WHO-AIMS

WHO-AIMS REPORT ON

MENTAL HEALTH SYSTEM IN ALBANIA

MINISTRY OF HEALTH
OF ALBANIA

WHO-AIMS REPORT ON

MENTAL HEALTH SYSTEM

IN ALBANIA

A report of the assessment of the mental health system in Albania using the World Health Organization - Assessment Instrument for Mental Health Systems (WHO-AIMS).

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Please refer to *WHO-AIMS* (WHO, 2005) for full information on the development of WHO-AIMS at the following website.
http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

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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 155 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 improving actions. 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.

Key words: Albania, Mental Health Services, WHO-AIMS, World Health Organization

Declaration of Interest: none

INTRODUCTION

The World Health Organization (WHO) in the *World Health Report 2001. Mental Health: New Understanding, New Hope* (WHO, 2001) 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 (WHO, 2000).

The WHO Atlas study (WHO, 2005) 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.

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 WHO Mental Health Atlas (WHO, 2001) and from a paper published in 2004 (Suli *et al.*, 2004), but they were insufficient to achieve a global picture. 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)

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 (WHO, 2005; Saxena *et al.* 2005). 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 155 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 allows 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.

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 (UNO, 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% (UNO, 2004, WHO 2004). The literacy rate is 99% for men and 98% for women (UNO, 2004; WHO 2004).

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

RESULTS

1. 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 de-institutionalization 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.) For those that pay out of pocket, the daily cost of antipsychotic medication was 2.5% and of antidepressant medication was 1.4% 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).

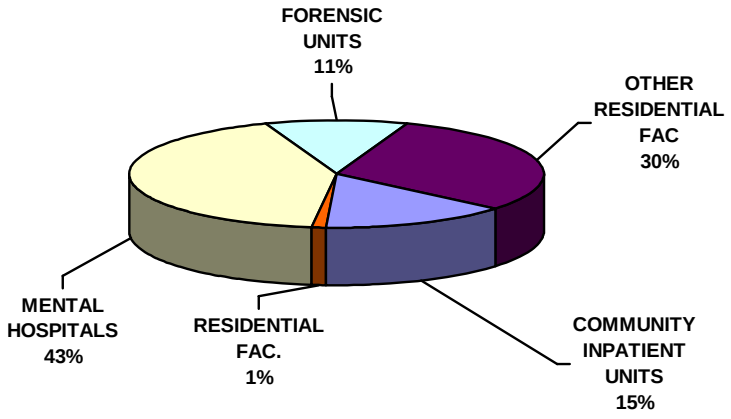
No national human rights review body exists, but training, meeting or other type of working session on human rights protection of patients have been held for staff in all the mental health facilities in the last 2 years.

2. Mental Health Services

In 2004, no distinct mental health administrative unit existed in the Ministry of Health. However, mental health priorities were included in the Mental Health Policy Document and the subsequent Operational Plan. Catchment areas are used in Albania.. Overall, however the link between mental hospitals and outpatient facilities in the community has been weak.

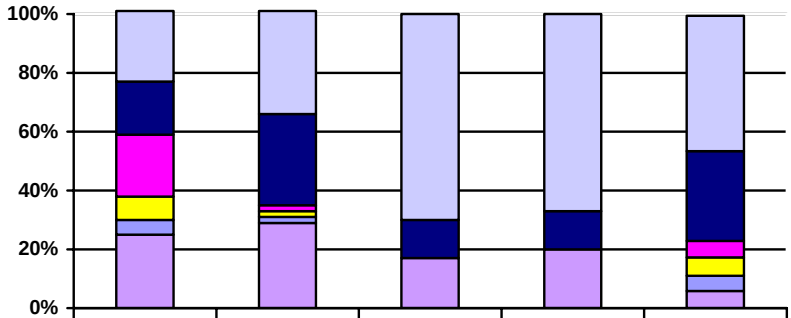
In Albania, the network of mental health facilities was composed of 2 mental hospitals, 34 outpatient facilities (2 of them for children and adolescents), 2 psychiatric wards in general hospitals, 5 day treatment facilities (3 of them for children and adolescents) and 2 community residential facilities. The number of beds in mental health facilities was 30.3 per 100.000 general population (Figure 1): 43% of all beds, the majority, were in mental hospitals (18.9 beds per 100.000); 15% were in general hospitals (6.5 beds); 1% were in community residential facilities (0.5 beds); and 11% were in secure units (5 beds). The number of beds in mental hospitals decreased in the last four years (-13%). While no beds were reserved for children and adolescents in the mental hospitals and community residential facilities, 15 were set aside (0.5 per 100.000) in general hospitals for this population. In addition to beds in mental health facilities, there were also 424 beds (13.6 per 100.000) 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.

Figure 1 - BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES



In 2004, 748 patients per 100.000 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 to the mental hospitals, 0.4 in community residential facilities and 1.8 in forensic units, while the rate of admissions in general hospital units was 60 per 100.000. In the whole about 860 patients per 100.000 general population were treated in mental health facilities. Children and adolescents represented 8% of patients treated yearly in outpatient facilities, 25% of those in day treatment facilities and 3% of admissions in general hospital. No children or adolescents were admitted in the mental hospitals.

Figure 2 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS



	OUTPATIENT FAC.	COMMUNITY INPATIENT UNITS	MENTAL HOSPITALS	COMM. RESIDENTIAL FAC.	DAY TREATMENT FAC.
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%
SUBSTANCE ABUSE	5%	2%	0%	0%	5%
OTHERS	25%	29%	17%	20%	6%

In terms of diagnostic breakdown by facility type (Figure 2), in mental hospitals schizophrenic disorders were the majority (70%), followed by mental retardation (17%) and mood disorders (13%). In general hospital units, schizophrenic disorders (35%), mood disorders (31%) and other disorders (29%) were the most prevalent diagnoses. In community residential facilities schizophrenia (67%) was the most frequent diagnosis[1]. Outpatient facilities treated mostly schizophrenia (24%), neurotic disorders (21%), mental retardation (25%), and mood disorders (18%); in day treatment facilities the majority of the patients were diagnosed with schizophrenic disorders (46%) and mood disorders (31%)[1].

Yearly the average number of contacts per user in outpatient facilities was 3, while the mean length of stay in community-based psychiatric inpatient units was 31 days, in community residential units 314 days and in mental hospitals 122 days. In mental

[1] Data from 2003 WHO - AIMS 1.0 survey

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-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 C *et al.*, 2003), inpatient care was still more prevalent: three days were spent in inpatient facilities (mental hospitals, general hospital units, 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 (anti-psychotic, 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 community-based psychiatric inpatient units (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 community-based inpatient psychiatric units 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 out of 12 regions in the country. This fact in combination with the country's poor infrastructure reduces the accessibility of the remote population to psychiatric beds.

3. Mental Health in Primary Health Care

The network of primary health care clinics is well developed in Albania. In 2004, 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 nurses 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

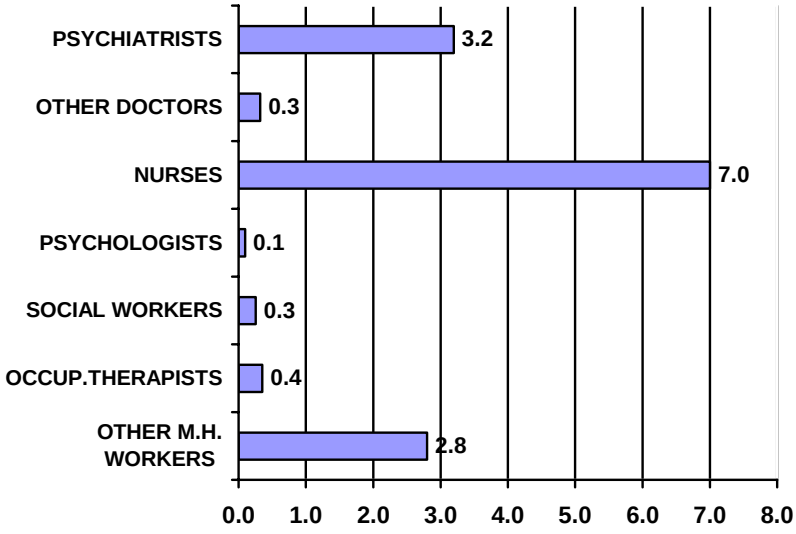
professional, but few primary health care doctors (less than 20%) were interacting with a mental health professional at least monthly. Furthermore, few (less than 20%) of mental health facilities interacted with other health professionals.

Health insurance rules were, by the beginning of 2004, allowing primary care doctors to continue the 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 the majority (51-80% for non-physician and 81-100% for physician) of primary health care clinics throughout the year.

4. Human Resources

In 2004, 13.3 professionals per 100.000 general population were working in mental health services (Figure 3): the majority were psychiatrists (3.2 per 100.000 population) and nurses (7.0 per 100.000), while the psychosocial staff (psychologists, social workers, and occupational therapists) and other mental health workers represented only 2.8 per 100.000 in total.

Figure 3 - HUMAN RESOURCES IN MENTAL HEALTH
(rate per 100.000 population)



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 community-based psychiatric inpatient units (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 were 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 were 0.35 nurses per bed in community-based psychiatric inpatient units, in comparison to 0.17 per bed in mental hospitals. Almost no psychologists, social workers or occupational therapists work in inpatient units or mental hospitals. Finally,

for other health or mental health workers, there were 0.06 per bed for community-based psychiatric inpatient units, and 0.08 per bed in mental hospitals. The distribution of human resources between urban and rural areas is disproportionate: the availability of psychiatrists and nurses is about one-third higher in or near Tirana than in the rest of the country.

The rate of professionals graduated last year in academic and educational institutions per 100.000 is as follows: no psychiatrists, 4.7 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 year training in mental health care. As regards to in-service refresher training, 8% of psychiatrists, 15% of other medical doctors, and no nurses attended training on the rational use of drugs, while 8% of psychiatrists, 15% of other medical doctors, 5% of nurses and 32% of psychosocial staff attended training on psychosocial interventions; no training was reported to be delivered on child/adolescent mental health issues.

There were no consumer associations. 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 the local level few mental health facilities (less than 20%) 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.).

5. 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, teachers, journalists on health matters, and police forces.

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 between mental health service departments/agencies and those 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 (less than 20%) had access to outside programs 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 (less than 20%) primary and secondary schools had school-based activities to promote mental health and prevent mental disorders. As for training, few police officers, judges and lawyers (less than 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.

6. 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 about half (44%) of outpatient facilities. Despite 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 research, policies and programmes analysis and pharmacological studies. Few mental health professionals (less than 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 100.000), 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 1 outpatient facility per 90.000 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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