government, International Organizations and NGOs to improve the mental health services in the country, but before the WHO AIMS data collection, little information were available on the mental health system in Albania. These data were derived from

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WHO Mental Health Atlas (World Health Organization, 2001b) and from a paper published in 2004 (Suli *et al.*, 2004), but they were insufficient to achieve a global picture. There was also a paucity of epidemiological data on mental illnesses in Albania in internationally accessible literature. Bilanakis et al. (2001) conducted a community survey using Langner and CES-D scales to identify psychiatric morbidity among 217 randomly selected subjects. The results showed that about 26.2% had some psychiatric morbidity and 18.2% had depressive features. Gater *et al.* (2005) analysed the pathways to psychiatric care in Easter Europe. In Albania the entry to psychiatric care was almost exclusively through hospital doctors (44%) and direct access (40%), with a few patients arriving via community/specialist nurses (6%) and native or religious healers (4%). General practitioners had a very limited role as "gatekeeper" (only 2% of the patients). Other studies were focused on mental health of Kosovo population following the war in Kosovo (Westermeyer, 2000; Lopes Cardozo *et al.*, 2003; Eytan *et al.*, 2004; Cardozo *et al.*, 2005).

The aim of this paper is to describe the mental health system and services in Albania, using the data collected in this country through WHO-AIMS.

METHOD

The *World Health Organization Assessment Instrument for Mental Health Systems* (WHO-AIMS) is a new WHO tool for collecting essential information on the mental health system of a country or region (World Health Organization, 2005; Saxena *et al.*, submitted for publication). The goal of collecting this information is to improve mental health systems and to provide a baseline for monitoring the change. WHO-AIMS is primarily intended for assessing mental health systems in low and middle income countries, but is also a valuable assessment tool for high resource countries. For the purpose of WHO-AIMS, a mental health system is defined as all the activities whose primary purpose is to promote, restore or maintain mental health. The mental health system includes all organizations and resources focused on improving mental health. WHO-AIMS 2.1 consists of 6 domains, 28 facets and 156 items to cover the key aspects of mental health systems. In addition, it includes other resources, such as a data entry programme and a template for writing a country report, which allow countries to efficiently collect data and then quickly translate that information into knowledge that can assist planning.

The implementation of WHO-AIMS can generate information on strengths and weaknesses to facilitate improvement in mental health services. WHO-AIMS will enable countries to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

There are two different kinds of data in WHO-AIMS: quantitative items and multiple-choice items.

- QUANTITATIVE ITEMS, where the measure is a number, a rate or a proportion. At the country level, the total value is calculated by adding up the values obtained from all the different mental health facilities.
- MULTIPLE-CHOICE ITEMS, where the categories represent a numerical range (generally a percentage: A=0%, B=1%-20%, C=21%-50%, etc.). The total country-level figure is calculated by taking a weighted average. When precise data are not readily available to complete a multiple-choice item (e.g. items with response options ranging from A to E), the key focal point should use different sources. Data sources that could aid you in making a best estimate include using focus groups, consulting experts in the area, consulting secondary data sources, sending out surveys, or forming a committee of key informants.

Further information is given in the WHO-AIMS Chapter "Guidance on Data Collection in WHO-AIMS", where the steps of the data collection process are explained and a guidance is given how to contact different data sources.

Albania participated to the pilot study in 2003, assessing WHO-AIMS 1.0 version. The data presented in this paper are mainly derived from the second survey that started in Albania in spring 2005 and used WHO- AIMS 2.1. The data are relevant to 2004. The implementation of WHO-AIMS in Albania was made possible through the close collaboration with the Mental Health Unit of the WHO Country Office that offered its own sources, knowledge about the local situation and the access to the national sources of information. The Mental Health Unit of the WHO Country Office was assisted in the implementation of the first version of AIMS from one focal point from the Albanian Development Center for Mental Health and in the second version from one assistant from the same NGO selected in consultation with the Ministry of Health.

The Country

Albania is a country with an approximate area of 29 thousand sq. km. Its population is 3,193 million, and the sex ratio (men per hundred women) is 104 (United Nations, 2004). The proportion of population under the age of 15 years is 27%, and the proportion of population above the age of 60 years is 10% (United Nations, 2004; World Health Organization, 2004). The literacy rate is 99% for men and 98% for women (United Nations, 2004; World Health Organization, 2004).

The country is a lower middle income group country, based on World Bank 2004 criteria (World Bank, 2004). The proportion of health budget to GDP is 3.7%. The per capita total expenditure on health is 150 international $, and the per capita government expenditure on health is 97 international $ (World Health Organization, 2004).

The language used in the country is Albanian. The largest ethnic group is Albanian (98.6%), and the another ethnic group is Greek (1.2%). The main religious groups are Muslim (majority), Orthodox Christian and Roman Catholic (religious disputes has never been an issue). The life expectancy at birth is 67.3 years for males and 74.1 years for females. The healthy life expectancy at birth is 60 years for males and 63 years for females (World Health Organization, 2004).

RESULTS

Policy and Legislative Framework

Albania is receiving considerable inputs by WHO in reforming its mental health system and services. The operations carried out by the WHO Country Office have ensured the endorsement of a Mental Health Policy and Plans as well as the congruent development of outdated psychiatric services towards community based mental health services using a multi-disciplinary approach.

In this frame, a national mental health policy was formulated in 2003, while the mental health plan was approved in 2005. The main focus of both, policy and plan, was the development of community mental health services emphasizing the primary importance of the deinstitutionalization of the psychiatric hospitals. Both documents were prepared in light of the human rights perspective, promoting the social inclusion of the mentally ill. Importance was also placed on other issues such as developing a mental health component in primary health care, increasing human resource capacity, encouraging the involvement of patients and families, focusing resources towards prevention and promotion, increasing financing, and improving the monitoring system. Budget, timeframe and specific intermediate goals were mentioned in the mental health plan.

Mental health legislation was approved in 1996. The main issues addressed were access to mental health care including access to the least restrictive care, rights of consumers and family members, competency, capacity, and guardianship issues for people with mental illness, voluntary and involuntary treatment and mechanisms to oversee involuntary admission and treatment practices, law enforcement and other judicial system issues for people with mental illness.

However, the implementation of the Mental Health legislation remains low, due to the inappropriate infrastructure (health, social and legal) that should further foster protection of the rights of the mentally ill and enhance their social inclusion.

The list of essential medicines was revised in 2004 and contains at least one psychotropic drug for each psychopharmacological class (antipsychotics, anxiolytics, antidepressants and mood stabilizers).

As regards financing of mental health services, 3% of health care expenditures by the government health department were directed towards mental health. Of all the expenditures spent on mental health, 97% were directed towards mental hospitals. It is important to notice that costs coming from reimbursements of psychotropic drugs prescribed from the Primary Health Care doctors and Outpatient Services are not included. About 1% of the population had free access to essential psychotropic medicines (the drugs - once prescribed - are provided to people with mental disorders free of cost or with reimbursement equal or more than 80% of the retail price.) The individuals who are entitled to completely free access to psychotropic medication are those who are evaluated as "full or partly invalids" by a special commission or are considered as "in need for economic aid" from local governments. 80% reimbursement of psychotropic medication purchase is offered to those who are contributing with social and health insurance regularly.

For those that pay out of pocket, the daily cost of antipsychotic medication was 3% and of antidepressant medication was 1% of the minimum daily wage (approximately 0.1 euro per day for antipsychotic medication and 0.05 euro per day for antidepressant medication). All severe and some mild mental disorders were covered by social insurance schemes and only a few restrictions were placed on the coverage of treatments (e.g. all admissions and many ambulatory interventions are provided).

No national human rights review body exists, but training, meeting or other type of working session on human rights protection of patients have been held for staff in all the mental health facilities in the last 2 years.

Mental Health Services

In 2004, a Mental Health Sector in the Ministry of Health did not exist, but it was included in the priorities of the Mental Health Policy Document and the subsequent Operational Plan Community integrated mental health services, based on catchment areas, existed, however the link between mental hospitals and outpatient facilities in the community was weak.

In Albania, the network of mental health facilities was composed of 2 mental hospitals, in Elbasan (310 beds) and in Vlore (280 beds), 34 outpatient facilities (2 of them for children and adolescents), 2 general hospital psychiatric wards, in Tirana (115 beds) and in Shkodra (90 beds), 5 day treatment facilities (3 of them for children and adolescents) and 2 community residential facilities (i.e. supported accommodations). The number of beds in mental health facilities was 30.3 per 100000 general population (): in mental hospitals there were 18.9 beds per 100000 (61%), in general hospital psychiatric wards 6.5 beds (21%), in community residential facilities 0.5 beds (2%) and in secure units 5 beds (16%). The number of beds in mental hospitals decreased in the last four years (-13%). About 2% of the available beds are reserved to children and adolescents.

In addition to beds in mental health facilities, there are also 424 beds (13.6 per 100000) in residential facilities within or outside the health system that provide care for people with mental retardation and for people with substance abuse (including alcohol) problems.

In 2004, 748 patients per 100000 general population had at least one contact with outpatient facilities, 9.8 patients at least one attendance in day treatment facilities, 40 patients were admitted in mental hospitals, 0.4 in community residential facilities and 1.8 in forensic units, while the rate of admissions in general hospital psychiatric wards was 60 per 100000. In 2004, on the whole about 800 patients per 100.000 general population were treated in mental health facilities and new cases represented in 2003 one fifth of the total.

Children and adolescents represented 6% of patients treated yearly in outpatient facilities, 25% of those in day treatment facilities and 3% of admissions in general hospital psychiatric wards

No children or adolescents were admitted in mental hospital.

Table I. – *Patients treated in mental health facilities by diagnosis.*

	OUTPATIENT FACILITIES	GEN. HOSP. PSYCHIATRIC WARDS	MENTAL HOSPITALS	COMM. RESIDENTIAL FACILITIES	DAY TREATMENT FACILITIES
Substance abuse	5%	2%	0%	0%	5%
Schizophrenia	24%	35%	70%	67%	46%
Mood dis.	18%	31%	13%	13%	31%
Neurotic dis.	21%	2%	0%	0%	6%
Personality dis.	8%	2%	0%	0%	6%
Others	25%	29%	17%	20%	6%

In terms of diagnostic breakdown by facility type (table I), in mental hospitals schizophrenic disorders were the majority (70%), followed by mental retardation (17%) and mood disorders (13%). In general hospital psychiatric wards, schizophrenic disorders (35%), affective disorders (31%) and other disorders (29%) were the most prevalent diagnoses. In community residential facilities schizophrenia (67%) was the most frequent diagnosis. Outpatient facilities treated mostly schizophrenia (24%), neurotic disorders (21%), mental retardation (25%), and affective disorders (18%); in day treatment facilities the majority of the patients were diagnosed with schizophrenic disorders (46%) and affective disorders (31%)[1].

Yearly the average number of contacts per user in outpatient facilities was 3, while the mean length of stay in general hospital psychiatric wards was 31 days, in community residential units 314 days and in mental hospitals 122 days. In mental hospitals a quarter of the patients stayed in the facilities less than 1 year, while about a half (44%) more than 5 years.

About 18% of community outpatient facilities provided routine follow-up community care, that means follow-

[1] Data from 2003 WHO-AIMS 1.0 survey.

up care outside the premises of the facility (e.g., follow-up home visits to check medication adherence, to ensure proper care for the user, to identify early signs of relapse, to assist with rehabilitation), while one facility had mental health mobile clinic teams that provide regular outpatient clinics in different places to address inadequate physical access to mental health facilities.

As regards the balance between outpatient and inpatient care (Lund & Fisher, 2003), inpatient care was still more prevalent: three days were spent in inpatient facilities (mental hospitals, general hospital psychiatric wards, community residential facilities) per one community contact in outpatient facilities.

In all the inpatient and outpatient facilities at least one psychotropic medicine of each therapeutic class (antipsychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) was available in the facility all year long. As regards psychosocial interventions (like psychotherapy, provision of social support, rehabilitation activities, interpersonal and social skills training, and psycho-educational treatments), their availability is wider in outpatient facilities and in general hospital psychiatric wards (where 21-50% of the patients received at least one psychosocial intervention in the past year) than in mental hospitals (less than 20% of the patients).

In 2003 about 30% of all admissions to general hospital psychiatric wards and 16% to mental hospitals were involuntary[1]. The percentage of patients who were physically restrained or secluded patients at least once in the last year in mental hospitals or in community-based psychiatric inpatient units was unknown.

In terms of equity, the distribution of psychiatric beds between the largest city and the rest of the country remains unfair although the figures do show a rational distribution (the ratio of number of psychiatry beds in or near the largest city to the total number of psychiatry beds in the country is 0.79). The beds are concentrated in four regions (out of 12) while the country's poor infrastructure reduces the accessibility of the remote population to the beds. In proportion to their relative population size, rural users are roughly equally represented in their use of outpatient services.

Mental health in primary health care

The network of primary health care clinics was well developed in Albania. There was one GP per about 2000 inhabitants and one primary care nurse per 500 inhabitants.

In terms of training, only 2% of under-graduated training hours for medical doctors and nurses were devoted to psychiatry/mental health in the Faculties of Medicine and Nursing in the University. In-service refresher training programs for primary health care staff were given to 4% of doctors, while no nurse received any training.

Assessment and treatment protocols for key mental health conditions in primary health care clinics were not available. The majority (51-80%) of the full-time primary health care doctors made on average at least one referral per month to a mental health professional, but few primary health care doctors (less than 20%) were interacting with a mental health professional at least monthly.

Health insurance rules were, by the beginning of 2004, allowing primary care doctors to initiate prescription of psychotropic medicines. Nurses and non doctor/non nurse primary health care workers were not allowed to prescribe psychotropic medications in any circumstance. Psychotropic medicines were available in pharmacies nearby in the majority (51-80%) of primary health care clinics throughout the year.

Human Resources

In 2004, 31 professionals per 100.000 general population were working in mental health services (figure 1): the majority were psychiatrist (28%) and nurses (61%), while the psychosocial staff (psychologists, social workers and occupational therapists) represented only 6%. Regarding the workplace, almost all the psychosocial staff and most of the psychiatrists (73%) worked in community outpatient facilities, while the majority of nurses worked in mental hospitals (45%) and in general hospital psychiatric wards (33%). Almost all the psychiatrists (90%) worked only in or for government administered mental health facilities.

In terms of staffing in mental health facilities, there are 0.09 psychiatrists per bed in community-based psychiatric inpatient units, in comparison to 0.02 psychiatrists per bed in mental hospitals. As for nurses, there are 0.35 nurses per bed in general hospital psychiatric wards, in comparison to 0.17 per bed in mental hospitals. Finally, for other health or mental health workers, there are 0.06 per bed for general hospital psychiatric wards, and 0.09 per bed in mental hospitals. The distribution of human resources between urban and rural areas is unfair: the availability of psychiatrists and nurses is about one-third higher in or near Tirana than in the rest of the country.

The rate per 100000 of professionals graduated last year in academic and educational institutions per 100000 is as follows: no psychiatrist, 4.6 medical doctors, 10 nurses, 1.2 psychologists with at least 1 year training in mental health care and 2.3 social workers with at least 1

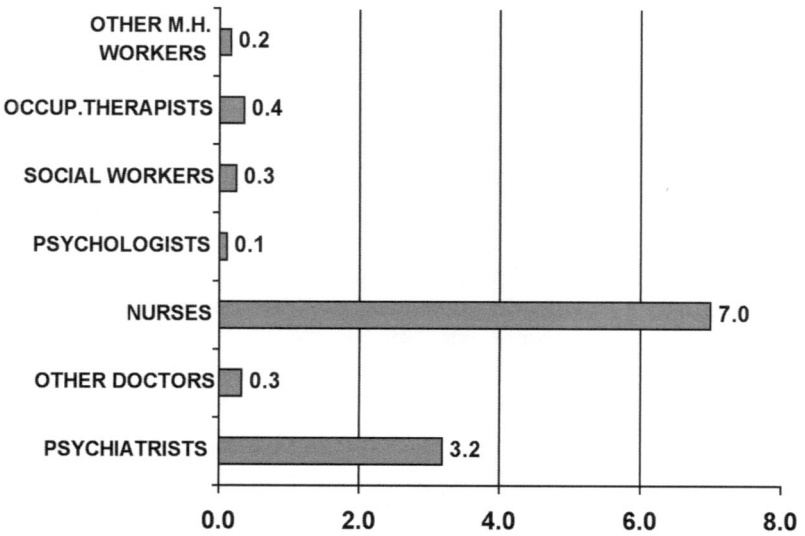

Figure 1. – *HUMAN RESOURCES IN MENTAL HEALTH (rate per 100.000 population)*

year training in mental health care. As regards in-service refresher training, 8% of psychiatrists and no nurse attended training on the rational use of drugs, 8% of psychiatrists, 5% of nurses and 32% of psychosocial staff attended training on psychosocial interventions; while no training was reported to be delivered on child/adolescent mental health issues.

There is a growing recognition of the importance of families and service user involvement in mental health service planning and delivery. (Thornicroft & Tansella, 2005). In Albania there were no consumer associations, but one hundred and thirty people were instead members of family associations, which were involved in community and individual assistance activities (e.g., counseling, housing, support groups, etc.). The government did not provide economic support for family associations. Family associations had been involved in the formulation or implementation of mental health policies within the past two years, but at local level few mental health facilities interacted with these associations.

In addition to family associations, there were 65 other NGOs involved in policies, legislation, or mental health advocacy and 24 in community and individual assistance activities (e.g., counseling, housing, support groups, etc.).

Public Education and links with other Sectors

There were no coordinating bodies that oversee public education and awareness campaigns on mental health and mental disorders. Government agencies, NGOs, professional associations, private trusts and foundations, and international agencies all promoted public education and awareness campaigns in the last five years. These campaigns targeted different groups: the general population, children, adolescents, women, and trauma survivors. In addition, there were public education and awareness campaigns targeting professional groups including health care providers, social services staff and teachers.

Legislative provisions concerning a legal obligation for employers to hire a certain percentage of employees, which were disabled or protection from discrimination (dismissal, lower wages) solely on account of mental disorder, existed but were not enforced. At the present time, there are no provisions for housing and against discrimination in housing for people with mental disorders.

In addition to legislative and financial support, there were formal collaborations with the Departments/ Agencies responsible for primary health care/community health, HIV/AIDS, reproductive health, child and adolescent health, substance abuse, child protection, education, employment, housing, welfare and criminal justice.

Few mental health facilities (1-20%) had access to programs outside the mental health facility that provide employment for users with severe mental disorders.

About one third (31%) of the primary and secondary schools had either a part-time or full-time mental health professional. Few (1-20%) primary and secondary schools had school-based activities to promote mental health and prevent mental disorders. As for training, few police officers (1-20%) and judges and lawyers (1-20%) participated in educational activities on mental health in the last five years. In prisons, the proportion of prisoners with mental illness was estimated to be less than 2% for mental retardation and 2-5% for psychosis. Regarding mental health activities in the criminal justice system, less than 20% of prisons had at least one prisoner per month in treatment contact with a mental health professional.

About 1% of the population received social welfare benefit because of disability due to mental disorder.

Monitoring and Research

The Ministry of Health did not define in 2004 a Minimum Mental Health Data Set (i.e., data that ought to be collected in all mental health facilities). Data collection and data transmission to the Ministry of Health was operative in all the mental hospitals and community mental health facilities, with exception of a half of outpatient facilities. Despite of these information flows, no specific report on mental health data was published by Department of Health in the last two years.

As regards mental health researches, about 2% of health publications on Albania, as identified on *PubMed*, were on mental health in the last five years. Research on mental health were mainly epidemiological studies in community samples or in clinical samples, mental health service researches, policies and programmes analysis and pharmacological studies. Few mental health professionals (1-20%) working in mental health services in the last 5 years were involved in mental health research as an investigator or co-investigator.

DISCUSSION

Starting from the global picture of the mental health system in Albania, drawn through WHO-AIMS, we can understand better which areas should be prioritized in planning.

The mental health component in primary care should be improved increasing the training of GPs and particularly of primary care nurses (actually absent), in order to improve the capacity of treating common mental disorders at this level. Regulations by the Ministry of Health on prescription of psychotropic medicines should support GPs to initiate psychopharmacological treatments. The referral system to mental health services should be more selective and reserved to severe mental illness, while the interactions between primary care and mental health facilities should be intensified.

Although the role of mental hospitals have been declining in the Albanian mental health system (the number of beds has decreased over the last five years and more than half of mental health staff were working outside mental hospitals), 97% of the resources were still spent inside these institutions. Without a clear shift of resources from mental hospitals to community facilities, unlikely the system will move towards community care. The closure of mental hospitals should be supported by the development of residential care for long stay patients still living in mental hospitals (14 per 100000), who cannot be discharged at home, and by the increase of general hospital care for patients who were admitted in mental hospital because of acute mental disorders.

In 2004 there was one outpatient facility per 90000 population, without evident problems of equity among rural and urban areas. The ratio between outpatient and inpatient care still points out the clear preponderance of the latter. Outpatient facilities will play an important role in mental health system reform, treating severe mental illness in the community and assuring routine follow up care (only one fifth of the facilities were able to). Refresher in-training for mental health staff on child and adolescent mental health issues should be implemented in a country, where more than a quarter of population is under 15.

The mental health information system should be expanded and improved as regards the completeness of data collection in community facilities. Finally, a report on mental health data should be published and disseminated by Ministry of Health.

As a result of the completeness and quality of WHO-AIMS data collected by the focal point, it was possible to reach an in-depth understanding of the mental health system in Albania, never reached before. WHO AIMS was feasible, able to describe in a comprehensive way all the system and not only the mental health services, sensible to change (as assessed in the two different data collections in 2003 and 2004) and useful for planning, as proved by the improving actions planned in these last months. WHO AIMS was used as a tool for the identification of gaps in the mental health care delivery in Albania while defining the Operational Plan for the implementation of the Mental Health Policy. Not only did the tool allow the prioritisation and the planning of the necessary actions, but it also did coherently support their implementation.

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