Declaration of interest

None.

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SPECIAL PAPER

Transitioning to community-based mental healthcare: reform experiences of five countries

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Following the growing global focus on deinstitutionalisation in the past 50 years, accessible community mental health services was a highlighted commitment in the European Mental Health Action Plan 2013–2020 to improve well-being of patients and families. The progress of transition has been uneven in some Eastern European countries. This paper aims to update and reflect on the examples of five countries across the region.

Healthcare systems in Eastern Europe are diverse and often reflect historical legacies dating back to the Cold War era. Countries in the Western Bloc (e.g. Turkey) were some of the first to adopt population-oriented systems. States from the former Yugoslavia (e.g. Serbia) relied on sectorised, hospital-based psychiatric care. Former Soviet countries (e.g. Ukraine, Georgia and Kyrgyzstan) were influenced by the Semashko model, with highly centralised healthcare infrastructure, funding and staffing. Despite their different backgrounds, all countries have made respectable efforts to reform mental healthcare in the recent years, motivated by the growing need for affordable and efficient community mental healthcare.

Establishing community centres in Serbia

The National Strategy for Development of Mental Health Care, approved in 2007 in Serbia, identified deinstitutionalisation and the development of community services as the main aspects in the reform of psychiatry care in the country.[1] It was recognised that community mental healthcare should be based mainly at centres for mental health (*centri za mentalno zdravlje*), which would provide all-inclusive mental healthcare for persons with psychiatric disorders. Five centres for mental health have been opened in Serbia since

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2019, covering only 2.3% of the whole territory. The National Programme for the Protection of Mental Health in the Republic of Serbia for the period 2019–2026[2] sets out the new strategies of community service development: reorganisation of the network of psychiatric institutions, strengthening existing psychiatric services in general hospitals, and gradual reduction of the number of beds in large hospitals and the number of patients in institutions. The main emphasis of this new strategy is on the development of specific services, such as those for child and adolescent psychiatry, early interventions, rehabilitations and work training, older persons and others, and on the development of additional mental health centres that will cover about 15% of the country.

Developing specialised services in Turkey

The Turkish Republic, founded in 1923, continued the tradition of large, in-patient service-oriented mental health institutions from the late Ottoman era. Following patchy attempts at deinstitutionalisation through the 1980s and 1990s, a unified programme for provision of accessible community mental health services was presented in 2006.[3] As a result of this programme, 177 community mental health centres have been opened, affiliated with state hospitals for training and education of residents, universities and mental health hospitals. This coincided with re-organisation and reduction of in-patient mental health beds. However, these centres mostly focused on adult patients with schizophrenia or mood disorders. Community services for other populations, especially children and adolescents, as well as early identification and prevention, are still lacking. As a first step to improve those shortcomings, the National Action Plan for Individuals with Autism Spectrum Disorders for the period 2016–2019 was published under the coordination of the Ministry of Family and Social Policies.[4] In accordance with this plan, an emphasis has been put on the establishment of a specialised care for autism spectrum disorder and developmental delay in infants and toddlers. This effort culminated in the establishment of a specialised Department for Children with Autism, Mental Special Needs and Rare Disorders in January 2020.

Ukraine's challenge of financial restructuring

As of January 2018[5], 4% ($n = 1\,847\,113$) of Ukraine's 44 million population received mental healthcare. Among them, over 80% attended out-patient services, around 17% were treated in psychiatric hospitals and 2% attended day hospitals. Mental health services exist under different ministries and departments. The Ministry of Health is in charge of 122 hospitals and dispensaries with 35 599 psychiatric beds and 1102 medical offices, and the Ministry of Social Policy governs 152 institutions providing 40 000 social rehabiliation for people with psychiatric disorders. In today's national system of mental health, the Soviet heritage of psychiatric care remains evident in its focus of in-patient care, insufficient and inefficient use of available financial resources, and lack of specialist mental healthcare provision for children. People with mental disorders often suffer stigmatisation, discrimination and social exclusion.

In October 2017, the Parliament of Ukraine initiated a health reform, guaranteeing additional government funding of public medical services. The second phase of reform (April 2020), focusing on secondary and tertiary care, resulted in severe budget cuts because services now need to make individual agreement with the National Health Service.[6] Plans were hampered by the unexpected COVID-19 pandemic. Recommendations[5] by the World Psychiatric Association include: (a) regular consultations between the Ministry of Health and psychiatric associations, (b) approving the national mental health action plan proposed in December 2017 so that service development till 2030 can be implemented, and (c) a continuation followed by gradual reduction of in-patient care funding during development of community services.

Georgia's increase in service access

A 2018 survey in Georgia[7] found a significantly lower number of people using mental health services ($n = 49\,789$) than officially registered cases ($n = 102\,977$). Main diagnoses for referrals were psychotic disorders (31%) and intellectual disabilities (27%); affective and anxiety disorders represented only 7% and 9%, respectively. These numbers were not comparable to the prevalence of the disorders. More than half of the patients likely avoided referrals because of stigma, poor service quality and insufficient geographical and financial accessibility.

The strong push for deinstitutionalisation in the past 7 years has started to mature.[8] Two main policy documents are the 'Concept on Mental Health Care'[9], implemented in 2013, and the first strategic plan for 2014–2020 of mental healthcare[10], approved in 2014. Since 2017, the state programme for mental healthcare has evolved significantly. The funding has been raised from €4 million to €7 million in the past 3 years,[11] directed primarily to community-based services, particularly out-patient and mobile team services. The introduction of the standard of a qualitatively new type of out-patient service improved the ratio of institutional and community care from 75:7% in 2018 to 42:58% in 2020.[12,13]

Today, the most challenging and undeveloped areas are child and adolescent mental healthcare, housing and psychosocial care for chronic patients with mental disorders. There is still a substantial lack of qualified psychiatric nurses and social workers. However, formation of multidisciplinary operational groups and an active National Institute of Mental Health have laid a good foundation for development.

Responsibility sharing in Kyrgyzstan

Kyrgyzstan is a former Soviet country located in central Asia. Considered as part of the World Health Organization's European region, its experience echoes some other Eastern European countries. From 1991 until recent years, Kyrgyzstan's mental health services were isolated from the country's general medical network.[14] Financial and human resources were concentrated on tertiary in-patient care. The Program for the Protection of Mental Health of the Population for 2018–2030 emphasises the development of community psychosocial services at primary level, and provides evidence-based psychiatric clinical guidelines for the first time.[15]

Currently, state community mental healthcare is represented by 12 pilot multidisciplinary community teams and a capital-based psychotherapeutic centre. Family doctors are responsible for identifying, treating and preventing psychiatric disorders, entirely funded by the Mandatory Health Insurance Fund. In 2020, this payment amounted to 3.2% (around €87 500) of the total mental healthcare budget. Public organisations are allowed to develop local community psychosocial services with government funding.

The reform is still limited by the lack of funding and interagency cooperation between ministries. The main motivators for the reform are a few nongovernmental organisations, mainly consisting of mental health professionals and funded by foreign donors. Despite their fruitful work, the development of sustainable financing mechanisms is in its infancy. Much of the psychiatric care remains available only in hospitals or family medicine centres. A small number of private psychosocial rehabilitation centres operate independently, without following evidence-based service standards. There is yet any specialised community service for children or the elderly with mental disorders. The involvement of patients and their relatives is still lacking in the decision-making process.

Implications for future development

Historical heritage, financial difficulties and delayed specialist service development are three central themes in all five countries we covered. This is understandable, given that community mental health reform requires a fundamental culture shift supported by new infrastructure and staffing models. Priorities need to be set carefully, reserving own strengths. Further, countries face a harder battle when the previous system was further away from the Western 'prototype', or the government is less involved.

High-quality multidisciplinary collaborative forces are an important campaigner of progress and a focal point for action. They may originate from local interagency discussions, or formed by psychiatric associations. In countries that have completed the community mental health transition, research has focused on how to maximise the effects of these integral multidisciplinary teams. A popular model is intensive case management, generally emphasising a higher clinical intensity and a small caseload. A meta-analysis suggested that the advantages of intensive case management are maximised when baseline hospital usage is high.[16] The team structure (e.g. being a primary source of care) may be more important than pursuing specific staffing features, such as team size. Also, children and adolescents may benefit more from the increased therapeutic intensity,[17] and a supported discharge model has been found to result in shorter hospital stays and reduced repeated self-harm.[18] The most recent comprehensive review on this topic found inconsistent evidence of benefits of intensive case management and a lack of high-quality trials outside of Australia and North America.[19] Localised research is likely needed to answer whether all countries can benefit from a more intensive team organisation, especially under finite resources.

Financial stability and a clear funding plan are essential. Regardless of the strategies of reform, a crystallised and committed strategy is the basis for future consultation and adjustment. Community mental health reform is a gradual process, requiring patience. International and domestic collaborative efforts evident in our examples provide a good reason to remain hopeful in this long journey.

Author contributions

B.H.-C.W. contributed to structuring and writing the manuscript, edited and merged the inputs from all authors. E.C., L.P., I.P., D.S. and A.E.T. contributed to the first draft of the section for each respective country. N.S. provided critical comments and contributed to the manuscript structure. D.O. contributed to the conception and design of the collaboration. All authors contributed to the revision and final approval of the manuscript.

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MENTAL HEALTH LAW PROFILE

Mental health law in Algeria: new amendments, old concerns

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Since 2018 Algeria has had a new mental health law intended to be more practical and in line with international standards for patients' rights and supervision of coercive measures. Despite its simpler formulation compared with the previous law it remains far from what psychiatrists need and what patients hope for. Some chapters are confusing and difficult to grasp. Like previous mental health laws, it is unlikely that the current law will actually be applied, owing to the huge gap between the core text and the available services.

In 2018 the Ministry of Health of Algeria issued a new health law which, as usual, embedded a section on mental health. It is the third national mental health law since independence in 1962 (the previous law goes back to 1985) and the fourth if we take into account French mental health law that prevailed between1962 and 1976.[1]

As expected, each enactment of new mental health law engenders hopes of improvements in mental healthcare but also raises doubts over whether those intended improvements will actually follow. So far, no mental health law has ever been effectively and genuinely implemented in the country, or been evaluated and assessed to appraise where it has been successful and where it has fallen short.[2]

The revision process of the new health law has been dragging on for years; the first draft dated back to 2003 at least.[3] Hopes were high because these amendments, if done properly, would have enabled mental health providers to improve everyday practice and optimise provision of care in accordance with the available services and human resources.

The current law is more concise, its text is clearer and its chapters are more coherent than the previous law.[4] The changes brought about by this law include improved rights for the mentally ill in relation to involuntary hospitalisation, the