ZELDA

RESOURCE CENTRE FOR PEOPLE WITH MENTAL DISABILITY

REPORT ON THE IMPLEMENTATION OF THE WORLD HEALTH ORGANISATION'S MENTAL HEALTH DECLARATION AND ACTION PLAN IN LATVIA

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FOREWORD

Almost five years ago, in January 2005 in Helsinki, health ministers from the World Health Organisation's (WHO) European region signed the Mental Health Declaration and Action Plan for 2005-2010. By signing both documents, each country, including Latvia, undertook to implement the guidelines enshrined in the documents in order to facilitate the improvement of mental healthcare. As these documents contain many promises which are of importance to protecting the rights of psychiatric service users, the Resource Centre for People with Mental Disability ZELDA considered it important to evaluate how and to what extent the guidelines in the aforementioned documents had been implemented over the last five years.

This report consists of 12 sections which align with the chapters of the Mental Health Action Plan of the Declaration. Each section includes an overview of significant changes in policies and laws as well as conclusions and recommendations.

It is notable that prior to the preparation of this report, the Mental Health Declaration and Action Plan had not been translated into Latvian and was therefore not accessible to the majority of mental healthcare specialists and psychiatric service users. We have therefore provided a translation of both documents in an annex to the Latvian version of this report.

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We are also grateful to our non-staff authors Dr. Uldis Veits and Rinalds Muciņš, as well as Dr. Māris Taube (Director of the Health Economics Centre's Public Health Department), Dr. Līga Kozlovska (Head of the Latvian Country General Practitioners' Association) and Dr. Biruta Kupča (Associate Professor at Riga Stradiņš University's Department of Psychiatry and Narcology), who provided valuable data and information for the report.

Finally, we would like to thank our cooperation partners – all of the psychiatric service users who throughout this year have joined us for discussions and helped us understand the reality of access to mental healthcare services.

Ieva Leimane-Veldmeijere
Director, RC ZELDA

BASIC INFORMATION ON LATVIA AND ITS MENTAL HEALTH CARE

Latvia is one of the three Baltic States (located in Northern Europe on the eastern shore of the Baltic Sea), which regained its independence from the Soviet Union in 1991. Latvia's territory covers 64,589 km^2 and has approximately 2.27 million inhabitants. The ethnic composition is 59% Latvians, 28% Russians, 3.7% Belarusians, 2.5% Ukrainians, 2.4% Poles and 4.4% other nationalities. Latvia is a democratic parliamentary republic. Latvia has been a member state of the European Union since 2004[1].

At the beginning of 2008, psychiatric assistance was provided by eight psychiatric hospitals with 2,854 beds, and psychiatric wards in general hospitals with 265 beds. At the beginning of 2008, outpatient psychiatric assistance was provided by 91 medical institutions, including outpatient departments of psychiatric hospitals, 24 mental health care units in municipal health care facilities and 60 psychiatrists' practices.[2]

At the beginning of 2008, 65,727 or 2.9% residents of Latvia were registered with mental disabilities. According to Public Health Agency data[3], the highest registered morbidity was with schizophrenia (29% or 18,753 persons), organic mental disorders (24% or 15,903 persons) and intellectual disabilities (22% or 14,535 persons).

METHODS USED IN PREPARING THE REPORT:

- Analysis and evaluation of Latvian policy documents and laws and regulations relating to each chapter of the Mental Health Action Plan of Declaration;
- Analysis of available statistics;
- Study of reports, opinions and recommendations from international organisations;
- Requesting of information on various matters from responsible institutions (for example, requesting data from psychiatric hospitals, courts, the Ombudsman's Office and the Health Inspectorate of Latvia with regard to the implementation of Article 68 of the Medical Treatment Law);
- Study of available court judgements on various aspects of psychiatric service users' rights (involuntary admission, legal capacity issues, fundamental rights etc.);
- Telephone interviews – gathering of background information from state officials, state institutions, other NGOs, etc.
- Data gathered by the report authors from previous reports, for example "Needs Assessment of Users of Mental Health Care Services," by I. Leimane-Veldmeijere and U. Veits;
- Discussions with psychiatric service users on 14.03.2009, 06.06.2009 and 03.11.2009 regarding access to outpatient psychiatrist and access to social assistance as well as other issues covered in the action plan (access to general practitioners, employment, information, etc).

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1 Data from Latvia Institute website, http://www.li.lv/index.php?option=com_content&task=view&id=12&Itemid=1060&lang=lv, [last accessed on 05.11.2009]

2 Data from Taube. M., Krievkalna R., Kišuro A., Apsīte A., Līce V., Jakovela G., Sidoroviča D., Pulmanis T., Šlosberga I., Psychiatric Healthcare in Latvia in 2007, Statistical Yearbook, Volume 8, Riga: Public Health Agency, 2008, p.37., p.51 http://sva.vi.gov.lv/files/gariga%20veseliba/mental_health_care_2007_lv.pdf, [last accessed on 05.11.2009]

3 Data from Taube. M., Krievkalna R., Kišuro A., Apsīte A., Līce V., Jakovela G., Sidoroviča D., Pulmanis T., Šlosberga I., Psychiatric Healthcare in Latvia in 2007, Statistical Yearbook, Volume 8, Riga: Public Health Agency, 2008, http://sva.vi.gov.lv/files/gariga%20veseliba/mental_health_care_2007_lv.pdf, [last accessed on 05.11.2009], p 16.

1. MENTAL HEALTH PROMOTION

The aim of promoting mental health is to protect, support and maintain emotional and social wellbeing, create individual, social and environmental conditions facilitating optimum psychological and psycho-physiological functioning, and improve mental health by respecting the values of culture, justice, social equality and self-respect. Mental health promotion initiatives involve persons who are not members of risk groups, as well as those suffering or recovering from mental illness. These initiatives aim to achieve a positive mental health condition, thereby improving quality of life and reducing the gap in health outcomes between countries and groups.

Preventive measures of mental healthcare focuses on ascertaining risk factors and fostering factors which protect mental health, with the aim of reducing the risk, prevalence, spread and relapse of mental illnesses, as well as to reduce the amount of time spent suffering from illness symptoms or conditions increasing the risk of mental illness, delaying or preventing a relapse of the illness, as well as to reduce the impact of the illness on the sufferer, their family and society.[4]

In order to facilitate the implementation of public health policy and improve public health indicators, on 6 March 2001, the Cabinet of Ministers of the Republic of Latvia approved the *Public Health Strategy* for 2002-2010[5]. Under the tasks listed for the 5th objective of this strategy, it is stipulated that "achieving the objectives requires (...) a multi-sector strategy directed towards (...) promoting mental health". The Public Health Strategy stipulated that in forming public health policy attention should concentrate on forming a home and work environment which supports the improvement of mental health, as well as creating modern mental healthcare institutions focussed on the early intervention.

The strategy also stipulates the need to reduce the economic problems of inhabitants by implementing the measures set out in the *Poverty Reduction Strategy*[6], which would also positively affect mental health. The strategy also anticipates training healthcare and other professionals (especially teachers) in the early detection of mental health problems, what actions to take, and improving stress-management skills (at schools, during attending general practitioner, at work, etc.);

Shortly before the adoption of the WHO Mental Health Action Declaration and Plan, the Cabinet of Ministers adopted the *Action Programme for the Implementation of a Public Health Strategy* for 2004-2010[7], which stipulated a relatively narrow range of measures relating to mental health – ensuring access to psychological assistance at every school, National Armed Forces' training centre and at institutions of the Interior Ministry. With regard to the rest of the population, no mental health promotion measures were planned.

In 2004 the government adopted the *National Action Plan for Reducing Poverty and Social Exclusion* (2004-2006)[8], which found in relation to mental health that "no significant improvement

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4 Mental Health Policy and Practice across Europe, Open University Press, WHO, European Observatory on Health Systems and Policies, 2007, p. 189.

5 Approved by the Cabinet of Ministers on 6 March 2001, http://phoebe.vm.gov.lv/misc_db/web.nsf/bf25ab0f47ba5dd785256499006b15a4/17cb8c1218bf81cdc2257313001f391a/$FILE/sab_ves_strategija.pdf, [last accessed on 15.10.2009]

6 Approved by the Cabinet of Ministers on August 28, 2000, on July 15, 2004, the Cabinet of Ministers accepted Latvia's National Action Plan for Reducing Poverty and Social Exclusion (2004-2006), http://polsis.mk.gov.lv/view.do?id=1394, [last accessed on 09.11.2009]

7 Approved by the Cabinet of Ministers on 9 March, 2004, http://polsis.mk.gov.lv/view.do?id=1193, [last accessed on 15.10.2009]

8 Approved by Cabinet of Ministers Order No. 513 of 23 July 2004, http://www.lm.gov.lv/text/549, [last accessed on 09.11.2009]

or catastrophic decline has been witnessed in the mental health sphere." The plan stresses that significant problems in mental healthcare are leading to the deterioration of the social conditions of patients, which in turn limits their access to satisfactory treatment. The plan also stated that there was a noticeable increasing trend in the social alienation and isolation of mentally ill persons.

The Action Plan proposed the following primary long-term policy objectives:
1) overcoming problems associated with educational opportunities and quality;
2) creating an accessible labour market and promoting employment;
3) using wages, tax policy and the social security system to ensure adequate incomes for all;
4) ensuring adequate housing for all;
5) ensuring access to state-guaranteed minimum healthcare services and medications;
6) strengthening family cohesion and protecting children's rights by creating a healthy social and economic environment favourable to families;
7) developing social services to ensure that people have access to social services that meet their needs as close as possible to their homes;
8) creating a cooperation network for institutions and NGOs and increasing organisational capacity.

In 2005[9] and 2006[10] a number of measures were carried out under the *National Action Plan for Reducing Poverty and Social Exclusion* which also had an impact on mental health issues. The main activities were in the spheres of employment and education, which are examined in more detail in Section 3 of this report.

Finally, 2008 saw the approval of the long-prepared and anticipated *Framework Policy Document* "*Improvement of Inhabitants' Mental Health for 2009-2014*"[11]. The framework policy document includes a separate section on promoting mental health. In describing the situation in the sphere of promoting mental health, it concluded that there is no implementation of a national and regional level preventive mental health care programme which would ensure for regularly informing and educating the public and professional groups, create a positive and non-judgemental attitude towards the mentally ill and their treatment and increase inter-sector cooperation for resolving problems. It was also found that the public had not been sufficiently and regularly informed regarding suicide risk factors and options for receiving healthcare assistance in crisis situations, and healthcare workers had not been sufficiently educated in the early detection and treatment of depression, which is one of the main reasons for the high number of suicides. The framework policy document also revealed that there was no system, available in all regions, for helping sufferers of long-term stress, experiencing loss or depression, nor was 24 hour counselling available for all persons in crisis situations.

The framework policy document "*Improvement of Inhabitants' Mental Health for 2009-2014*" intends to educate and inform the public about mental healthcare promotion and preventive measures, to conduct two monitoring studies in the mental health sphere (in 2010 and 2013). Additional preventive mental healthcare measures will be planned in accordance with the monitoring results. Although an implementation plan for the framework policy document has not been drafted yet and an official government report on implementing the framework policy document has yet to be prepared, it should be noted that the Public Health Agency (PHA) has performed some mental healthcare promotion and preventive measures.

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9 Informative report on the implementation in 2005 of Latvia's National Action Plan for Reducing Poverty and Social Exclusion (2004–2006), 06.07.2006, http://polsis.mk.gov.lv/LoadAtt/file41108.doc, [last accessed on 09.11.2009]

10 Informative report on the implementation in 2006 of Latvia's National Action Plan for Reducing Poverty and Social Exclusion (2004–2006), http://polsis.mk.gov.lv/LoadAtt/file41109.doc, [last accessed on 09.11.2009]

11 Approved by the Cabinet of Ministers on 6 August 2008, http://polsis.mk.gov.lv/view.do?id=2753, [last accessed on 15.10.2009]

Activities carried out by the PHA promoting mental health

The PHA in cooperation with the WHO Country Office for Latvia organised a two day educational seminar "Mental Health Promotion and Prevention of Mental Illnesses" on 16-17 October 2007. The seminar was led by mental health specialists from WHO, Professor Clemens M.H. Hosman and Dr. Eva Jane-Llopis. Representatives from all psychiatric hospitals as well as numerous nongovernmental organizations (e.g. RC ZELDA, *Paspārne*, *Gaismas stars* and the Latvian Initiative Group in Psychiatry) attended the seminar.

The PHA began the campaign "There is always a solution"[12] at the end of 2007. The aim of the campaign was to teach people to recognise the symptoms of depression as well as to treat people with mental disabilities with tolerance. Two television clips were made in the course of the campaign and shown on television (TV3, Tv3+ and TV6) during the pre-holiday period. The campaign emphasized that depression is not an insoluble problem and help is available, people only have to overcome their prejudices and apply for assistance. Addresses where free psychiatric assistance is available were indicated.

At the beginning of 2009, with the deterioration of the economic situation in Latvia, the PHA started the campaign "Think Positively". The PHA created a section in its website with the title "Think Positively!" which included a specialist's suggestions for promoting mental health. People, who think positively along with their everyday experience in solving and overcoming various negative situations and problems were also described in this section. Taking into account the increasing level of tension and depression in society that arose when the economic situation in Latvia deteriorated in 2008, the PHA prepared recommendations on how different age groups could rediscover the joy of living, deal with worries and negative emotions, and where to look for support if help would be needed.[13] For example, mental health care specialists from the PHA prepared recommendations for talking to children about crisis situations in the family and how to act if a family is faced with such a situation.[14] Likewise, the PHA website offered practical advice on maintaining mental health in the global financial crisis, which has severely affected Latvia.[15]

The section "Mental Health"[16] on the Public Health Agency's website included informative materials on different issues linked to mental health, such as annual statistical information about mental healthcare in the country, activities for promoting mental health etc. The website also suggested where to turn for professional mental healthcare assistance. Unfortunately, due to the reorganization of the PHA the further development of the website is uncertain, but the site archive can still be found on the website of the Health Inspectorate of Latvia.[17]

Food policy and physical activities

In 2003, the government approved the framework policy document "*Healthy Food for 2003 – 2013*".[18] The principle of this framework policy document is that healthy and nutritious food is a significant precondition for the promotion of public health. The Ministry of Health publishes healthy food

[12] Information available at: http://old.sva.lv/aktualitates/2007/20.12.php, [last accessed on 09.11.2009]

[13] *SVA aicina domāt pozitīvi*, *Diena*, 28.02.2009, http://www.diena.lv/lat/politics/hot/sva-aicina-domat-pozitivi, [last accessed on 09.11.2009]

[14] Information available at: http://sva.vi.gov.lv/lv/parsva/dompozitvi/brniunkrze/, [last accessed on 09.11.2009]

[15] Information available at: http://sva.vi.gov.lv/lv/parsva/dompozitvi/kmobiliztspk/, [last accessed on 09.11.2009]

[16] Information available at: http://sva.vi.gov.lv/lv/garigaveseliba/, [last accessed on 09.11.2009]

[17] Public Health Agency website archive, can be found at: http://sva.vi.gov.lv/, [last accessed on 09.11.2009]

[18] Approved by the Cabinet of Ministers on 2 September 2003, http://polsis.mk.gov.lv/view.do?id=846, [last accessed on 15.10.2009]

recommendations for different groups in society,[19] including healthy food recommendations for people over 60.[20]

National policy, is on the whole, directed towards increasing consumption of healthy food and reducing consumption of unhealthy products. For example, starting in autumn 2006, the sale of unhealthy food (carbonated drinks with high sugar levels, salty snacks, etc.) in schools has been restricted and healthy food promoted.[21] Since 2004, the fight against smoking has been stepped up nationwide and the spread of the increase in smoking is being combated.

Health promotion measures are being integrated in the educational and health systems. Since 2002, procedures have been in place governing how preventive healthcare and first aid should be provided for pupils in educational institutions.[22] These procedures stipulate that preschool establishments and school nurses together with the head of the educational institution in general educational institutions and professional educational institutions, must ensure access to healthy food and offer methodical help in promoting a healthy lifestyle and to popularize health promoting measures to teachers.

Preschool establishments and school nurses in general educational institutions and professional educational institutions have the duty to carry out preventive measures against addictions from smoking, alcohol, psychotropic and toxic substances as well as preventive measures against sexually transmitted diseases. In 2008, the Public Health Agency prepared methodical recommendations for school nurses to identify cases of early childhood addiction to addictive (psychoactive) substances.[23]

The work environment and mental health promotion

The work environment is an important place where a person spends a large part of their life. Therefore, it is important to promote and protect mental health at work. It is particularly important to balance work and rest to prevent mental and physical overload and exhaustion, which can result in mental health problems. In accordance with the Labour Law[24], standard daily working hours in Latvia must not exceed eight hours and the maximum standard work week is 40 hours (Article 131). In the EU, in 2008 the standard length of the work week ranged from 35 hours in France and 37 hours in Denmark to 40 hours in Bulgaria, Estonia, Greece, Hungary, Lithuania, Malta, Poland, Romania and Slovenia.[25] Latvia has one of the longest working weeks in the EU, 41.7 hours in 2008, equal to the length of the working week in the Czech Republic.[26] Nonetheless, the situation has improved since 2002, when full time workers in Latvia worked about 43.6 hours a week. In contrast, the average length of the working week in EU states is 38.7 hours.[27]

In Latvia, the requirements for work protection are determined by the Labour Protection Law.[28]

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[19] Information available at http://www.vm.gov.lv/?id=197&top=117&sa=118, [last accessed on 15.10.2009]

[20] Information available at: http://mail.vm.gov.lv/misc_db/web.nsf/bf25ab0f47ba5dd785256499006b15a4/195448bbbf7b0975c2257313001f19e0/$FILE/leteikumi_veciem_cilvekiem_250707.pdf, [last accessed on 15.10.2009]

[21] *Šodien tiek atklāts pirmais veselīgas pārtikas automāts skolā*, 14.10.2009, available at: http://www.pozitivaszinas.lv/posts/view/sodien-tiek-atklats-pirmais-veseligas-partikas-automats-skola, [last accessed on 05.11.2009]

[22] Cabinet of Ministers' Regulation No. 279 "Procedures for ensuring the provision of preventive healthcare and first aid for students at educational institutions", approved by the Cabinet of Ministers on 2 July 2002, http://www.likumi.lv/doc.php?id=64202, [last accessed on 09.11.2009]

[23] Methodical recommendations, http://www.sva.lv/ka_atpazit_narkotiku_lietotajus_2009.pdf, [last accessed on 09.11.2009]

[24] Adopted by the Parliament on 21 June 2001, http://www.likumi.lv/doc.php?id=26019, [last accessed on 09.11.2009]

[25] Working time developments – 2008, European Foundation for the Improvement of Living and Working Conditions, p. 8, http://www.eurofound.europa.eu/docs/eiro/tn0903039s/tn0903039s.pdf, [last accessed on 09.11.2009]

[26] Ibid, p. 19

[27] *Latvijā visgarākās darba stundas ES*, BNS, http://www.apollo.lv/portal/news/72/articles/15499, [last accessed on 09.11.2009]

[28] Adopted by the Parliament on 20 June 2001, into force since 1 January 2002, http://www.ttc.lv/advantagecms/LV/meklet/meklet_dokumentus.html?query=labour+protection+law&Submit=Mekl%C4%93t&resultsPerPage=10, [last accessed on 23.10.2009]

According to this law, the work environment is defined as a workplace with physical, chemical, psychological, biological, physiological and other factors that the employed person is subjected to while doing his or her job. Nevertheless, the main focus of the law is on physical factors. **Workplace mobbing, bossing, working hours and other factors that particularly influence mental health are not mentioned in the law.**

Work environment risk is the possibility that a worker's safety or health may be harmed in the work environment. Employers must create work environments which avoid work-related risk or reduce the influence of unavoidable work-related risk. The employer's duty is to evaluate work-related risk, taking into account that risks to workers' health and safety are generally created by:

1. the location and layout of the workplace;
2. selection and usage of work equipment;
3. the impact of physical, chemical, psychological, biological, physiological and other work environment factors;
4. selection and usage of work and production methods, as well as the organisation of work processes and work time.

Requirements for Labour Protection in Workplaces[29] stipulate that employers must provide regular verification of safety equipment and devices which are used to decrease or prevent the influence of dangerous or harmful (physical, chemical, psychological, biological, physiological and other) factors whose influence on the worker (depending on the level and duration of the influence) generates occupational illness, injuries, and loss of or decrease in work capacity.

The procedures for the investigation and registration of accidents in the workplace in Latvia have been defined.[30] These procedures stipulate that a statement about an accident in the workplace must be prepared if an investigation shows that an accident which has caused loss of work capacity or death has a causal relationship with the fact that the victim has used alcoholic, narcotic, toxic, psychotropic or other harmful substances or products and was not caused by the usage of the aforementioned substances in the work process or inadequate storage or transfer of the respective substances, as well as in the case of a suicide or attempted suicide and this is proven by law enforcement bodies. In 2007, three workplace accidents out of a total of 1,929 in Latvia were caused by mental tension, stress or shock. No such cases were found in 2008.[31]

Opinions of mental health care services' users on health promotion

In the discussion organized by RC "ZELDA," mental health care services' users stated that information generally is inadequate. However, some participants during the discussion remembered some health promotion activities such as information in TV shows, Public Health Agency's brochures in health care institutions, and in newspapers published by users themselves. The participants during the discussion mentioned users' support associations as their preferred venue for exchanging information, where they feel that they are amongst equals and can discuss similar problems. One of the users mentioned that he stopped smoking after his daughter showed him a website where

[29] Cabinet of Ministers' Regulation No. 125 of 19 March 2002 "Requirements for Labour Protection in Workplaces", http://www.ttc.lv/advantagecms/LV/tulkojumi/dokumenti.html?folder=%2fdocs%2fLRTA%2fMK_Noteikumi%2f&currentPage=3, [last accessed on 09.11.2009]

[30] Cabinet of Ministers' Regulation No. 585 of 9 August 2005 "Procedures for Investigating and Registration of Accidents at Work", http://www.ttc.lv/advantagecms/LV/tulkojumi/dokumenti.html?folder=%2fdocs%2fLRTA%2fMK_Noteikumi%2f&currentPage=35, [last accessed on 09.11.2009]

[31] Public Report of the State Labour Inspectorate, 2008. http://www.vdi.lv/files/statistika/2008_gada%20_parskats_apstiprinats.pdf, [last accessed on 09.11.2009]

negative consequences of smoking were demonstrated.[32]

Conclusions:

1. Latvia has realised the need for long-term promotion of mental health, and this has been emphasised in numerous policy planning documents. However, the courses of action stipulated in these documents are declarative and the planned measures are fragmented and crumbled.
2. Even among specialists there is no common understanding of the role and significance of mental health promotion in improving mental health. Until now specialists have had no experience in mental health promotion as the emphasis in the system has been on treatment.
3. Separate measures and campaigns have been carried out to promote mental health.
4. Actions were taken in order to integrate into one institution the implementation of common public health and health promotion policies. However, at the end of 2009 the further institutional development of the system and its competence is uncertain and opinions have been expressed that in light of the economical crisis public health and health promotion activities should be reduced or stopped.
5. The public has been told relatively little about how to deal with burn-out and where to seek help. Only in rare cases (for example, Riga City Council provided supervision for the employees of municipal social care institutions) is supervision offered to workers in the caring professions.

Recommendations:

1. To prepare and approve the implementation plan for the framework policy document "*The Improvement of Inhabitants' Mental Health in 2009–2014*", envisaging overall measures for promoting mental health.
2. To continue working with municipalities in forming a united system in Latvia for health promotion.
3. To ensure access to information on mental health by using effective information channels and putting emphasis on the issue of stigmatisation.
4. To continue and develop the mental health promotion work initiated by the Public Health Agency.
5. To support activities of the non-governmental sector in mental health promotion, especially by supporting associations for users of mental health care services.
6. To develop and implement support measures for the families of people with mental health problems - the particular target group which is in the closest contact with users of mental health care services.

2. DEMONSTRATING THE CENTRALITY OF MENTAL HEALTH

Article 11 of the Constitution of the Republic of Latvia[33] stipulates that one of the basic functions of the state is to "protect people's health and guarantee a minimum level of medical assistance to all." On 6 March 2001, the Cabinet of Ministers approved the *Public Health Strategy*[34] which states that

[32] RC ZELDA discussion with mental health care services' users regarding the implementation of the WHO Mental Health Declaration and Action Plan, 3 November 2009.

[33] Republic of Latvia Constitution, http://www.ttc.lv/advantagecms/LV/meklet/meklet_dokumentus.html?query=Constitution&resultsPerPage=10, [last accessed on 11.01.2009]

[34] Public Health Strategy for 2002-2010, approved by the Cabinet of Ministers on 6 March 2001, http://sva.vi.gov.lv/files/normativie%20akti/sab_ves_strategija.pdf, [last accessed on 09.11.2009]

every individual's right to help is the cornerstone of quality of life, personal and family wellbeing and of society as a whole. The current government and its predecessors have all promised to improve the health of every resident of Latvia. Long-term economic and social development can only be produced by a healthy population in a stable economic, social and ethical environment.

A mentally healthy society is an important precondition for creating such a stable and secure economic, social, working and living environment, while in turn every individual's mental health impacts on social, economic and environmental factors, lifestyle, habits and knowledge – often to a greater extent than physical health. The impact of these diverse factors and their interaction with mental health illustrates the centrality of mental health in improving the quality of life in society. Latvia's policies for improving mental health are based on interdisciplinary and multidisciplinary cooperation in the social, educational, security, legal, environmental and other spheres, developed several years before the approval of the WHO Mental Health Declaration and Action Plan.

One of the core documents relating to healthcare, *the Medical Treatment Law*[35], adopted in 1997, puts significant attention on mental health and inter-sector cooperation to ensure its improvement. Section 3 of this law stresses the importance of mental health, stating that "health is physical, mental and social well-being, the natural basis of the existence and survival of the State and the nation. Health care is the complex of measures for ensuring and maintaining health." Section 5 of the law states that "Everyone has a duty to take care of, and everyone is responsible for, his or her own health, the health of the nation, and the health of his or her relatives and dependants", and calls for broad cooperation and for each individual to strive and accept responsibility for maintaining their own mental health and that of society as a whole. Section 11 of the Medical Treatment Law - "Mental illness" - (articles 65-69) is directly linked to mental health and mental illnesses and their consequences. This section stipulates the rights of mentally ill persons and the principles for providing psychiatric assistance in cases where the patient does not give his/her consent to receive psychiatric assistance, the legal procedures for considering cases of involuntary admission and providing legal assistance, and cooperation with the police in cases of threats to public safety in accordance with the Medical Treatment Law and the Law "On Police"[36]. With regard to promoting mental health, the Medical Treatment Law sets out the responsibilities of every member of society, including healthcare professionals, the state, ministries and their institutions and local governments, and coordinates cooperation at the interdisciplinary and inter-sector level.

The *Public Health Strategy*[37] characterises the national public health situation as dramatic, which was why the Strategy was developed for the period up to 2010 with the aim of improving the health of Latvia's inhabitants as quickly as possible and reaching the health indicators of the best European countries. The strategy stipulates 20 objectives and priority courses of action, the achievement of which requires a range of measures performed by every member of society, "from each individual through to the government (...) with the involvement and support of many sectors and spheres." The Strategy is based on European Union's directives in the health sphere with regard to public health risk factors, environmental protection, food safety, animal health, consumer safety, the free movement of healthcare specialists, workplace health and safety, pharmaceutical preparations, the social security system and research and information technologies. The *Public Health Strategy* has been developed based on inter-sector experience and with broad public involvement. An Inter-sector Coordination Committee on healthcare issues was set up, three seminars were held in

[35] The Medical Treatment Law, adopted by the Parliament on June 12, 1997, entered into force October 1, 1997, http://www.ttc.lv/advantagecms/LV/meklet/meklet_dokumentus.html?query=Medical+treatment+law&Submit=Mekl%C4%93t&resultsPerPage=10, [last accessed on 09.11.2009]

[36] The Law "On Police," adopted by the Parliament on 4 June 1991, http://www.ttc.lv/advantagecms/LV/meklet/meklet_dokumentus.html?query=On%20Police&resultsPerPage=10, [last accessed on 09.11.2009]

[37] Public Health Strategy for 2002-2010, approved by the Cabinet of Ministers on 6 March 2001, http://sva.vi.gov.lv/files/normativie%20akti/sab_ves_strategija.pdf, [last accessed on 09.11.2009]

relation to the Strategy and there was wide-ranging discussion of the draft version of the Strategy. The discussion of the draft version of the Strategy involved numerous ministries, state and local government institutions and NGOs.

One of the Strategy's objectives applies directly to mental health: improving the mental health of Latvia's inhabitants and ensuring that all inhabitants have access to qualitative mental healthcare services by 2010. Since the *Public Health Strategy* is based on interdisciplinary and inter-sector cooperation, almost all of the courses of action stipulated for achieving the Strategy's 20 objectives also impact on improving mental health. In turn, improving the mental health of society has a direct or indirect impact on the planned results for other objectives, including ensuring justice and equality in the health sphere, the health of school-age children, teenagers and adults a healthy and active old age, a healthy and safe environment, healthy lifestyles, and reducing the effects of violence. Cooperation, involvement and support at the interdisciplinary and inter-sector level in the health, social, educational and other spheres are necessary for the implementation of the *Public Health Strategy* and the improvement of the quality of life and mental health in society.

In order to implement the *Public Health Strategy*, the *Action Programme for Implementing the Public Health Strategy for 2004-2010*[38] was drafted in 2004 which, in line with the priorities set out in the Strategy, stipulates concrete measures and activities, completion deadlines, financial resources and responsible institutions. Inter-sectoral cooperation and joint performance of activities requires the involvement of a number of ministries, including the health, welfare, education and science, economy, transport, regional development and local government affairs, environment and justice ministries.

The *Informative Report on the Implementation of the Public Health Strategy for 2007-2008*[39] prepared by the Ministry of Health provides an overview in 2009 of the implementation of the *Public Health Strategy*. The following table includes information taken from the Informative Report regarding the implementation of activities directly or indirectly connected with improving mental health. In order to reflect the implementation of inter-sector cooperative activities, the table also indicates the ministries responsible for each activity.

Planned activity (year of fulfilment)	**Planned result**	**Fulfilment**	**Responsible institution (institutions involved)**
Objective – improvement of mental health			
Implementation of the project "Optimisation of the operation of outpatient psychiatric assistance services" (2004-2007)	Reduce the number of outpatient and inpatient psychiatric patients and reintegrate these patients into society	Short-term result achieved, One mental health outpatient care centre (*Veldre* in Riga) began operating in 2005, reduction in the number of inpatient psychiatric patients	Ministry of Health
Provision of access to psychological assistance in every general education school (2004-2005)	Provision of qualified psychological assistance in every general education school	Result partially achieved. Out of a total of 958 day schools nationwide, 614 schools have access to a psychologist (482.28 staff unit rates). On average, there is one psychologist for every 520 students nationally.	Ministry of Education and Science (Ministry of Health)

[38] Action Program for Implementing the Public Health Strategy for 2004-2010, approved by the Cabinet of Ministers on 9 March 2004, Order No.150, http://polsis.mk.gov.lv/LoadAtt/file27442.doc, [last accessed on 09.11.2009]

[39] "Informative Report on the Implementation of the Public Health Strategy for 2007-2008", prepared by the Ministry of Health, 2009, http://polsis.mk.gov.lv/LoadAtt/file25733.doc [last accessed on 09.11.2009]

Development of a training program for National Armed Forces' (NAF) doctors and nurses and organising of seminars for the early detection of psychiatric disorders (2004)	Training program developed and NAF specialists trained	Result partially achieved. In line with the training program for 2005-2006, two seminars and one lecture on post-traumatic stress were held for NAF doctors and nurses. Thirty NAF doctors and 60 paramedics and nurses took part in the seminars and lectures.	Ministry of Defence (Ministry of Health)
Provision of psychological assistance at NAF training centres (2004-2005)	Provision of qualified psychological assistance in crisis situations	Short-term result achieved The NAF Psychological Service (5 specialists) was established in 2006, providing qualified psychological assistance to all NAF units.	Ministry of Defence (Latvian Doctors' Association)
Provision of psychological assistance in institutions of Ministry of Interior (2005-2007)	Provision of qualified psychological assistance in crisis situations	Result partially achieved. Psychology seminars prepared and delivered for State Police officials. In crisis situations institutions of Ministry of Interior provide psychological assistance using the resources of medical institutions.	Ministry of Interior (Latvian Doctors' Association)
Improvement of the mental health information system (2004-2006)	Rapid-response, computerised mental health services information system set up	Result partially achieved. In 2008 the State Data Inspectorate registered five databases at the Riga Psychiatric and Narcology Centre	Ministry of Health
"Multidisciplinary Team Activities" Pilot project (2004-2006)	Outpatient multidisciplinary teams in 26 districts	Short-term result achieved - three outpatient mental healthcare centres are operating	Ministry of Health
Development of the Health Protection Law (2004)	Adoption of the Health Protection Law (basic principles of health protection with a patients' rights protection mechanism in accordance with the 1994 Helsinki Patients' Rights Declaration.)	Result has not been achieved, Work continues on draft versions of the Health Protection and Patients' Rights Law. The deadline for activity implementation has been postponed until the next reporting period	Ministry of Health (Cabinet of Ministers, RL Parliament)
Objective – justice and equality			
Periodic evaluation of differences in health indicators for various socioeconomic groups (2004 - 2009)	Two studies on health indicator trends conducted	Result partially achieved, because special studies were not conducted and previous data was analysed	Central Statistics Bureau (Ministry of Economy, Ministry of Health)
Objective – the health of school-age children and teenagers			
Studies on the health of children and teenagers (including mental health) (2004 - 2009)	Studies on the health of children and teenagers	Result achieved by taking part in the WHO-supported International School Pupil Health Habits Study (HBSC) on the mental health of school-age children	Ministry of Health (Ministry of Education and Science)

Objective – adult health, healthy and active old age			
Alternative care - care at home and day centres (2004 – 2007)	At least 20 alternative care centres opened	Result partially achieved by establishing four day centres for persons with mental disorders.	Local municipalities (Ministry of Welfare)

The table shows that activities affecting the mental health of society had been partially implemented by 2008. The planned result has been fully achieved with regard to the studies of children's and teenagers' health conducted by the Ministry of Education and Science, while six measures have seen partial fulfilment of the anticipated results and short-term results have been achieved for three measures, which require that their activities should be continued. The general objective, development of the Health Protection Law, had not been achieved by 2008, and therefore the deadline for the activity's completion has been transferred to the next reporting period. The table also reveals that the majority of activities are being performed through the cooperation of a number of ministries or their subordinate institutions.

One of the *Public Health Strategy's* stipulated courses of action which requires an interdisciplinary and inter-sectoral approach to planning and implementing mental health policy is the *Framework policy document "Improvement of Inhabitants' Mental Health for 2009 -2014"*.[40] This framework policy document has been developed by the Ministry of Health in conjunction with health sector institutions and inter-sectoral support. The framework policy document places great importance on interdisciplinary and inter-sectoral cooperation, which would result in the significant improvement of mental health and mental healthcare. The framework policy document sets out problems that have been found in connection with poor cooperation and coordination in the interests of mental health, since mental health and psychiatric issues are mainly resolved between specialists, and the mental healthcare service is a closed system. The opinions of service users and their families regarding the service, policy principals and objectives are not given enough weight, and as a result public stigmatisation arises and the rights of people (and their families) living with, or affected, by mental health problems are directly or indirectly ignored and infringed upon. Analysing the national mental health situation, there is clearly a lack of cooperation between local governments, state institutions, NGOs, law enforcement institutions, and education and healthcare workers.

The framework policy document indicates that the problem can be resolved through involving the public in evaluating the impact on health and informing the public about mental health issues. This would increase the public's knowledge, dispel myths and negative stereotypes about mentally ill people and integrate persons with mental health problems into society. The Framework policy document sets out the courses of action to be taken to achieve this. One of these courses of action is the creation of community based mental healthcare services. A range of other activities to be implemented, through interdisciplinary and inter-sectoral activities, are set out in the implementation program for the *Public Health Strategy*.

An inter-institutional discussion was held in 2008 on developing an implementation plan for the framework policy document "*Improvement of Inhabitants' Mental Health for 2009-2014*," with the participation of directors of psychiatric hospitals, representatives of Latvian Psychiatrists' Association and officials from the Ministry of Health. However, the plan has not been developed to date.
The principles of inter-sectoral cooperation in the sphere of improving mental health have been taken into account in the Conception "Equal Opportunities for All"[41] developed by the Ministry of

[40] The framework policy document "Improvement of Inhabitants' Mental Health for 2009-2014," approved 6 August 2008, by Cabinet of Ministers' Order No.468, http://polsis.mk.gov.lv/LoadAtt/file27442.doc, [last accessed on 09.11.2009]

[41] Conception "Equal Opportunities for All", approved by the Cabinet of Ministers on 30 June 1998, http://www.lm.gov.lv/upload/normativie_akti/koncepcija_viv.doc, [last accessed on 09.11.2009]

Welfare in 1996 and adopted in 1998, which aims to establish a framework for creating equal opportunities for all members of society to fulfill normal roles depending on age, gender, social and cultural factors. The Conception has been developed based on the principals set out in the UN Declaration on the Rights of Persons with Disabilities, the Declaration on the Rights of Mentally Retarded Persons, the Declaration on the Rights of the Child, the UN Standard Rules on the Equalisation of Opportunities for People with Disabilities, and Council of Europe Recommendation No.R (92) 6 (A Coherent Policy For the Rehabilitation of People with Disabilities). In 2009, the Ministry of Welfare prepared the Report on the implementation in 2008 of the Conception "Equal Opportunities for All".[42] The fulfilment of a number of the Conception's tasks is connected with tackling public mental health issues through the involvement of various ministries and institutions in its implementation. The following table provides information about the planned activities, the institutions involved in their implementation and the implementation itself, in 2008.

Planned activity (year of fulfilment)	Planned result	Fulfilment	Responsible institution (institutions involved)
Task – ensure that disabled persons enjoy rights to an adapted environment and equal opportunities			
Prepare and publish information in "easy-to-read language" for persons with mental disabilities (Starting from 1999.)	Opportunities created for persons with mental disabilities to receive information in an understandable form. Institution established for preparing and publishing information in "easy-to-read." Specialists trained.	In 2008, sections titled "Easy to read" were created on the websites of two ministries, featuring information about objectives, spheres of activity, news, ministers, contact persons and contact facilities. The websites also feature the UN Convention on the Rights of Persons with Disabilities translated into "easy-to-read language."	Ministry of Education and Science, Ministry of Welfare
Task – ensure that disabled persons are economically and socially protected			
Create a network of day centres for people with mental disabilities (Starting from 1999.)	Opportunities created for people with mental disabilities to integrate into society and develop their potential. Changed public attitudes towards persons with mental disabilities. Network of day centres created, number of places in specialised social carte centres reduced.	Eight group homes (apartments) and five group houses have been created and are operating nationwide. In 2008, 1,274 persons with mental disabilities attended day care centres. A client can spend all day in weekdays at the centre and receive assistance..	Ministry of Welfare, local governments

[42] Report on the implementation of the Conception "Equal Opportunities for All" in 2008, prepared by the Ministry of Welfare, http://www.lm.gov.lv/text/1147, [last accessed on 11.11.2009]

Ensure the provision of healthcare services to persons with psychiatric illnesses (Starting from 1999).	Opportunities created for mentally ill people to receive the help they require.	1. In 2008 contracts were signed with medical institutions throughout Latvia for state-funded outpatient psychiatric assistance. 2. The Framework policy document "Improvement of Inhabitants' Mental Health for 2009–2014" has been developed. 3. Methodical materials have been developed for the identification and preventive treatment of depression, suicide risk, schizophrenia etc. 4. The Recommendations**:** "Suicide Prevention. Materials for General Practitioners" have been developed	Ministry of Welfare, Ministry of Health, local governments
Task – ensure that disabled persons enjoy rights to legal protection			
Develop programs to protect the rights of disabled persons who are partially or fully unable to exercise their rights or manage their property. (Starting from 1999.)	System created ensuring legal protection for persons with disabilities (protection of persons and property). Orphans' Courts' operations improved. Specialists trained.	In 2008 Department of Supervision and Methodical Management of the Orphans' Courts held a seminar for Orphan's Courts' directors, with the participation of representatives from the Ombudsman's Office.	Ministry of Justice, Ministry of Welfare
Task – ensure that disabled persons enjoy rights to legal protection			
Ensure the inclusion of the disability aspect in all stages of policy development	Create a system ensuring cooperation between state institutions and NGOs.	1. In 2008 the conference "Legal aspects of cooperation between local governments and NGOs" was held. 2. In 2008 NGOs became involved in developing social inclusiveness policy and had the chance to participate in decision making at the highest national political level. 3. In 2008 the working group "Preparing for the ratification of the UN Convention on the Rights of Persons with Disabilities" was established, with the following bodies involved in its work: sector ministries, Ombudsman, Latvia's planning regions, social partners, and organisations representing disabled persons – the Latvian Cooperation Organisation for Persons with Special Needs SUSTENTO, the Association of Disabled People and their Friends APEIRONS, the Support Group for Patients with Mental Disorders and their Families "*Gaismas stars*", the Latvian Disabled Women's Association "*Aspazija*", the Resource Centre for People with Mental Disability ZELDA, and the Latvian Disabled Persons' Society.	All ministries, NGOs

In assessing what has been done in 2008, the Report concludes that while some results have been achieved, work on ensuring equal opportunities for the disabled must proceed in a better and more

constructive manner. A lack of funds is a significant barrier to implementing the Conception. There is also a lack of good will in relevant ministries to speed up the integration process for the disabled people by resolving identified practical problems immediately and rectifying legal discrepancies. Closer and more productive cooperation between sectors, ministries and local governments is needed in order to promote the social integration of persons with mental disabilities and to develop the network of halfway houses and group homes/apartments.

The Ministry of Welfare has prepared the *Framework Policy Document for Reducing Disability and its Consequences for 2005-2015*[43], a ten-year, long-term planning document encompassing the main principles, objectives and priorities for state policy covering disability prevention and social protection for the people with disabilities. Since many disabled persons have mental disorders, implementation of this framework policy document will impact significantly on the mental health of society.

Aspects relating to social protection policies for inhabitants, including equality and non-discrimination (including gender equality) were taken into account in developing this framework policy document. Implementation of social protection policy requires coordinated activities between the welfare, health, education and science, economics and finance ministries in addition to the activities of the Ministry of Welfare. The principles of cooperation, support and participation are critical for policies to reduce the consequences of disabilities, requiring interdisciplinary and inter-sectoral cooperation for both policy planning and implementation. Following adoption of the framework policy document, the action plan has been developed, anticipating inter-sectoral and interdisciplinary cooperation between specialists in the following directions: development and implementation of a range of disability prevention measures; improvement of the disability determination process by establishing new criteria for assessing disability; promotion of employment for disabled persons and improvement of the social employment system for the disabled.

The Ministry of Welfare has prepared the *Informative Report on the Implementation of the Action Plan for the framework policy document for Reducing Disability and its Consequences for 2005-2015*[44], which states that preventive measures for disabilities have been implemented through the productive cooperation of the Welfare and Health ministries. Further, the report states that the procedure for providing rehabilitation services has been improved to stipulate that medical rehabilitation services are provided not on the basis of diagnosis, but in compliance with the person's state of health, associated functional limitations and their potential for rehabilitation. The report also mentions, that the structure of the Ministry of Health, which provides control and data collection on provided healthcare and rehabilitation services and issued work incapacity forms, has been optimised.

Activities relating to the course of action "Promoting Employment for Disabled Persons" are also in the implementation process. The State Employment Agency of the Ministry of Welfare, within limits, has started actively to promote measures for people with disabilities (including persons with mental disorders) through developing new professional rehabilitation programs and introducing teaching methods suited to the needs of people with disabilities. For example, new methods have been developed for determining professional suitability and risk factors for stress and burnout, which permits evaluation of an individual's suitability for various professions and positions requiring stress endurance, thereby reducing possible mental health risks.

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[43] Framework policy document for Reducing Disability and its Consequences for 2005-2015, http://polsis.mk.gov.lv/LoadAtt/file43119.doc, [last accessed on 09.11.2009]

[44] "Informative report on the implementation of the action plan for the Framework policy document for reducing disability and its consequences for 2005-2015," http://polsis.mk.gov.lv/LoadAtt/file18613.doc, [last accessed on 09.11.2009]

Regarding the course of action "Improvement of the social security system for persons with disabilities," the Ministry of Welfare has proposed amending the Law on State Social Allowances to establish a new state social benefit - "Benefit for disabled persons requiring care." This substantially affects also persons with mental disabilities. In addition, a number of Cabinet of Ministers' regulations have been amended to increase social benefit payments to participants in the Chernobyl nuclear accident cleanup operation and the families of deceased Chernobyl cleanup operation workers.

Within the framework of the working group the Ministry of Welfare in collaboration with other ministries, the Riga City Council and eight NGOs have reviewed the mechanisms for receiving and disbursing the services of a personal assistant. Many courses of action involve cooperation between the Welfare and Health ministries, as well with other ministries and institutions.

The Ministry of Welfare has developed the document *"Program for Developing Social Care and Social Rehabilitation Services for Persons with Mental Disabilities for 2009- 2013,"*[45] which was approved by Cabinet of Ministers' Order No. 157 of 5 March 2009. The Program aims to develop such social care services which would be consistent with people's needs.

The program's activity "Increasing accessibility to social care services", which intends to reduce waiting lists, can be implemented only starting from 2012, when the necessary funding is planned. The second activity - "Improving the quality of social care services" intends to provide qualitative services for 650 clients. The third activity - "Development of alternative care services" impacts substantially on mental health, as 15 group homes were established in 2005-2007. The implementation of this activity has reduced waiting lists for social care centre homes and increased the number of persons receiving qualitative social care services, and has improved access to alternative social care services.

The Ministry of Finance has drafted the document *"Social Safety Net Strategy,"*[46] which was adopted by the Cabinet of Ministers on 8 September 2009 for the period from 1 October 2009 to 31 December, 2011. The Strategy aims to develop a range of emergency measures which would reduce the negative social impact of the recession. The Strategy states that Latvia currently is in recession, and has experienced a fall in GDP of 4.6% in 2008. Further falls in GDP are expected in 2009-2010, and slight growth of 1.5% has been forecasted for 2011, with an associated increase of unemployment and poverty. In this situation, the Strategy establishes safety programs for various sectors. For the healthcare sector, which also includes persons with mental disabilities or those at risk of becoming mentally ill, it is anticipated that basic health care services must be provided and basic medications must be made available to poor people through the following courses of action:

1. Creation of a compensation mechanism for covering patient contribution payments for poor persons, thus maintaining access to health care, ensuring that such persons can duly access medical care institutions and receive required care.
2. 100% compensation of medication for poor patients if the patient's co-payments for medications under the compensation system reach 50 lats (71 Euros) in a calendar year.
3. Creation of a compensation mechanism for covering hotel expenses for poor people (staying in "hospitals' hotels").
4. Provision of home care for poor, severely ill patients.
5. Concentration of inpatient services for poor people with mental disabilities through a reduction in the number of beds and the development of day care centres.

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[45] "Program for the Development of Social Care and Social Rehabilitation Services for Persons with Mental Disorders for 2009 - 2013," http://polsis.mk.gov.lv/LoadAtt/file39342.doc, [last accessed on 09.11.2009]

[46] "Social Safety Net Strategy," http://www.lps.lv/images/objects/committee_files/p_files/6efdfb8806c6d353eec30bd8a2503bdfSocialais_tikls.pdf, [last accessed on 09.11.2009]

In drafting this document, the Ministry of Finance has made proposals, expressed its views and stated its readiness to be involved in inter-sectoral cooperation to achieve set objectives.

Policy planning directions regarding work-related illnesses are set out in the document "*General Strategy – Health at Work for All,*"[47] which aims to improve occupational health and safety indicators by 2000. The Strategy provides a brief analysis of the situation, indicates the most important occupational health and safety needs at the national and international level and makes recommendations for the WHO Workers' Health Program. This policy document does not directly touch Latvia's situation or stipulate concrete courses of action. The Strategy emphasises that work is becoming more intensive and requires maximum attention and concentration, therefore attention must be paid to the suitability of work for the physical and mental abilities of the workers, and in resolving psychosocial and organisational issues. From the psychosocial viewpoint, stress and burnout play an increasing role. Stress at work depends on working conditions and the workers' attitude towards them. Stress and dissatisfaction at work may be caused not only by factors such as a fast working pace, responsibility and excessive workload, but also by such factors as artificial lighting, noise, vibrations, fluctuations in the microclimate, the presence of chemicals, unsuitable workspace, cramped conditions and old equipment.

Employers' obligations with regard to mandatory health checks in Latvia are set out in the Work Protection Law.[48] Cabinet of Ministers' Regulation No.219 "Procedures for Conducting Mandatory Health Checks",[49] adopted on 10 March 2009, sets out the procedures for conducting mandatory health checks, in which a person's ability to perform a particular job is evaluated based on mental health in connection with psycho-emotional factors, mental illnesses and behavioural disorders.

The *National Development Plan for 2007 – 2013*[50] was approved on 4 July 2006, by Cabinet of Ministers' Regulation No. 564. This Plan is hierarchically the highest medium-term planning document and it is described as "a compass for politicians, officials and all residents of Latvia." It stipulates the main priorities for Latvia's development and the most important tasks that must be accomplished to achieve the further goal of a gradual increase in the quality of life. All ministries, local governments, NGOs and social partners are broadly represented in its development.

The following tasks to be undertaken in the area of human health are set out in one of the sections of the *National Development Plan (NDP)*:

1. To improve people's access to healthcare services by developing healthcare infrastructure, paying particular attention to primary healthcare and emergency medical assistance.
2. To provide and develop human resources in healthcare in the long term.
3. To develop a balance between national and individual responsibility for maintaining and improving one's health, to develop awareness of healthy lifestyle and diet in the society, and to involve the community in the struggle against addictions (alcohol, narcotic, psychotropic, toxic substance, gambling or computer game dependence).
4. To promote integrated mental healthcare (to promote cooperation between community-based mental health services and administrative bodies involved in the solution of mental health issues; to educate the community about mental health and psychiatric illnesses) in the community.
5. To promote the importance of preventive activities;
6. To increase gradually funding for healthcare and to improve people's knowledge about the

[47] "General Strategy – A Union for All," http://www.parks.lv/home/ioeh/WHO%20Strategija.doc, [last accessed on 11.11.2009]

[48] Labour Protection Law, http://www.ttc.lv/advantagecms/LV/meklet/meklet_dokumentus.html?query=Work+Protection+Law+&Submit=Mekl%C4%93t&resultsPerPage=10, [last accessed on 11.11.2009]

[49] Cabinet of Ministers' Regulation "Procedures for Mandatory Health Checks," http://www.lm.gov.lv/upload/darba_tirgus/darba_aizsardziba/mk_219.doc, [last accessed on 11.11.2009]

[50] "National Development Plan," http://polsis.mk.gov.lv/LoadAtt/file44075.doc [last accessed on 09.11.2009]

possibilities of receiving state-funded healthcare services;
7. To support the introduction of new evidence-based treatment methods;
8. To develop the use of e-health solutions and information technology;
9. To reduce newly born and infant (up to the age of 1year) mortality;
10. To promote the active participation in sporting activities by people, especially children and youth.
11. To promote cooperation between government and NGOs which work with families, children, youth and socially excluded risk groups (including HIV infected persons) in the field of healthcare.

Mental health issues are emphasized in the *National Development Plan* and the necessity of undertaking activities to improve inhabitants' mental health by working together in the implementation of many tasks has been outlined. Working groups of experts in various areas regularly prepare and release reports about the process of implementation of the *National Development Plan*. The most recent report on the introduction of the *National Development Plan,* to the first half of 2008, was submitted by the working group - "Increase in Inhabitants' Well-being."[51] The report established that in 2007 for implementing NDP's task "to promote integrated mental healthcare in the community," the Ministry of Health carried out five activities, affecting the improvement of mental health care services: an international seminar was held, articles were published in the media about mental health promotion, and a public information campaign was launched. The aim of the campaign was to draw people's attention to specific mental health issues in order to reduce the number of suicides, as well as to reduce the community's prejudices against people with mental health problems and promote the integration of these people into society.

In order to implement this NDP's task it was also planned to approve and implement the Framework policy document "*Improvement of Inhabitants' Mental Health for 2009-2014*" (the Framework policy document was approved on 6 August 2008, by Cabinet of Ministers' Regulation No.468). Implementation of this Framework policy document will ensure qualitative mental healthcare suited to people's needs, and will initiate the transition from institutional care to community based mental healthcare. Public information campaigns will be continued, and health promotion activities will be carried out within the framework of the activity 1.3.2.1 "Improvement of Health in the Workplace to Encourage Long Term Employment" of the EU-funded programme "Human Resources and Employment".

In the *National Development Plan*, health is rated as one of daily life's most important resources and the sound health of every person must be one of the nation's fundamental goals. Particular attention is drawn to the fact that "the improvement of the health condition must be integrated into all of the national action policies."

Conclusions

1. Mental health as an inseparable component of public health has an important place in health and other sector policy planning documents which are developed in Latvia.
2. The development of public health and mental health policy documents and the planning of their implementation are based on interdisciplinary and inter-sectoral principles.
3. Occupational health and safety issues in the mental health area are determined mainly through compulsory health checks.
4. Due to insufficient inter-sectoral cooperation, efficiency in the implementation of mental

[51] NDP, expert working group "Increasing the wellbeing of the person" report for the first half of 2008, http://www.nap.lv/lat/NAP_istenosana/zinojumi/?doc=1134&page, [last accessed on 11.11.2009]

health policy has been low. Activities have often taken place without including the mental health risk group as the target group.

5. Mental health care in Latvia is relatively isolated, institutionally oriented, and insufficiently provides opportunities for receiving community-based and alternative care and services.
6. Until now there has not been sufficient progress and development in the implementation of the tasks stipulated in the *National Development Plan* (to promote and develop integrated mental health care in the community, shift services from institutional to community care and develop cooperation between administrative bodies involved in addressing mental health issues).
7. In these circumstances of limited financial resources caused by the recession, future development perspectives of mental health care in the next few years can be considered to be pessimistic.

Recommendations

1. The use of wider and more comprehensive inter-disciplinary and inter-sectoral cooperation principles are required in the introduction of the activities planned in policy documents.
2. To develop and adopt an Action plan for the implementation of the Framework policy document "*Improvement of Inhabitants' Mental Health for 2009-2014*". To allocate also the necessary funding for implementation of the previously mentioned Action plan.
3. In the occupational health and safety area, mental health care specialists should carry out research and make recommendations regarding burnout syndrome, bullying, bossing and workforce ageing.
4. In future, if mental health policy documents are developed, it is recommended to integrate in the analysis also the planned activities of other sectors which have an influence on mental health. The result of all these combined activities should be evaluated.

3. ADDRESSING STIGMA AND DISCRIMINATION

Relevant policy documents

In evaluating nationally adopted policy planning documents on reducing the effects caused by stigma and discrimination, it can be concluded that a number of conceptions and programs as well as framework policy documents affecting this area have been adopted since 2005. One of the most significant documents approved recently by the government in relation to people with mental disabilities, which also covers the fight against stigma and discrimination, is the *Implementation Plan of UN Convention on the Rights of Persons with Disabilities for 2010-2012*, the goal of which is "to commence the Convention's implementation with the existing resources available, carrying out improvements and developments in 2010-2012, which would facilitate the achievement of the goals set out in the Convention".[52] Activities for the next three years, which are included in the Implementation Plan, do not require additional resources from the national budget. In evaluating the current situation, the Ministry of Welfare has recognized that "the major difficulty in implementing the Convention lies in ensuring access," referring this not only to making the environment accessible, but also to many other areas.[53]

The Convention's Implementation Plan prescribes the implementation of a number of activities and tasks within the next three years. In implementing the promotion of equality and reduction

[52] Implementation Plan of UN Convention on the Rights of Persons with Disabilities for 2010-2012, (Introduction), http://polsis.mk.gov.lv/view.do?id=3196, [last accessed on 02.11.2009]

[53] Ibid, section: Description of the Situation.

of discrimination task, it is planned to "evaluate the necessity of regulating all issues relating to discrimination by one joint (so-called "umbrella") act." Similarly, in 2010, it is planned to make amendments to the Consumer Rights Protection Law, prescribing that "unequal treatment of a consumer due to a person's disability is also prohibited."[54] The Convention's Implementation Plan also contains activities for raising awareness, including the organisation of training for teachers about persons with disabilities and their rights, as well as informing the public about "equal opportunities and rights of persons with disabilities, including on the specific needs of persons with mental disabilities."[55] The vast majority of activities are planned for the provision of access to the environment and information, including adaptation of the environment for persons with mental disabilities. In the education area it is planned to promote "the integration of children with disabilities into pre-school, general education and professional education institutions." In turn, in the employment area it is planned to improve the opportunities for employment of persons with disabilities, as well to include training programs for people with disabilities within the State Employment Agency's active employment measure "Professional training, re-qualification, attaining higher qualification and attainment of non-formal education."

A significant policy planning document in relation to persons with mental disorders is the *Framework policy document "Improvement of Inhabitants' Mental Health for 2009-2014"*[56], adopted in August 2008. The framework policy document identifies many problems linked with effects caused by discrimination and stigmatisation. One of the problems mentioned is the lack of unified statistics on mental disorders, taking into account that some part of patients turn to private psychiatrists or even decline to seek the help of professional mental health care specialists, fearing possible stigmatisation and discrimination.[57] Consequently "a significant proportion of patients with relatively mild psychiatric disorders are treated by general practitioners, internists and neurologists, because patients think that treatment not related to the mental health care service is more acceptable and less stigmatising."[58] To address this situation, the framework policy document envisages the reduction of stigmatisation, discrimination and inequality with the goal of "reducing the negative public attitude to users of mental health care services and their family members" as one of the area's fundamental policy principles.[59]

In 2005, the framework policy document *"Reducing Disability and its Consequences for 2005-2015"* was adopted. The employment of persons with disabilities, from the viewpoint of the equality principle is mentioned as one of the most important issues included within this framework policy document. It also recognizes that only 10%, of all the people with disabilities were officially working in 2005.[60] The framework policy document also identifies problems linked to the employment of persons with disabilities and concludes that "not one law or regulation covers issues on the provision of systematic and coordinated measures for disabled people's professional suitability, professional training, settlement into employment and maintaining or continuing the employment."[61] Similarly, the framework policy document establishes that: "employers are not interested in employing disabled people. There is no awareness of the necessary conditions for employing a disabled person and there are no funds for adaption of the workplace to suit the needs of a disabled person."[62]

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54 Ibid, section: Measures and Tasks: Implementation of the Convention.

55 Ibid.

56 Framework policy document "Improvement of Inhabitants Mental Health for 2009-2014", http://polsis.mk.gov.lv/view.do?id=2753 [last accessed on 02.11.2009]

57 Ibid, Paragraph 1.1.

58 Ibid, Paragraph 2.1.12.

59 Ibid, section: Main Policy Principles, Principle 3.

60 "Reducing Disability and its Consequences for 2005-2015", Paragraph 1.3, http://polsis.mk.gov.lv/view.do?id=1826, [last accessed on 02.11.2009]

61 Ibid, Paragraph 2.3.

62 Ibid.

The framework policy document defines a number of policy results to be achieved within the period of the next ten years (for example, it aims to achieve a 15% increase in the number of employed disabled people)[63] in order to improve the integration of persons with disabilities into the labour market. On 19 July 2006, Cabinet of Ministers' Regulation No.541 *Action Plan for the Implementation of Framework Policy Document "Reducing Disability and its Consequences for 2005-2015*[64] was adopted.

The framework policy document, as well the Action Plan envisages the adoption of the Law on Employment of Persons with Disabilities, which would promote employment of disabled people. For instance, the law would develop subsidised employment activities for disabled people and establish a responsible institution for assessing disabled people's workplaces and the installation of technical aids corresponding to the functional disorders of the disabled person.[65] In addition, the development of new professional rehabilitation programs for disabled people, the acquisition of new professions in demand in the labour market, the introduction of teaching methods suited to the needs of disabled people, and the continuation of development of subsidised employment activities for disabled people who require short-term support in their return to work, as well other activities are planned.[66]

In addition to the policy documents closely connected with the health area which have already been analyzed, policy documents in other areas must be mentioned, since they also foresee activities for the fight against discrimination and stigmatisation. The Conception *"Equal Opportunities for All"*[67] has been developed for the period to 2010. One of the Conception's planned achievable results relates directly to persons with disabilities: "disabled people's self-confidence and self-determination will be increased, opportunities for disabled people to feel like full-fledged members of the community will be created, ensuring as much as possible a full-fledged, independent and good life, taking into account the severity of the disability and the needs and desires of the disabled person."[68]

The Conception covers various areas: health, education, employment, a suitable environment and social security. In relation to education, the Conception mentions that in 1998, 63 special education institutions offered education to students with 11 different types of developmental disorders and illnesses. In total, in the 1997/98 teaching year, 9,943 children with various mental and physical developmental disabilities studied in special education institutions and in special classes of mainstream schools.[69] About 8,000 children, with various developmental disabilities studied at mainstream education institutions. In evaluating the integration of children with various disabilities in mainstream schools, the Conception concluded that "disabled children's integration into mainstream schools is problematic due to the shortage of adequately qualified teachers for this work and due to an inadequately equipped environment for the needs of disabled children. The integration of disabled children is also difficult because of the large number of children per class."[70] A number of obstacles have been identified which hinder disabled children's integration into mainstream schools. This is linked with the special school systems' exclusion from the community, as well as with engineering-technical unsuitability of mainstream schools and the

63 Ibid, Paragraphs 5.2., 5.5.

64 Action Plan for the Implementation of the Framework Policy Document "Reducing Disability and its Consequences for 2005-2015", http://www.lm.gov.lv/serach/?search=R%C4%ABc%C4%ABbas+pl%C4%81ns+invalidit%C4%81tes+un+t%C4%81s+izrais%C4%ABto+seku+mazin%C4%81%C5%A1anas+politikas+pamatnost%C4%81d%C5%86u+%C4%ABsteno%C5%A1anai+2005.-2015.gadam&x=13&y=16, [last accessed on 03.11.2009]

65 Framework Policy Document "Reducing Disability and its Consequences for 2005-2015", Paragraph 6.3.2., http://polsis.mk.gov.lv/view.do?id=1826, [last accessed on 02.11.2009]

66 Ibid, Paragraph 3.

67 Conception "Equal opportunities for all," http://www.lm.gov.lv/text/61, [last accessed on 02.11.2009]

68 Ibid, section: Objectives.

69 Ibid, Paragraph 3.2.

70 Ibid.

equally determined length of classes, which prevents children with special needs from developing to the utmost. In addition, insufficient funding is a significant obstacle, as well as the fact that the principle, "money follows the client," is not followed in the educational system.[71]

In relation to employment of persons with disabilities, the Conception recognizes similar problems which have been included in the previously mentioned framework policy document *"Reducing Disability and its Consequences for 2005-2015"*.[72] Taking into account the problems identified, a number of solutions and activities to be undertaken were determined. Accordingly, the Conception introduces tasks for the integration of children with disabilities in mainstream schools as well as various activities connected with the promotion of employment (for example, the creation of an institution which would adapt the workplace in line with requirements for safety (which derive from the nature of the worker's disability) and would follow the worker's adaptation process, as well as would create a mechanism for promoting employers' interest in ensuring suitable work conditions for disabled people).[73]

Activities undertaken to tackle stigma and discrimination

- In order to raise public awareness on mental disorders, in August 2007, the Public Health Agency" (PHA)[74] prepared a handbook on mental health which was distributed to inhabitants, together with daily *Diena*. At the same time (autumn 2007), video clips about the prevention of suicide were broadcast on television for a period of three months.[75] In 2008, the PHA also prepared a number of informative materials about mental disorders and stereotypes associated with them. For example, the material "Don't lose your smile... recognising depression, myths and prevention"[76] on the symptoms of depression and prejudices associated with it was prepared. The PHA also published a similar booklet on schizophrenia, its recognition, myths and support for schizophrenia patients - "Don't be afraid to get support." However it must be mentioned that these PHA publications have been available only on their website and were distributed at various seminars.[77] **Thus it can be concluded that the distribution of the materials was limited and their effect on changes of public perceptions and attitudes has been minimal.**

- One of the most significant activities which has been implemented in the period since 2005, and in facilitating access to the labour market for persons with mental disabilities, is the aforementioned EQUAL project "Integration of people with mental disturbances and psychiatric illnesses in the labour market," which was implemented in the period from 2005-2007. The project was carried out with 75% financial support from the European Union's European Social Fund and 25% support from the State budget of Latvia. The project was implemented by Riga Psychiatric and Narcology Centre in cooperation with Jelgava *Ģintermuiža* hospital, Daugavpils Psychiatric hospital, Children's Psychiatric hospital *Ainaži*, Strenči Psychiatric hospital, Vecpiebalga Psychiatric hospital, Aknīste Psychiatric hospital, the Latvian Centre for Human Rights, the Public Health Agency and the Resource Centre for People with Mental Disability "ZELDA". Project's funding was 385,659 lats (548,743 Euros).

  Persons who suffer from psychiatric illnesses or who are diagnosed with other types of mental

[71] Ibid.
[72] Ibid, Paragraph 3.3.
[73] Ibid, Paragraph 4.3.
[74] Based on Cabinet of Ministers' Order No. 509 of 29 July 2009 "On the Reorganisation of State Administrative Bodies under the Ministry of Health," as of 1 September 2009, the PHA no longer exists.
[75] Telephone interview with Dr. Māris Taube, Director of Public Health Department at State Economy Centre on 06.11.2009.
[76] Information available at Public Health Agency website archives: http://sva.vi.gov.lv/en, [last accessed on 06.11.2009]
[77] Telephone interview with Dr. Māris Taube, Director of Public Health Department at State Economy Centre on 06.11.2009.

disorders were the target audience of this project. In total, 243 patients were involved in work (178 persons had psychiatric illnesses and 65 persons had disorders of a mental nature, mainly intellectual disability). Patients worked for two years, three hours a day within the framework of the project. Patients also undertook some work outside the psychiatric hospitals. In the final stage of the project, patients were provided with a social work specialist for three months to assist them to settle into working life.[78] A booklet was released as part of the project "Work: Information for Users of Psychiatric Services." In turn, a brochure was developed to promote employer understanding – "Information for employers: the employment of persons with mental disorders."[79]

- The State Employment Agency (SEA) provides opportunities for persons with disabilities to apply for subsidised jobs. In such cases it is possible for employers to receive state co-funding through the SEA for a fixed period of time to employ target groups of unemployed, at the same time providing the unemployed with the chance to acquire basic professional skills necessary for work.[80] It must noted that in 2007, experts analysed access to the labour market for persons with disabilities within the framework of the EQUAL project, and they indicated that "measures offered by the SEA (subsidised employment programme) does not provide sufficient support. The current allowances for employed people with disabilities are comparatively small". In order to improve this situation, experts pointed out the necessity of opening discussion about taxation policy regarding the employment of persons with disabilities and the necessity of introducing a quota system.[81]

- Since 2009, the State Employment Agency has implemented active employment measures, "Complex Support Events", which are conducted as part of the European Social Fund project "Combined Support Measures".[82] As part of this project it is planned to support the return of people who are particularly at risk of social exclusion, including persons with disabilities (paying particular attention to the adaptation of the work place) to the labour market. In the project, the provision of complex, mutually connected support measures is planned. For instance, consultations with occupational therapist for persons with established disabilities will be provided, also support activities for the development of work skills under the supervision of a work supervisor for period of up to six months, as well the assistance of an attendant, assistant and sign language interpreter will be provided for persons with established disabilities.[83] Overall, as a part of the combined support measures, the SEA plans to provide support for 2,000 unemployed persons from problem groups in 2009.

Changes in laws and regulations

Chapter VIII of the Constitution of the Republic of Latvia protects fundamental human rights and has been into force in Latvia since 6 November 1998. Section 91 of the Constitution prescribes an overall prohibition of discrimination.[84] In turn, the Medical Treatment Law guarantees special

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78 Taube M., Leimane-Veldmeijere I., Promotion of the Employment Opportunities for People with Intellectual Disabilities and Psychiatric Illnesses in Latvia, the Conceptual Paper, Riga, 2007, p 11, http://sva.vi.gov.lv/koncept_risin_nodarbi_eng.pdf, [last accessed on 05.11.2009]

79 Information available at Public Health Agency website archives: http://sva.vi.gov.lv/en, [last accessed on 06.11.2009]

80 Information from Ministry of Welfare, available at : http://www.lm.gov.lv/text/202, [last accessed on 06.11.2009]

81 Taube M., Leimane-Veldmeijere I., Promotion of the Employment Opportunities for People with Intellectual Disabilities and Psychiatric Illnesses in Latvia, the Conceptual Paper, Riga, 2007, p 23, http://sva.vi.gov.lv/koncept_risin_nodarbi_eng.pdf, [last accessed on 05.11.2009]

82 Information available at State Employment Agency website: http://www.nva.lv/index.php?cid=3#kompl, [last accessed on 05.11.2009]

83 Ibid.

84 Constitution, Article 91, available at: http://www.ttc.lv/advantagecms/LV/meklet/meklet_dokumentus.html?query=Constitution&Submit=Mekl%C4%93t&resultsPerPage=10, [last accessed on 04.11.2009]

protection for persons with mental disabilities and prescribes that "Mental disorders or mental illness shall not be a basis for discrimination against an individual."[85] The Labour Law prohibits the discrimination in the employment area, irrespective of a "person's race, skin colour, gender, age, disability, religious, political or other conviction, ethnic or social origin, property or marital status, sexual orientation or other status."[86] The amendments to the Labour Law of 22 April 2004 included a requirement for the adaptation of the working environment to promote the employment of a person with disability - "in order to promote the adoption of the principle of equal rights in relation to disabled persons, an employer has a duty to take measures that are necessary in conformity with the circumstances in order to adapt the work environment to facilitate the possibility of disabled persons to establish employment legal relations, fulfill work duties, be promoted to higher positions or be sent for occupational training or the raising of qualifications, insofar as such measures do not place an unreasonable burden on the employer."[87] The children's equal rights principle is outlined in the Protection of the Rights of the Child Law, which prescribes that the state ensures children's rights and freedoms for all children without any discrimination.[88]

Since 2005, a number of steps have been taken in Latvia to improve laws and regulations on the protection of the rights of persons with disabilities. One of the most significant events has been the signing of the UN Convention on the Rights of Persons with Disabilities on 18 July 2008. On 12 October 2009, the *Implementation Plan of the UN Convention on the Rights of Persons with Disabilities for 2010-2012*, was adopted and on 6 October 2009 the Cabinet of Ministers approved and later submitted to the Parliament a draft law on the ratification of the Convention.[89]

With respect to regional protection of human rights documents, a significant step has been the full transposition of EU Directive 2000/78/EC (Employment Directive), which establishes a unified system for equal treatment in employment and professions by the end of 2006. In order to transpose the EU Directive 2000/43/EC (Race Directive), amendments to the Consumer Rights Protection Law were adopted on 19 June 2008. The amendments prohibit an unequal treatment based on a consumer's gender, race or ethnicity.[90] Unfortunately, these amendments did not include the prohibition of unequal treatment based on a consumer's disability and the Consumer Rights Protection Law currently does not prescribe for such a prohibition. A similar problem can be identified in the Education Law, which provides for the right to gain an education "regardless of their property or social status, race, nationality, gender, religious or political convictions, state of health, occupation or place of residence".[91] Disability as a basis for the prohibition of discrimination in the area of education is not prescribed.

The laws and regulations applying to people with mental disabilities have other significant problems, one of the most serious being the procedures for removing and reinstating a person's legal capacity. This matter in Latvia is regulated by the Civil Law adopted in 1937. The subsection of Civil Law

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85 Medical Treatment Law, Article 65, http://www.ttc.lv/advantagecms/LV/meklet/meklet_dokumentus.html?query=Constitution&Submit=Mekl%C4%93t&resultsPerPage=10, [last accessed on 04.11.2009]

86 Labour Law, Article 7, http://www.ttc.lv/advantagecms/LV/meklet/meklet_dokumentus.html?query=labour+law&Submit=Mekl%C4%93t&resultsPerPage=10, [last accessed on 04.11.2009]

87 Ibid, Article 7 (3).

88 Protection of the Rights of the Child Law, Article 3, http://www.ttc.lv/advantagecms/LV/meklet/meklet_dokumentus.html?query=Children%E2%80%99s+Rights+Protection+Law&Submit=Mekl%C4%93t&resultsPerPage=10, [last accessed on 04.11.209]

89 Cabinet of Ministers' Order No. 693 "On the Implementation Plan for 2010–2012 of the United Nations Convention on the Rights of Persons with Disabilities", adopted 12.10.2009, http://www.likumi.lv/doc.php?id=199220, [last accessed on 05.11.2009]

90 Amendments to the Consumer Rights Protection Law, Article 3, http://www.likumi.lv/doc.php?mode=DOC&id=177913, [last accessed on 05.11.2009]

91 Education Law, Article 3, http://www.ttc.lv/advantagecms/LV/tulkojumi/dokumenti.html?folder=%2fdocs%2fLRTA%2fLikumi%2f&currentPage=2, [last accessed on 05.11.2009]

dealing with the revoking of legal capacity has not been amended since the law was adopted.[92] In the spirit of the 1930's attitudes towards mentally ill people, the Civil Law only provides for full removal of legal capacity on the grounds that the person requires protection. Legal capacity is deprived for an indefinite period of time, with no provision for periodic review. Several persons may file a petition in the court regarding depriving of legal capacity, including the respective person's family members, prosecutors, as well as "any unknown person who has proven their interest in the case."[93] Examining court practice in cases of depriving of legal capacity, it can be concluded that complaints are often lodged in the court by neighbours or family members, who have an interest in the person's property. Depriving a person's legal capacity not only restricts his/her rights to conclude any and all types of contracts (including employment or marriage contracts),[94] but also restricts the person's property rights,[95] voting rights[96], the right to have custody of[97] or adopt a child.[98] A person's legal capacity may only be reinstated if "a court has deemed that the mentally ill person has recovered from their illness, i.e. they are 'legally capable.'"[99] Such a legal formulation makes the reinstatement of legal capacity practically impossible, because in most cases people do not fully recover from their illnesses and in some cases (for example, intellectually disabled people) they do not have an illness to recover from. In the period from January 2006 to 30 June 2009, eight people in Latvia had their legal capacity reinstated, while 981 their had legal capacity removed.[100]

Evaluating the aforementioned legal provisions and the restrictions they entail, it can be concluded that a person who loses legal capacity is fully isolated from society and becomes dependent on a guardian's decisions in all areas of life. The current provisions of the Civil Law are discriminatory in respect to mentally ill people who have had their legal capacity removed, and to those with similar disorders who have retained their legal capacity. These Civil Law provisions do not comply with standards of civil rights set out by Council of Europe recommendations[101] or Article 12 of the UN Convention on the Rights of Persons with Disabilities. The European Court of Human Rights also gave its judgement of similar regulations in the case of Shtukaturov v Russia.[102] The court found that full removal of a person's legal capacity for an indefinite period of time is a breach of a person's right to private life protection. The Court is currently hearing similar complaints brought against Bulgaria and Lithuania.

Opinion of psychiatric service users

In 2009, RC "ZELDA" organised a number of meetings with users of mental health care services to find out their views about the manifestations of stigma and discrimination over the last year. During the discussions a number of questions were asked about changes in public attitudes which they have felt since 2005.

In the discussion about the degree to which psychiatric service users feel a reduction in stigma and discrimination, users indicated that they had not observed any big changes. The users of

92 Civil Law, Family Law Section, http://www.ttc.lv/advantagecms/LV/meklet/meklet_dokumentus.html?query=Civillikums&resultsPerPage=10, [last accessed on 05.11.2009]

93 Ibid, Article 359.

94 Ibid, Article 1405.

95 Ibid, Article 361.

96 Saeima Elections' Law, Article 2, http://www.likumi.lv/doc.php?id=35261, [last accessed on 06.11.2009]

97 Civil Law, Family Law Section, Article 242 (1). http://www.ttc.lv/advantagecms/LV/meklet/meklet_dokumentus.html?query=civillikums&resultsPerPage=10, [last accessed on 05.11.2009]

98 Ibid, Article 163.

99 Ibid, Article 364.

100 Information provided by the Court Administration on 17.09.2009, available at RC Zelda.

101 Council of Europe Recommendation No. (99)4 On the principles concerning the legal protection of incapable adults, Council of Europe Recommendation No. (2004)10 of the Committee of Ministers to member states concerning the protection of human rights and dignity of persons with mental disorder.

102 Judgement of the European Court of Human Rights in *Shtukaturov v Russia case*. 27.06.2008, No. 44009/05.

mental health care services do not feel better accepted into the community and they frequently face a negative attitude, often even from their friends and families. For example, a participant in the discussion stated that there had been times when people had not wanted to let her into a crowded bus as they were afraid when she shows her identity card, that of a disabled person. In addition, the discussion participant's friends have said that they would rather buy her a bus ticket than have her show her disabled person's identity card. In turn another participant indicated that she is concerned about how her illness (schizophrenia) and the stigma associated with it affect her children. At the moment both of her children have started dating, therefore she is concerned if and how to tell her children's partners about her illness. Some users indicated that they have felt a lot of family support, while others indicated that their family members still do not believe that mental illness is to blame and say that the person is simply lazy or just pretending. When asked if they feel any difference between the public attitude in Riga and in smaller towns or in rural areas, discussion participants indicated that in Riga there is the feeling that "at least something is happening." Recently, in connection with the recession, they have noticed the promotion of more community activities on positive thinking, as well they have noticed more information provided on suicide and depression.

The invited psychiatric service users had diverse opinions on the subject of employment. About half of the users were employed and spoke very positively about their employers, indicating that they are very understanding and responsive. The majority of people work in the private sector and their employers are informed about their employees' mental health problems.[103] One participant, employed in the public sector (in a kindergarten as a nanny), said that she has not mentioned anything to her employer about her illness, because "who would want me to work with little children then." Another participant mentioned that in 1992 he had the second disability group and when his employer found out about his disability, he did not give him any more work.

Regarding access to higher education, one user indicated that she had tried to enter in a training program of Social Integration Agency, but due to her health condition she was not enrolled and now has to wait for five years to try again. Overall, users believed that it is better if education has been gained before the illness, because afterwards it is very difficult to do anything.

It must be emphasised that according the *Eurobarometer* survey "Discrimination in the European Union" conducted in 2009, disability was mentioned as the reason for discrimination by 64% of respondents in Latvia, which ranks disability in the second place behind discrimination on the basis of age.[104]

Conclusions

1. Discussions with users confirmed the importance of understanding the mental disorders, their manifestation and treatment by families, people around them and the general public. Fear of possible stigmatisation can enable persons with mental disabilities to isolate themselves, dissociate from the community, and as well reduce their desire to use state provided services and initiatives in areas of medical treatment or employment.
2. Although informative activities undertaken in relation to reducing stigma and discrimination were a positive step, the distribution of materials was limited and influence on public opinion and changes in attitude had been marginal (activities had been tangible mainly only in Riga, and not in other regions of Latvia).
3. Despite the measures implemented in the area of employment, the proportion of employed

[103] It is important to note that the discussion participants were long-term users of mental health care services with extensive experience of taking part in various social activities.

[104] News item from LETA, http://www.nap.lv/lat/attistibas_planosana/iesakam_izlasit/?doc=1550, [last accessed on 10.11.2009]

persons with disabilities is still relatively low.

4. Existing Latvian laws only provide for full removal of legal capacity without guarantees for periodic review. Persons who are declared legally incapable are completely isolated from society and are denied making decisions that have an impact on their lives. In evaluating the procedures for removing and reinstating legal capacity, it must be concluded that existing procedures do not comply with international human rights standards that are binding on Latvia.

Recommendations

1. To promote people's full integration into the society and labour market, it is necessary not only to evaluate activities which would improve access to various services and fields for persons with mental disabilities. It is also necessary to consider how to decrease the stigma and discriminatory attitude in order that people would have the desire and motivation to use the particular services.
2. The preparation of various informative materials can make a positive change in public attitudes, however more attention should be focussed on distribution of informative materials in order to reach the maximum possible number of people (especially in rural regions and towns of Latvia).
3. In relation to the promotion of employment, discussion should be started on taxation policy regarding the employment of persons with disabilities and the necessity of introducing a quota system.
4. It is necessary to amend the Consumer Rights Protection Law and the Education Law in order to prevent discrimination against persons with mental disabilities in education and the private sector on the grounds of disability.
5. Taking into account Recommendations of the Council of Europe, the case law of the European Court of Human Rights and the UN Convention on the Rights of Persons with Disabilities, it is necessary to review and amend the provisions of the Civil Law, which only provide for full removal of legal capacity and does not provide for periodic review. It is also necessary to review the provisions of the Civil Law regulating the reinstatement of legal capacity.

4. PROMOTING ACTIVITIES IN SUPPORT OF VULNERABLE GROUPS

Policies, normative acts and implemented measures regarding children with mental disabilities

Vulnerable groups such as children, teenagers and the elderly form a significant proportion of people with mental health problems. These groups comprise 36 - 37% of all registered patients. Data reveal that from 2005 to 2007, the number of children as a proportion of all patients with mental disorders declined, while the number of persons aged 65 and over increased. However, state policy towards the elderly is less specific and this group is not specially accented.

Number of unique patients with mental disorders in active care[105]

	Total number of registered patients in age group (%)	First-time patients (%)	Total number of registered patients in age group (%)	First-time patients (%)
Age group	2007	2007	2005	2005
0-19	18.6	32.7	21.71	36.8
65 and more	18.2	26.8	16.1	23.57

The state pays special attention to protecting children's rights and the provision of all necessary services for children. The *Law on Protection of the Rights of Child Protection Law*[106] has been in force in Latvia since 1998. The law declares that children's rights and interests are a priority and must be a priority in all activities, performed by state or local government institutions, NGOs and other natural or legal persons, courts and other law enforcement bodies, which relate to children.

The Law on Protection of the Rights of Child defines the duties of state and local governments to help children. In case a family's parent-child relationship is not favourable to a child's development, or a child has a chronic illness, the local government can help the family by arranging assistance from a psychologist, social teacher or other specialist or by assigning a support family or supporting person to help to improve relations between the child and parents. State and local governments provide support to institutions and organisations working in the spheres of family and children's education, health promotion, culture, sport and recreation in order to facilitate the physical and creative development of children, provide them with free time activities and render other services.

By law, children who have psychological or behavioural disorders due to alcohol abuse must be provided with compulsory treatment and social rehabilitation in accordance with procedures stipulated by the Cabinet of Ministers. The state budget earmarks funding for this purpose. In case of a child or its parents that do not agree to compulsory treatment, it can be performed based on an order from the respective Orphan's court (according to the child's place of residence).

The Law on Protection of the Rights of the Child stipulates that children may not use narcotic, psychotropic, toxic or other intoxicating substances. Children are protected from using narcotic, psychotropic, toxic or other intoxicating substances which have a negative impact on the body, and from the production, sale and any form of distribution of such substances. Child victims of crime, exploitation, sexual abuse, violence or any other illegal, cruel or humiliating actions are provided with free-of-charge assistance to regain their physical and mental health and reintegrate into society. Such treatment and reintegration must take place in an environment which is favourable to the child's health, self-esteem and dignity, and with the careful guarding of the child's intimate secrets.

Responsibility for protecting children's rights in Latvia is held by the Children's Rights Department of the Ombudsman's Office of Latvia and the Ministry of Welfare's State Children's Rights Inspectorate, which conducts regular inspections of various institutions providing services to children.

In May 2008, the parliament adopted amendments to the *Medical Treatment Law*[107], which included an additional provision stipulating that healthcare for pregnant women and children is a priority.

[105] Mental Healthcare in Latvia 2007. Statistical Yearbook, Volume 8, http://sva.vi.gov.lv/files/anglu%20valoda/mental_health_care_2007_lv.pdf, [last accessed on 09.11.2009]

[106] Law on Protection of the Rights of Child, adopted by the Parliament on 19 June 1998, http://www.ttc.lv/advantagecms/LV/meklet/meklet_dokumentus.html?query=Protection+of+the+Rights+of+the+Child+Law+&Submit=Mekl%C4%93t&resultsPerPage=10, [last accessed on 09.11.2009]

[107] Amendments to the Medical Treatment Law, adopted by the parliament 8 May 2008, http://www.likumi.lv/doc.php?id=175922&from=off, [last accessed on 09.11.2009]

The Cabinet of Ministers has stipulated that medical institutions must make the provision of health care for pregnant women and children a priority[108]. However, despite this provision and the fact that state policies are directed towards children's interests, there is no clarity in the practical delivery of health care services on an everyday basis.

Studies

In 2008 the Public Health Agency published a brochure titled *Health and Emotional Wellbeing in School-aged Children*[109]. This publication used data from a study of the health behaviour of school pupils[110] to analyse three indicators of health: self-appraisal of health, satisfaction with life and subjective health complaints. Some forms of psycho-emotional distress are also indicators of health and wellbeing. The study was conducted in 2005/2006, and revealed that in the previous six months 50.8% of boys and 64.2% of girls had felt annoyed or in a bad mood at least once per week. The proportion of girls also significantly exceeded boys with regard to complaints about nervousness and sadness. The report also analysed the proportion of pupils with subjective health complaints more than once per week. Compared with other member states covered in the study, the proportion of Latvian school children with at least two subjective health complaints more than once per week was slightly above average for all three age groups and almost twice as high as in Austria.

In 2009, the Ombudsman's Office published a report titled "Violence and Mobbing in Latvian Schools", which found that despite the fact that Latvia "does not have a unified plan for preventing and eliminating bullying, some schools have established practices on how to act in such situations, involving the children's parents, school support staff, and if necessary the police." It was also found that teachers lack experience in recognising mobbing and understanding how to act in conflict situations.[111]

Help for children in crisis situations

On 1 February 2006, the State Children's Rights Protection Inspectorate began operating a Confidential Hotline for Children and Teenagers (80006008). It was established to provide psychological help to children and teenagers and give them support in crisis situations. The Hotline's most important role is helping children and teenagers cope with various issues and life situations. The Hotline is a subunit of the State Children's Rights Protection Inspectorate where children in difficulties can get advice and support in complex situations.

The Hotline is manned by psychologists. Children and teenagers can call from 8:00 AM to 11:00 PM on weekdays, from 8:00 AM to 10:00 PM on Saturdays and from 10:00 AM to 10:00 PM on Sundays. Calls to the Hotline are free of charge from both fixed line and mobile phones[112].

Access to psychologists in schools

In the 2005/2006 academic year, over half of all general education schools in Latvia's regions had an educational or school psychologist. In 2006, there were 974 general education schools in Latvia. In

[108] Cabinet of Ministers' Regulation No. 1046 of 19 December 2006, "Procedures for organising and financing healthcare" Article 135.9., http://www.likumi.lv/doc.php?id=150766&version_date=01.11.2009&from=off, [last accessed on 09.11.2009]

[109] Brochure available at: http://www.sva.lv/files/datu%20analize/hbsc_psihoemoc_veseliba.pdf, [last accessed on 09.11.2009]

[110] The Health Behaviour in School-aged Children (HBSC). The study was conducted in 2005/2006 with 41 participating nations. The study was supported by the WHO.

[111] Zanda Rūsiņa, Violence and Bullying in Latvian Schools, Ombudsman's Office, May 2009, http://www.tiesibsargs.lv/lat/petijumi_un_viedokli/petijumi/?doc=594, [last accessed on 09.11.2009]

[112] Information available at: http://www.bti.gov.lv/lat/uzticibas_talrunis/, [last accessed on 09.11.2009]

the 2005/2006 academic year, 543 schools employed psychologists and 440 did not.[113]

Up to 22 December 2008, it has been stipulated that there must be one psychologist for every 500 pupils at general education schools. Local governments determine the precise number of psychologists. In 2008, 614 schools out of a total of 958 day schools in Latvia had access to a psychologist (482.28 staff units). On average, there is one psychologist for every 520 pupils at general education schools.[114] Since 2006, the number of schools employing a psychologist has risen by 71.

The government has stipulated that local governments may spend no more than 15% of received earmarked subsidies for the salaries of school principals, deputy principals and support staff (librarians, speech therapists, psychologists, special educators) (Article 15).[115] As the economic crisis has become aggravated, the opinion has been expressed that the first to suffer could be speech therapists and school psychologists. This possibility is backed up by legislative amendments[116] – whereas previously there were stipulated numbers of psychologists, speech therapists, extended day group educators and special educators per pupil, this requirement was abolished in December 2008.[117]

Educational opportunities for children with mental disabilities

In 2008, there were 63 special education institutions in Latvia. A total of 9,202 pupils i.e. 2.7% of pupils in the country, studied at such schools. In 2008, there were 40 special education institutions in Latvia with 4,586 children with developmental disabilities and 23 special education institutions with 3,184 children with various illnesses[118]. In 2008, 5,590 children with mental disorders (of whom 552 had psycho-neurological illnesses, 4,586 had intellectual disabilities and 452 had psychological development problems and learning difficulties) studied at special education institutions, and 931 children (of whom 1 child had a psycho-neurological illness, 530 children had intellectual disabilities and 400 had psychological development problems and learning difficulties) were integrated into mainstream general education schools.[119]

Mental health care for children

State-guaranteed health care services for children are covered fully by the state without a patient co-payment. In 2007, there were 50 certified child psychiatrists in Latvia, of whom 26 (14 outpatient and 12 inpatient) provided state-funded healthcare services.[120] Latvia has one specialised children's psychiatric hospital (in Ainaži), three children's psychiatric wards in specialised psychiatric hospitals (Daugavpils, Jelgava and Liepāja) and one children's psychiatric ward in a general hospital (Riga).

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[113] Around half of general education schools in Latvia do not have psychologists, 19.01.2007, ahttp://www.skolotajs.lv/PublicUI/AboutPortal.aspx?TopicArticleID=7564, [last accessed on 09.11.2009]

[114] Informative Report on the Implementation of the Action Program for the Public Health Strategy in 2007-2008, http://polsis.mk.gov.lv/LoadAtt/file25733.doc, [last accessed on 15.10.2009]

[115] Regulation No. 837 of 28 July 2009 "Procedures for calculating and disbursing state budget targeted grants for local government general education primary and secondary schools for the payment of teachers' salaries and compulsory state social insurance payments," http://www.likumi.lv/doc.php?id=195579&from=off, [last accessed on 09.11.2009]

[116] Amendments made on 22 December 2008, to Cabinet of Ministers' Regulation No. 746 of 24 September 2004, "Regulations on Teachers' Salaries", available at: http://www.likumi.lv/doc.php?id=185950, [last accessed on 09.11.2009]

[117] Taupīs arī uz skolu psihologu rēķina. *Diena*. 11.02.2009, http://www.diena.lv/lat/politics/hot/budzets2009/taupis-ari-uz-skolu-psihologu-rekina, [last accessed on 09.11.2009]

[118] Ministry of Education and Science, Public report of 2008, p. 38., http://izm.izm.gov.lv/upload_file/1312-09aaa-2.pdf, [last accessed on 09.11.2009]

[119] Ibid, p 40.

[120] Mental Healthcare in Latvia 2007. Statistics Yearbook, Volume 8, p. 54., http://sva.vi.gov.lv/files/anglu%20valoda/mental_health_care_2007_lv.pdf, [last accessed on 09.11.2009]

Social care for children

At the end of 2008 Latvia had 33 specialised state social care homes, which provided long-term social care for children – orphans (including also children with mental disabilities) and for adults, including also persons over 65 years. In 2008, Latvia had 22 day care centres for people with mental disabilities,[121] several of these centres provided day care for children.

Conclusions

1. Children's rights issues are being broadly addressed in Latvia and there is extensive public support and good access to information.
2. Compared with children's rights, issues affecting the rights of the elderly are scantily addressed in both policy planning documents and legislation.
3. The creation and ongoing support for the school psychologist institution is a positive development.
4. Although services are beginning to be provided outside of institutions, the institutional approach still dominates in dealing with mental health issues.
5. There is a lack of community-based services for both children and the elderly. There are only a few day care centres for children and youth.
6. The integration of children with mental disabilities into mainstream schools still takes place slowly.

Recommendations

1. In planning mental health policy, more emphasis should be put on the problems of the elderly, especially considering the ageing of the population.
2. Community-based mental health care services accessible to children and the elderly should be developed.
3. Special information sources and channels should be set up to provide these social groups with information.

5. PREVENTION OF MENTAL HEALTH PROBLEMS AND SUICIDES

In evaluating what has been achieved in preventing suicides during the period from the beginning of 2005 to mid 2009, it should be noted that promises to prevent suicides were made in both the *Public Health Strategy* approved by the Cabinet of Ministers in 2001 and the *Framework policy document "Improving Inhabitants' Mental Health for 2009-2014",* approved in 2008. Objective 6 of the sub-objectives of the Public Health Strategy - "Improvement of Mental Health" stipulates for reducing suicide indicators by at least 25% by 2010. As can be seen in the Report on implementation of the Public Health Strategy's action program in 2007/2008, the objective of reducing the number of suicides has not been achieved. As a possible reason for this the worsening of the economic situation in the state has been mentioned.[122] The framework policy document "Improvement of Inhabitants' Mental Health for 2009- 2014", approved by the Cabinet of Ministers in August 2008, may also have a significant impact on suicide prevention, but it is too early to tell what effect it has

[121] Welfare Ministry, Report on Implementation of the Conception "Equal Opportunities for All", http://www.lm.gov.lv/text/1147, [last accessed on 09.11.2009]

[122] Ministry of Health, Informative Report on the Implementation of the Public Health Strategy's Action Programme for 2007.-2008, www.nvo.lv/files/1_Info_zinojums_Sabiedribas_veseliba.doc, [last accessed on 06.11.2009]

had, since the implementation plan for the framework policy document has yet to be developed and funding has not yet been allocated.

At its 38th session in May 2007, the UN Committee on Economic, Social and Cultural Rights expressed its concern about the high number of suicides in Latvia and called on Latvia to study the root causes of suicides and develop a national suicide prevention strategy based on this research.[123] The Committee has requested that the Latvian government provide information about progress in implementing the Committee's recommendations on suicide prevention in the next reporting period.

On 19 February 2009 the European Parliament adopted Resolution (2008/2209(INI)) calling on EU Member States to "to implement cross-sectoral programmes for the prevention of suicide, especially among young people and adolescents, promoting a healthy lifestyle, reducing the risk factors such as easy access to pharmaceuticals, drugs, harmful chemical substances and alcohol abuse"[124]. This Resolution also called on EU Member States to "guarantee the provision of treatment for people who have attempted to commit suicide and of psychotherapeutic treatment for the families of people who have committed suicide". It is recommended that EU Member States support suicide prevention by establishing regional information networks including health care workers, service users and people with mental health problems, their families, educational institutions, employers, local organisations and representatives of the general public. Another recommendation made in the Resolution is ensuring "greater publicity for the single European emergency call number 112, which can be dialled in emergencies such as suicide attempts or emotional crises, thereby facilitating rapid intervention and the provision of emergency medical assistance" and creating special training courses for general practitioners and psychiatric treatment institutions' personnel, including doctors, psychologists and nurses, about depressive disorders and identifying and averting suicide risks".[125]

A contribution to the study of the situation has been made by a Situation report published by the Public Health Agency (PHA)[126] in May 2009, titled "Suicides in Latvia: Situation, Perspectives and Solutions", which presents both statistics and recommendations on how to improve the situation in Latvia. The suggested solutions include restricting the availability of alcohol; paying attention to high-risk groups (for example, the report identifies young men with large loan obligations which they cannot repay due to the recession as a new group at risk); restricting access to means for committing suicide; improving the role of the media in preventing suicides; and improving and expanding services of psychiatric assistance.[127]

Statistics

In comparing suicide data, in the period from 2005 to 2009 it was found that since 2008 suicides have tended to increase. There were 567 suicides in Latvia in 2005, 489 in 2006, 453 in 2007, and 527 in 2008.[128]

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[123] UN, Committee on Economic, Social and Cultural Rights, Concluding Observations of the Committee on Economic, Social and Cultural Rights, Latvia, E/C.12/LVA/CO/1, 07.01.2008, http://daccessdds.un.org/doc/UNDOC/GEN/G08/400/67/PDF/G0840067.pdf?OpenElement, [last accessed on 05.11.2009]

[124] European Parliament Resolution on Mental Health, February 19, 2009 (2008/2209(INI)), http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+TA+P6-TA-2009-0063+0+DOC+XML+V0//EN, [last accessed on 05.11.2009]

[125] European Parliament Resolution on Mental Health, February 19, 2009 (2008/2209(INI)), http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+TA+P6-TA-2009-0063+0+DOC+XML+V0//EN, [last accessed on 05.11.2009]

[126] The PHA ceased operating on 1 September 2009, transferring its functions to a number of other bodies: the Ministry of Health, the Health Inspectorate, the State Agency "Latvian Infectology Centre," the Disasters' Medicine Centre and the Health Economy Centre.

[127] PHA, Suicides in Latvia: Situation, Perspectives and Solutions, Situation Report, Riga, 2009, p 23-26., http://sva.vi.gov.lv/suicides_latvia_2009_en.pdf [last accessed on 05.11.2009]

[128] Data for 2005-2007 from the PHA Statistics Yearbook "Mental Healthcare in Latvia 2007", Riga, 2008, p. 25., http://sva.vi.gov.lv/files/anglu%20valoda/mental_health_care_2007_lv.pdf, [last accessed on 05.11.2009], statistics for 2008 provided by Dr. Māris Taube, Director of the Health Economic Centre's Public Health Department.

Study of the causes of suicide and suicide attempts

Until now there have been few studies which have analysed the causes of suicide and suicide attempts. Such an in-depth study of causes could be useful in creating suicide prevention strategies and in planning training for various target groups involved in mental health care. During 2002-2007, two projects were implemented to provide support to patients, after suicide attempts, at the Riga Psychiatric and Narcology Centre (2002-2004) and *Gaiļezers* Hospital (2004 – 2006), with the financial support of the Soros Foundation-Latvia and the Open Society Institute. As part of both projects, 371 patients received counselling and psychological support immediately after a suicide attempt, and were offered further support by attending support groups for people after suicide attempts. In analysing the results of both projects, it can be concluded that the most frequent causes of suicide attempts are connected with:

- long-term conflict within a family (with a partner, children, parents, relatives), furthermore in most of these cases this disharmony was linked with the alcoholism of someone close, or violence from a family member;
- unresolved or potential social problems (unemployment, debts, the threat of losing accommodation);
- divorce;
- health problems (malignant tumours; chronic illness (Hepatitis C, asthma, sugar diabetes));
- the death of someone close;
- addiction (alcoholism) problems and depression.

Of course, the causes mentioned above cannot be considered as a comprehensive analysis of the problem, but they can provide certain directions for policy makers in considering the assistance strategies required and where attention should be drawn in the suicide prevention area.

Assistance available to residents in crisis situations

In crisis situations, Latvia's inhabitants can turn to the *Skalbes* Crisis Centre's crisis hotline (67222922) and the Children's and Youth Confidential Hotline (toll-free calls can be made 24 hours a day to the fixed line number 80009000 or 28809000 for TELE2 and *Zelta Zivtiņa* users or 1860 for BITE and TOXIC users (available from 9:00 AM to 11:00 PM)). Riga City Council's Children's Rights Protection Centre (CRPC) hotline will operate until autumn 2009, when it will close down after the CRPC ceases operation.

In addition to telephone counselling, both *Skalbes* and the Children's and Youth Confidential Hotline provide individual psychologist counselling as well as support groups. It should also be noted that in April 2007, Children's and Youth Confidential Hotline employees and potential volunteer telephone counsellors (16 in total) received training on crisis intervention for persons with suicidal tendencies as part of a Soros Foundation-Latvia supported project.

Despite budget cuts in 2009, as a result of which *Skalbes* Crisis Centre was forced to close the 24 hour hotline and offer the service only until 10:00 PM,[129] the organisation has responded to the effects of the economic crisis by beginning a new service, a support group for the unemployed called "A step ahead," which will operate once a week from November 2009 until February 2010.

[129] On 9 October 2009, the news agency LETA reported that management of the crisis centre Skalbes had announced that the Riga City Council had found the necessary 15 000 lats (21343 Euros), to enable the hotline to function 24 hours a day from 1 January 2010. Information available at: http://www.nozare.lv/nozares/welfare/arhitem/BD8B7565-A313-4E20-B90E-99DFF4B8D2CC/?phase=pa%C5%A1n%C4%81v%C4%ABbas, [last accessed on 05.11.2009]

Raising public awareness and training of particular target groups

Over the past years, training of particular target groups has been carried out, informative materials have been distributed and public information campaigns organised. The Public Health Agency has been active in 2007/2008, releasing a handbook on mental health in August 2007 which placed particular emphasis on reducing stress and adopting a positive attitude to life. In autumn 2007, TV3 broadcasted videos prepared by the PHA titled *Anna* (aiming to facilitate the integration of people with mental health problems into the community and to reduce prejudices) and *Telephone Booklet* (aiming to reduce the number of suicides by identifying possible symptoms of depression and to ask pay attention to care for others). In 2008, the PHA developed informative materials about depression, schizophrenia, eating disorders, as well as informative methodical materials about identifying suicide risks, titled *To be or not to be*.[130] Furthermore, at the beginning of 2009, in response to the economic crisis, the PHA commenced the campaign *Think positively*, part of which involved online consultations by PHA specialists on mental health issues. Unfortunately, insufficient thought was given to the distribution of these materials, which were only available on the PHA website and at some seminars. The lack of information was also emphasised by participants of the users' discussion organised by RC ZELDA.[131]

Training of the media

In May 2006, some progress was made in work with the media. The Latvian Centre for Human Rights in cooperation with *MediaWise* (Great Britain) organised a two day training seminar, on May 30-31 for journalists from the Baltic States titled *Reporting on Closed Institutions (prisons, police cells, psychiatric institutions, detention cells for illegal migrants)*. As part of the seminar, a discussion led by *MediaWise* experts about news reporting on deaths and suicides in institutions was held.[132] In total, 23 participants from Latvia, Lithuania and Estonia took part in the seminar. As part of the seminar, guidelines for journalists about reporting on suicide were also distributed in English[133], Latvian and Russian.

Training of prison employees

The Latvian Centre for Human Rights also contributed to training for prison employees about suicide issues on 18 May 2005, in cooperation with the Latvian Prison Administration's Social Rehabilitation Department, by organizing the seminar "Prevention of suicide in prisons", in which 28 participants from eight prisons in Latvia took part. Seminar participants were introduced to the Latvian Prison Administration's "*Recommendations for prison employees in work with prisoners who have suicidal tendencies*", as well as being informed about the guidelines of international organizations and other countries' experiences in prison suicide prevention. Seminar participants were also provided with practical training in providing assistance to a person who has attempted suicide by hanging, which is one of the most widespread methods of suicide in prisons.[134] The Ministry of Justice's Latvian Prison Administration Training Centre continued to organize seminars for prison employees on "Suicide and suicidal behaviour problems in prisons" in 2006 as well.[135]

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130 PHA informative materials are available at the PHA website archive, available at: http://sva.vi.gov.lv/en/, [last accessed on 05.11.2009]

131 RC ZELDA discussion with psychiatric service users on the implementation of the WHO Mental Health Action Plan and Declaration held on 3 November 2009.

132 The Latvian Centre for Human Rights, Seminar "News reporting on closed institutions (places of incarceration, police cells, psychiatric institutions", available at: http://www.humanrights.org.lv/html/news/publications/index.html?yr=2006, published 31.05.2006, [last accessed on 05.11.2009]

133 Training seminar for media *Reporting on Closed Institutions (prisons, police cells, psychiatric institutions, detention cells for illegal migrants),* http://www.humanrights.org.lv/html/news/28814.html, [last accessed on 05.11.2009]

134 The Latvian Centre for Human Rights, Seminar for prison staff "Preventing suicides in prisons": summary, http://www.humanrights.org.lv/html/28360.html, published on 19.05.2005, [last accessed on 05.11.2009]

135 Ministry of Justice, the Latvian Prison Administration, Public Report 2006, http://www.ievp.gov.lv/?sadala=92, [last accessed

Training of general practitioners

In 2009, the Public Health Agency prepared a translation of materials released by the WHO in 2000 for general practitioners titled *Preventing suicide: a resource for general physicians*. The PHA also prepared materials, in addition to the translated WHO materials for family doctors, including Article 68 of the Medical Treatment Law regarding the procedure for involuntary admission, as well as information on inpatient and outpatient institutions and psychiatrists under contract with the State Compulsory Health Insurance Agency, who provide psychiatric assistance.[136]

Conclusions

1. Although a report on the national suicide situation has been prepared, the UN Social, Economic and Cultural Rights Committee recommends that the causes of suicide should continue to be studied.
2. The PHA report *Suicides in Latvia: Situation, Perspectives and Solutions* may serve as the basis for creating a strategy and action plan for suicide prevention. Suicide prevention issues are partly addressed in the *framework policy document "Improvement of Inhabitants' Mental Health for 2009-2014"*, but an action plan needs to be developed for its implementation and funding must be allocated.
3. Over the past years there have been a number of good initiatives of training of particular target groups and informing public. Although the materials prepared by the PHA are available on the internet, insufficient thought has been put into the distribution of the prepared materials so that they reach the greatest possible number of people.

Recommendations

1. It is necessary to develop a suicide prevention strategy or to include such a strategy in the new Public Health Strategy, or to implement fully the *framework policy document "Improvement of Inhabitants' Mental Health for 2009-2014"*.
2. The introduction of a single, state-funded crisis hotline is necessary.
3. The continued training of various target groups is necessary, especially the inclusion of general practitioners in the identification and treatment of mental disorders.
4. It is recommended that information about support in possible crisis situations should be made available in local governments.
5. In preparing informative materials, thought should be put into the most effective distribution mechanisms, as not every person has access to a computer and the internet.

6. ENSURING ACCESS TO GOOD PRIMARY CARE TO ADDRESS MENTAL HEALTH PROBLEMS

A general practitioner (GP) is a specialist who provides primary healthcare, and in most cases is the first contact point between a patient and a health care service provider. The general practitioner addresses people's health problems by using simple and cost effective medical techniques.

One of the main evaluation methods for the operation of primary healthcare and general practitioners is good access to GP services, including territorial access. This is characterized by the

on 05.11.2006]

[136] Additional materials prepared by the Public Health Agency, available at: http://sva.vi.gov.lv/pashnavibu_novershana_papildmaterials.pdf, [last accessed on 05.11.2009]

number of GP practices, their location and the average number of inhabitants per GP practice in a territory. This is shown in the following table from a Ministry of Health informative report on "The implementation of inpatient and outpatient healthcare service provider development programs in 2008," prepared by the former State Agency for Health Statistics and Medical Technologies[137]

Territory (statistical region)	End of 2004		End of 2008	
	No. of PHC doctors' practices	Av. No. of inhabitants per practice	No. of PHC doctors' practices	Av. No. of inhabitants per practice
Riga	419	1764	439	1 634
Near Riga (Pierīga)	213	1685	209	1 820
Zemgale	189	1670	170	1 668
Kurzeme	171	1704	184	1 650
Vidzeme	149	1689	147	1 618
Latgale	208	1802	204	1 707
Latvia	**1,349**	**1,728**	**1 ,353**	**1, 678**

Only GP practices which receive funding from the state budget are included in the table. In the period from 2004 to the end of 2008, only four new GP practices have been created and the number of GP practices has remained virtually unchanged in the territories. The fact that during this period the number of GP practices remained virtually the same, while the number of inhabitants in Latvia decreased by 60600 means that the average number of inhabitants per GP practice in Latvia decreased by 50. Theoretically, it can therefore be considered that access to GP services has improved slightly.

Data on the breakdown of general practitioners according to the number of registered participants per territory have been included in the following table, using data for 2008 from the interim report "On Assessment of the Existing Primary Healthcare Model and Further Action"[138]. The data has been gathered according to the territories stipulated in Cabinet of Ministers' Regulation No. 1046 *"Health Care Organisation and Financing Procedure"*[139] of 19 December 2006, and does not align with statistical regions.

Number of registered participants	Kurzeme	Latgale	Riga	Vidzeme	Zemgale	Practitioners in total
0-499	2	1	11	0	3	17

[137] In accordance with Cabinet of Ministers' Order No. 509 (29.07.2009) "On the reorganisation of state administrative institutions under the Ministry of Health" the State Agency for Health Statistics and Medical Technologies ceased operating on 1 October 2009, and its functions were divided between the Health Economics' Centre, the Health Inspectorate and the State Agency of Medicines, available at: http://vsmtva.vec.gov.lv/web/lv/index.aspx, [last accessed on 11.11.2009]

[138] Interim report on the assessment of existing primary health care model and further action, 2008, Ministry of Health, available at: http://phoebe.vm.gov.lv/misc_db/web.nsf/bf25ab0f47ba5dd785256499006b15a4/f08a4b009a0f6b58c225742500391e69/$FILE/starpzinojums_jaunais.pdf, [last accessed on 11.11.2009]

[139] "Health Care Organisation and Financing Procedure", http://www.vnc.gov.lv/files/MK_1046_noteikumu_pamatteksts_speka_ar_011009.pdf, [last accessed on 09.11.2009]

500-999	20	18	48	31	24	141
1000-1499	55	52	130	57	65	359
1500-1999	102	66	275	67	79	589
2000-2499	30	41	79	32	38	220
2500-2999	5	9	7	2	1	24
3000-3499	0	0	2	0	0	2
3500-3999	0	0	0	1	0	1
Total	214	187	552	190	210	1353
% (over 2000 practices in the territory)	16%	27%	16%	18%	19%	18.3%

The data included in the table show that the number of registered participants at general practitioners' is highly variable and irregular. The majority of general practitioners (86%) have 1,000-2,500 registered participants, but for 30% of general practitioners the number of registered participants is not optimal or is too low. *"Development Programme for Outpatient and Inpatient Healthcare Service Providers"*,[140] drafted by the Ministry of Health and approved by Cabinet of Ministers' Regulation No. 1003, stipulates that no more than 1,800 participants may be registered with any one general practitioner, but in Latvia 18.3% of general practitioners have 2,000 or more registered participants. According to information included in the framework policy document "Improvement of Inhabitants' Mental Health for 2009-2014,"[141] the average number of registered participants at one general practitioner in the last few years has not changed significantly and is one of the highest among neighbouring countries (Estonia - 1,500, Norway - 1,205 and Germany - 679). The large number of registered participants encumbers the territorial availability of general practitioner services, increases the amount of work for general practitioners and shortens real contact time with each patient, which is crucial in cases of mental health problems. The heavy burden for general practitioners and assistant GPs reduces their opportunities to acquire the knowledge and skills needed to treat people with mental health problems. Risk identification and prevention of mental health problems is a time-consuming and labour intensive process. Due to the need to treat emergency cases, the preventive aspect of mental health care is not a priority for general practitioners. The reduction of the amount of work for general practitioners by limiting the number of registered patients and increasing the number of general practitioners would create favourable conditions for acquiring additional knowledge and skills in the field of mental health and would promote the role of general practitioners not only in the prevention of mental health problems, but also in diagnostics and treatment.

The basic functions of a general practitioner are to assess the health condition of a patient, carry out diagnostics and treatment of disease, and, if necessary, involve other specialists in the patient's healthcare. The framework policy document "Improvement of Inhabitants' Mental Health for 2009-2014" established that at present general practitioners lack sufficient knowledge regarding the treatment, care and rehabilitation of mental and behavioural disorders. Due to the heavy burden on general practitioners and insufficient knowledge, where possible they try to avoid providing healthcare for patients with mental and behavioural disorders. Although in the last few years mental health care specialists have drafted informative materials for general practitioners and other

[140] "Development Program for Outpatient and Inpatient Service Providers", available at: http://phoebe.vm.gov.lv/misc_db/web.nsf/bf25ab0f47ba5dd785256499006b15a4/17cb8c1218bf81cdc2257313001f391a/$FILE/strukturplans.pdf, [last accessed on 09.11.2009]

[141] Approved by the Cabinet of Ministers on 6 August 2008, http://polsis.mk.gov.lv/view.do?id=2753, [last accessed on 05.11.2009]

specialists working in mental health care, unfortunately the amount of teaching aids, guidelines, and instructions is not sufficient to ensure guidance for general practitioners. In addition, there are no formal networks to disseminate this information. In most cases, general practitioners lack sufficient knowledge and experience to provide timely diagnosis of mental disorders, establish the degree of disorders in order to start a patient's treatment, and send a patient to a psychiatrist for outpatient or inpatient treatment. The following table taken from the State Compulsory Health Insurance Agency's Journal (No. 14, No. 15, No. 16, No. 17 [142]) provides a breakdown of patient visits to general practitioners and psychiatrists for mental and behavioural disorders per year as a percentage (base diagnosis F00 – F99):

Year	GP visits	Specialist visits
2005	36.0%	64.0%
2006	16.4%	83.6%
2007	36.1%	63.9%
2008	28.5%	71.5%

The data in the table do not substantiate the claim that over the last few years general practitioners have had increasing numbers of patients with mental or behavioural disorders.

To enhance the competence of general practitioners regarding mental health care, Riga Stradiņš University's Department of Psychiatry and Narcology has in cooperation with pharmaceutical companies, developed several teaching aids on mental health disorders to be used by general practitioners. These guidelines on the diagnosis and treatment of depression, bipolar affective disorders, schizophrenia, and methodical recommendations on psycho-pharmacotherapy, suicide risk assessment and feature identification are given to general practitioners at professional conferences and seminars. According to data of 2007, included in the framework policy document "*Improvement of Inhabitants' Mental Health for 2009-2014*", 42.2% of general practitioners (565 in total) have undergone training in psychiatry while in residency. Support for the additional training of general practitioners has been expressed in interviews by general practitioners themselves, because it means that general practitioners do not have to send some of their patients in the suicide risk group to a psychiatrist but can instead provide assistance and support via the primary health care practice. Although general practitioners provided a positive evaluation of their interaction with mental patients, mental patients prefer to see a specialist i.e. a psychiatrist or attend psychotherapy sessions or other activities, regardless of the availability and preparedness of their general practitioner regarding mental health care. Interviews with both patients and general practitioners show that in case of mental health problems patients wish to be treated by a specialist rather than a general practitioner, because the latter is not considered competent enough and GPs themselves avoid treatment of such patients.

In future, if inpatient mental health care services are switched to outpatient healthcare service, and if the result indicator set out in the framework policy document "*Improvement of Inhabitants' Mental Health for 2009-2014*" is met – to increase community-based mental health care service by 7% – the social stigma, as well the need for inpatient services, and state budget expenses for inpatient bed-days will be reduced. By drafting methodical guidelines for general practitioners, municipalities and psychologists in educational institutions working with persons suffering from mental disorders, prevention of mental disorders will also be facilitated, thus reducing the illness rate and, accordingly, saving state budget funds. Improvement of general practitioners' knowledge

[142] State Compulsory Health Insurance Agency Gazette, available at: http://www.vnc.gov.lv/lat/publikacijas/agenturas_vestis/, [last accessed on 09.11.2009]

of risk factors and their prevention would help to detect patients' mental health problems at an early stage, thus improving the patient's quality of life and ensuring better retention in employment and a longer active life.

In order to improve or maintain good mental health, the majority of patients with mental and behavioural disorders must use psychotropic medication. Continuity of treatment is of major importance for such patients, therefore it is very important for patients also to use the medications while being outside of the health care institution. Patients suffering from certain mental disorders have the right to receive compensation for medication purchases. This is set out in Cabinet of Ministers' Regulation No. 899 *"Procedure for the Reimbursement of Expenditure for the Acquisition of Medical Products and Medical Devices Intended for Outpatient Medical Treatment"* [143], adopted on 30 October 2006. Annex 1 to the Regulation stipulates specific diagnosed diseases for which treatment costs shall be covered. Due to changes in available health care funding, the diagnosis groups, covered by the purchase reimbursement, have the amount of reimbursement periodically reviewed. The following table provides information on diagnosis groups and the amount of reimbursement, from 2004 until now, with regard to diagnoses related to mental disorders which are determined by amendments to national regulations.

Dg code	Diagnosis group/ diagnosis	Amount of reimbursement (%)						Restrictions
		2004	2005	2006	2007	2008	2009	
F00	Dementia in Alzheimer's disease	**75**	**75**	**75**	**75**	**75**	**50**	
F20	Schizophrenia	**100**	**100**	**100**	**100**	**100**	**100**	
F21, F22, F25, F31, F33, F71-F73	*Other mental and behavioural disorders*	**75**	**75**	**75**	**75**	**75**	**50**	
F98	Non-organic enuresis		**75**	**75**	**75**	**75**	**50**	
F02	Dementia because of other diseases classified elsewhere		**75**	**75**	**75**	**75**	**50**	
F06	Other mental disorders due to brain damage and dysfunction and to physical disease		**75**	**75**	**75**	**75**	**50**	
F84	Pervasive developmental disorders				**75**	**75**	**50**	
F10-F19	Mental and behavioural disorders due to psychoactive substance abuse					**100**	**100**	For children under 18

This table shows that since 2004, the range of diagnoses with reimbursement for the purchase of medications has gradually widened. However, due to the unfavourable economic situation in the

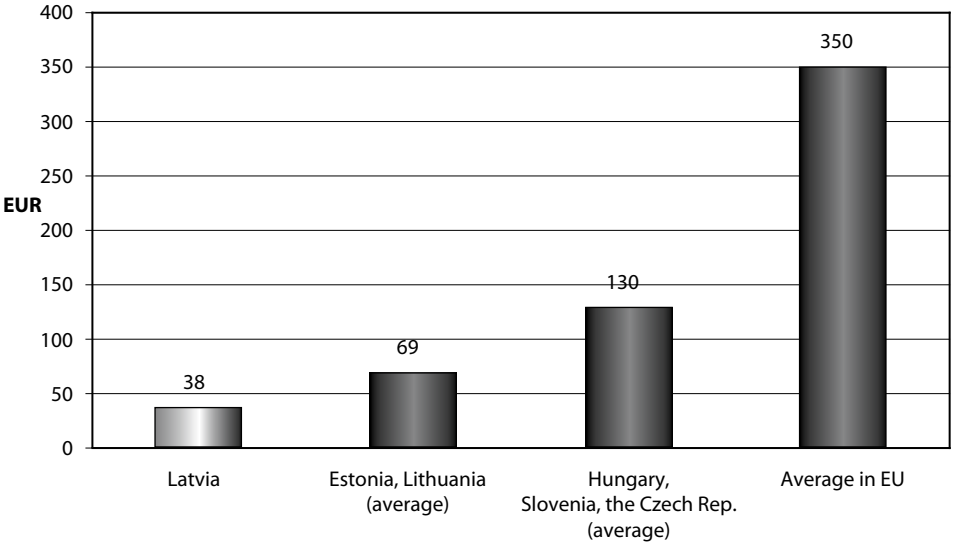
[143] Cabinet of Ministers' Regulations No. 899 "Procedure for the Reimbursement of Expenditure for the Acquisition of Medical Products and Medical Devices Intended for Out-Patient Medical Treatment" adopted on 30.20.2006, http://www.likumi.lv/doc.php?id=111208, [last accessed on 11.11.2009]

country, the amount of reimbursement has been reduced by 25% in 2009 for all diagnoses except schizophrenia and disorders due to addictive substance abuse for children.

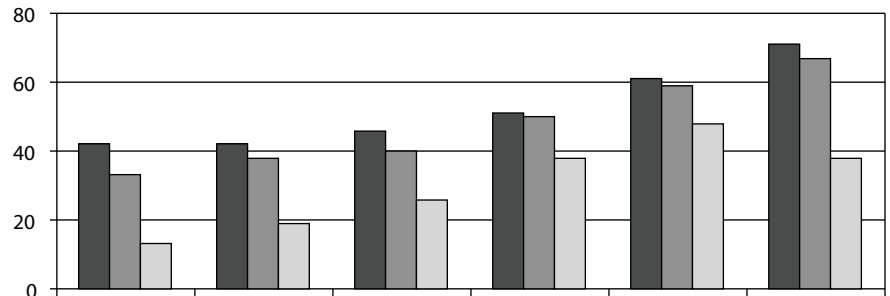
According to data from an informative report prepared by the Ministry of Health *"On the System of Reimbursement of Expenditure for the Acquisition of Medications and Medical Devices Intended for Outpatient Medical Treatment Starting from 2004, Disposition of Funds and Possible Further Development of the Reimbursement System in Latvia,"*[144] in comparison with other EC Member States, Latvia allocates significantly less funding for the reimbursement of medications.

[144] Informative report available at: http://www.mk.gov.lv/doc/2005/VMZin_030909_ZIKS.3191.doc, [last accessed on 09.11.2009]

The following diagram provides a comparison between countries with regard to the reimbursement of medications planned in 2009 (EUR per capita):



In recent years, the amount of funding (EUR, per capita) available for the purchase of medications to be reimbursed in Latvia in comparison with neighbouring countries has changed as follows:



	2004	2005	2006	2007	2008	planned in 2009
Estonia	42	41	46	51	61	71
Lithuania	33	38	40	50	59	67
Latvia	13	19	26	38	48	38

Due to plans to cut the funding for subsidised medications in 2009, the ongoing year-on-year trend to increase funding will stop, and it is expected that subsidies for patients with mental illnesses and behavioural disorders will also be reduced.

Like other state-funded specialists, GPs are entitled to prescribe subsidised medications to their patients to the sum stated in the agreement between the GP and the State Payment Centre. GPs are entitled to prescribe subsidised medications in cases of mental and behavioural disorders to the same extent as psychiatrists. However, these medications are mostly prescribed by psychiatrists. GPs have been granted a variety of resources for preventive mental health care, including opportunities to improve their knowledge in the mental health sphere. However, patients' interviews indicate that due to GPs' heavy workload and the social stigma surrounding mental illness, mental health issues, including possible risks and consequences are generally not discussed with GPs. Interviews with GPs show that a large number of patients complain about high stress levels due to overwork, fatigue or unemployment, however, a doctors' ability to reduce the causes of the problem is poor, after these key risks have been indicated.

The Ministry of Health's interim report "Assessment and Future Action on the Existing Primary Healthcare Model"[145] concludes that the reasons why GPs are often overloaded are a lack of GPs and nurses in some parts of Latvia, too many patients per doctor as well as increasing paperwork. As a result, doctors do not have enough time to promote mental health. GPs state that in order to lessen their workload, they are interested in timely identification of mental health risks and lessening factors that could trigger mental disorders. A range of methodology and guidelines have been drawn up to regulate the cooperation, and to divide functions, between GPs and mental health specialists when dealing with certain mental health issues, such as depression, mood swings and suicide risks. Meanwhile, no methodology has been introduced to divide responsibility between primary health care and mental health care specialists, or to highlight their actions to set an example of good practice in mental health care.

It is necessary to obtain a referral from a GP or a specialist in order to receive state-funded medical advice or diagnostic checks by a specialist. In this case, the referred person pays only the patient's fee. Both GPs and specialists are entitled to refer a patient to a specialist for diagnostic checks or consultations. In line with government's regulations, patients suffering from certain illnesses have been granted direct access to specialist doctors and do not need a GP's referral. Psychiatrists are amongst those listed as direct access specialists. Visiting a psychiatrist without a GP's referral is quicker, allows direct contact with the specialist and broadens the patient's range of options. Interviewed patients expressed approval of this arrangement and said they were using it. Patients usually inform their GPs on the progress of their mental illness, since there is no established system for information exchange between GPs and psychiatrists.

The broadest scope of mental health care services in Latvia is available in hospitals, where there is access to a larger number of mental health care specialists who have accumulated extensive experience regarding various mental disorders, their diagnostics and treatment. Most hospitals also provide outpatient treatment and promote mental health care in their local area. Hospitals work in cooperation with psychiatrists practicing in their administrative municipalities. Both outpatient and inpatient mental health specialists can be consulted on mental health issues by other doctors, mental health care users, mass media representatives and local government officials. There are no designated mental health competency centres in Latvia but relevant information is still exchanged between mental healthcare professionals and those concerned about mental health issues.

[145] Ibid.

State-funded inpatient psychiatric assistance in Latvia is available through specialised psychiatric clinics, however, for children's needs there is only one psychiatric ward which is integrated in a general children's hospital in Riga. Outpatient psychiatric assistance is available at psychiatrists' practises throughout Latvia as well as at the psychiatric departments of general hospitals in Latvia's four major cities – Riga, Daugavpils, Liepāja and Jelgava. Outpatient multidisciplinary psychiatric care is available only in Riga in two non-state psychiatric care centres, one of which is located in a primary healthcare centre. Major hospitals in Riga employ psychiatrists who are in charge of advising hospital patients regarding mental health issues. Outpatient healthcare centres mostly employ private psychiatrists who provide help using budgetary funds.

The Cabinet of Ministers' Order No. 1003 of 20 December 2004, "Development Program for Outpatient and Inpatient Service Providers"[146] states that: "(…) existing specialised hospitals will hand over their functions to multi-profile hospitals for emergency care purposes and after providing emergency care, patients will be transferred to the primary health care sector, health care centres or hospitals that provide long-term care. Some of the specialised hospitals will be retained and will provide planned health care services, while others will be reformed and turned into long term care hospitals. This mainly applies to psychiatry and tuberculosis." As a result, it is expected that in future inpatient psychiatry services will be integrated into multi-profile hospitals, which will provide higher quality and more efficient services and reduce the social stigma surrounding mental illness. The framework policy document "*Improvement of Inhabitants' Mental Health for 2009-2014*"[147] envisages further development of community-based mental health care centres, the development of multidisciplinary health care formats and integration of mental health care into general health care and outpatient centres.

Conclusions

1. Latvia has a shortage of GPs and in some parts of the country the location of GP practises is not balanced.
2. GPs lack sufficient knowledge and skills to provide qualitative mental health care for patients suffering from mental disorders.
3. Although GPs are entitled to prescribe psychotropic medicines, (including subsidised ones) to their patients, they routinely avoid doing so due to insufficient competency and a heavy workload. Patients usually choose to get advice from specialists, and it is rare for patients to receive assistance from their GP when experiencing mental health problems.
4. It is up to the patient to ensure that information regarding his/her mental health is regularly exchanged between the GP and psychiatrist, since the psychiatrist is listed as a direct access specialist and there is no need for GP referral. The psychiatrist may only provide relevant information to the GP with the patient's consent. The existing system encourages patients to seek medical advice from a specialist rather than a GP.
5. The competency and responsibility levels of GPs and psychiatrists are stated in occupational statutes. There are no guidelines or standards defining and separating GP's and psychiatrist's responsibilities regarding patients' mental healthcare.
6. There are no competency or experience centres for mental healthcare in Latvia. Major psychiatric hospitals carry out experience centre's functions.
7. There are a number of political planning documents that aim to integrate mental healthcare into general healthcare centres and hospitals. However, implementation of these measures has not been productive thus far.

[146] "Development Program for Outpatient and Inpatient Service Providers," available at: http://phoebe.vm.gov.lv/misc_db/web.nsf/bf25ab0f47ba5dd785256499006b15a4/17cb8c1218bf81cdc2257313001f391a/$FILE/strukturplans.pdf, [last accessed on 11.11.2009]

[147] Framework policy document "Improvement of Inhabitants' Mental Health for 2009-2014", http://polsis.mk.gov.lv/view.do?id=2753, [last accessed on 05.11.2009]

Recommendations

1. Increase the number of GPs and ensure their balanced dispersal across regions.
2. Encourage GPs to improve mental healthcare knowledge and skills so they can contribute to mental health maintenance, help reduce the relevant risks and lessen the social stigma surrounding mental illness and motivate patient to seek a GP's assistance when facing mental health problems.
3. Draw up guidelines dividing tasks and responsibilities between GPs, psychiatrists, psychotherapists and other mental healthcare specialists.
4. Consider defining and establishing mental healthcare competency (experience) centres.
5. Implement the measures stated in political planning documents in the mental health sphere.

7. PROVISION OF EFFECTIVE COMMUNITY-BASED CARE SERVICES FOR PERSONS WITH SERIOUS MENTAL DISORDERS

Access to community-based care services

Institutional care, which is provided by seven psychiatric hospitals (under the Ministry of Health) and 33 specialised social care homes for persons with mental disabilities (under the Ministry of Welfare), continues to dominate in Latvia in 2009. The UN Social, Economic and Cultural Rights Committee has indicated the necessity to implement a de-institutionalization policy, developing community-based mental health care and diverting more funding to it. Reviewing Latvia's regular report on the implementation of the UN International Covenant on Social, Economic and Cultural Rights in May 2007, the Committee expressed concerns about the fact that institutional care still continued to dominate while community-based care services were not being developed.[148]

Health care sector

Even though the adoption of the framework policy document *"Improvement of Inhabitants' Mental Health for 2009-2014,"* in August 2008, can be evaluated as a notable achievement, currently no implementation plan has been developed, nor has a budget been allocated for its implementation. This framework policy document envisages the creation of 24 community-based mental health care institutions, including six mental health care centres, six half-way homes and twelve group homes.[149]

Unfortunately, even before the adoption of the framework policy document, which establishes the directions for the development of the mental health care sector, in 2006-2007 the government guaranteed bank loans to a number of psychiatric hospitals for reconstruction work and expansion of their premises, i.e. the increasing the number of beds. The business plans developed for each hospital have not been publicly accessible, therefore there is a lack of accurate information to what extent each institution will be extended. The heads of the hospitals argued that the main reason behind the expansion of their hospitals is the creation of wards for social care – those would be beds for providing social care, therefore formally the number of beds for health care would not increase. From the perspective of effective policy and budget planning, it would have been more reasonable

[148] UN Committee on Economic, Social and Cultural Rights, Concluding Observations of the Committee on Economic, Social and Cultural Rights, Latvia, E/C.12/LVA/CO/1, 07.01.2008, http://daccessdds.un.org/doc/UNDOC/GEN/G08/400/67/PDF/G0840067.pdf?OpenElement, [last accessed on 05.11.2009]

[149] Framework policy document "Improvement of Inhabitants' Mental Health for 2009-2014", http://polsis.mk.gov.lv/view.do?id=2753, [last accessed on 05.11.2009]

to invest in psychiatric hospitals only after the adoption of the framework policy document, which sets the government's general priorities in the development of mental health care service.[150]

Although in the period from 1998 to 2006 the number of psychiatric hospitals' beds were reduced by 28.2% (from 4,371 to 3,139 beds)[151], until now there has not been sufficient political and financial support for the creation of community-based mental health services. In certain Latvian cities, community-based day care centres for persons with psychiatric illnesses are available, for example, in Jelgava and Riga, but their number is still insufficient. In Jelgava, for many years the *Ģintermuiža* hospital also provided a mobile, multidisciplinary team service for the hospital's out-patients living in Jelgava City. Up to now this mobile team was the only one in Latvia, which was set up in 2002 with financial support from the Soros Foundation-Latvia, the Open Society Institute (Budapest) and the Canadian government. After the project's funding ended, the local Sickness fund continued to provide financial support. At the end of 2008, due to the reduction of the budget caused by the economic recession, *Ģintermuiža* hospital had to modify the work of the mobile team and to reduce its workload. However, it is planned that the mobile team's work could be continued from October 2009 as part of the home care programme funded by the Ministry of Health.[152]

A positive aspect is that in 2005, the Riga Psychiatric and Narcology Centre outpatient mental health care centre *Veldre,* in Jugla commenced service in the City of Riga, providing outpatient psychiatric and psychological assistance, occupational therapy and consultations of social worker, as well group activities and day inpatient (25 beds) services. Continuing the development of outpatient psychiatric assistance services in Riga, in autumn of 2009 the Riga Psychiatric and Narcology Centre outpatient branch *Pārdaugava* was opened to provide services for the inhabitants of the Pārdaugava district of Riga. At the same time outpatient mental health care centre *Ziepniekkalns* was closed down (it was the only one in primary healthcare integrated outpatient psychiatric service). But overall, both the quantitative needs assessment of users of mental health care services, conducted in the summer of 2005, when 408 users were surveyed,[153] as well the RC "ZELDA" discussion with users which took place at the beginning of November 2009, indicated that the majority of users were not informed about community-based services (day centres, group houses, self-help groups etc.), available near their place of residence.

Welfare sector

The development of community-based or alternative care services is also prescribed by policy documents and normative acts developed by the Ministry of Welfare – accordingly, community-based services are being created with State and local governments' funding:

[150] RC "ZELDA" Newsletter No.1/2, July 2008, http://www.zelda.org.lv/?cat=76&lang=en, [last accessed on 05.11.2009]

[151] Data from the framework policy document "Improvement of Inhabitants' Mental Health for 2009-2014", http://polsis.mk.gov.lv/view.do?id=2753, [last accessed on 05.11.2009]

[152] Telephone interview with *Ģintermuiža* hospital's Chairman of the Board Dr. Uldis Čačus, 06.11.2009.

[153] Ieva Leimane-Veldmeijere, Uldis Veits, Needs Assessment of Users of Mental Health Care Services, Riga: Latvian Centre for Human Rights, 2006, http://www.humanrights.org.lv/html/news/publications/index.html?yr=2006, [last accessed on 09.11.2009]

- *Group homes/apartments[154] and half-way houses[155]*

In 2008, 13 group homes/apartments for persons with mental disabilities operated nationwide, of which eight group homes were completely financed from budgets of local governments and five group homes[156] also received state co-funding.[157] Since 2007, six halfway houses have been operating in Latvia. These half-way houses have been developed by the relevant social care homes for people with mental disabilities. Although, according to data of the Welfare ministry in 2007 and 2008, more clients than planned returned from institutions to independent life in group homes (70 and 33 persons respectively),[158] the number of group homes is still very small and insufficient. Also, services of group home are available only to those persons who return from long-term care institutions, but not to those users who currently live in the community with their families, but would like to live independently. The reintegration into the community of persons living in social care institutions with access to group home service is often hampered by the legal status of the person, namely the legal incapacity, the reinstating of which is very complicated (see Section 3). It should be also noted that since the end of 2008, "with the commencement of the economic recession, the opportunities for local governments to open new group homes have decreased, and consequently half-way houses' clients who have successfully completed a rehabilitation program do not have the opportunity to start living independently".[159]

- *Day care centres*

In 2008, 22 day care centres operated in Latvia and they were visited by 1,274 persons with mental disabilities.[160] The day centres mainly offer services for persons with intellectual disabilities, and only in Riga and Jelgava are operating day centres for persons with psychiatric illnesses as well.

The *Social Services and Social Assistance Law* stipulates that the state contributes to the funding required for day centres for persons with mental disabilities. Day centres' establishment and maintenance expenses are financed from the state budget: the state funds day centres for the first four years from 80% in the first year, 60% in the second year and 40% in the third year to 20% in the fourth year. Beginning with the fifth year all the funding of the day centre has to be covered by the local government.

The *Programme for the Development of Social Care and Social Rehabilitation Services for Persons with Mental Disabilities for 2009 – 2013,* developed by the Ministry of Welfare and adopted by the

[154] The group home/apartment provides following range of services: housing; correction of the client's self-care and social skills; improvement of the client's cooperation skills in relation to solving social and employment issues at state and local governments' institutions; development and implementation of the client's individual social rehabilitation plan (the plan is developed taking into account the client's previous rehabilitation program, covering measures of learning and developing independent living, self care and social skills. The plan includes additional individual or group measures for the client); providing personal support in job searching and learning new job skills; other services what the client requires, including support, advice, information, and protection of their personal interests and rights.

[155] The half-way house is a transitional stage between long-term social care and independent living. In half-way houses people with mental disabilities can learn basic domestic skills, such as cooking, doing laundry and self-care.

[156] The state provides 50% of funding annually for the establishment and equipping of group homes/ apartments and half-way houses for persons with mental disabilities. State also covers 50% of costs (from amount of long-term social care and rehabilitation in an institution per person) for the running costs of the group home/apartment for persons returning from long-term social care institutions.

[157] Ministry of Welfare, Report on the implementation of the Conception "Equal opportunities for All" in 2008, http://www.lm.gov.lv/text/1147, [last accessed on 09.11.2009]

[158] Ministry of Welfare, Annual Report of 2008, http://2009.gada 5. martā Ministru kabinetā www.lm.gov.lv/upload/gada_parskats/publ_parskats_2008_4_1.doc.pdf, [last accessed on 09.11.2009]

[159] Informative report on the implementation of the *National Social Inclusion Plan for 2008-2010* in 2008, http://polsis.mk.gov.lv/docSearch.do?searchtype=ows&clearnav=true, [last accessed on 09.11.2009]

[160] Ministry of Welfare, Report on the implementation of the Conception "Equal opportunities for All" in 2008, http://www.lm.gov.lv/text/1147, [last accessed on 09.11.2009]

government on 5 March 2009, unfortunately envisages continuing to invest the greater proportion of available funding for this area in institutional care rather than alternative community-based services. Thus, consequently, it cannot be predicted that access to group homes and day centres could increase in any real extent in the coming years.

Involuntary admission and medical treatment in a psychiatric hospital

Taking into account that in Latvia psychiatric hospitals are the most recognised treatment environments for persons with mental disorders, the issue of a person's involuntary admission to a psychiatric hospital is particularly important and additional attention should be focused on this. The provision of psychiatric assistance without the patient's consent is regulated by the Medical Treatment Law.[161] On 1 March 2007, amendments to the Medical Treatment Law were adopted which substantially changed the procedure for involuntary admission. As of 29 March 2007 (the moment when the amendments entered into force), the final decision about a person's admission is made by a judge and not by the Council of Doctors, as was previously.[162]

According to the current legislation, psychiatric assistance without a person's consent is provided if the person has threatened or threatens, someone has tried or is trying to do personal injuries to him/herself or to another person[163] or if a person has indicated or indicates an inability to care for him/herself or for a person under his/her care. In both cases it is necessary to determine that the person has a psychiatric disorder, the consequences of which (in the first case) could be the cause of serious bodily harm to the person him/herself or to other person, or unavoidable and serious deterioration of the person's health (in the second case). The initial decision on a person's admission in a psychiatric hospital is made by the Council of Psychiatrists within 72 hours from the person's admission into a hospital. The Council of Psychiatrists must inform the respective regional (city) court (in conformity with the location of the psychiatric hospital) in writing of their decision within 24 hours. After receiving the decision, the judge must promptly inform the regional (or city) prosecutor's office (in conformity with the location of the psychiatric hospital), the patient's representative and the psychiatric hospital about the time, day and place when the submitted materials will be reviewed. If the judge determines that the patient does not have a legal representative, the judge must promptly request that the Latvian Council of Sworn Advocates appoint a sworn advocate to represent the patient's interests. The judge must make a decision on a person's involuntary admission for a period up to two months in a closed session at the psychiatric hospital within 72 hours of the receipt of the Council of Psychiatrists' decision.

To evaluate how effectively the adopted Medical Treatment Law's amendments function in practice, RC "ZELDA" conducted monitoring from May to October 2009 and was asking the opinions from psychiatric hospitals, the courts, the Ombudsman's Office and the Health Inspectorate. The institutions mentioned were given a number of questions on their views of the amendments, problems that they had encountered during the process, the need for further amendments to be made, as well as on the number of persons admitted in the period since the amendments have been in force.

From the responses submitted by the institutions, the psychiatric hospitals and the courts, it can be concluded that the majority of psychiatric hospitals (for example, the Riga Psychiatric and Narcology Centre, *Piejūras* hospital (Liepāja), Strenči Psychiatricl hospital and Ģintermuiža hospital (Jelgava))

[161] Medical Treatment Law, Article 68, http://www.ttc.lv/advantagecms/LV/tulkojumi/dokumenti.html?folder=%2fdocs%2fLRTA%2fLikumi%2f&currentPage=7, [last accessed on 09.11.2009]

[162] Amendments of 8 November 2007 to the Medical Treatment Law, http://www.ttc.lv/advantagecms/LV/tulkojumi/dokumenti.html?folder=%2fdocs%2fLRTA%2fLikumi%2f&currentPage=7, [last accessed on 09.11.2009]

[163] The law does not clarify whether it is necessary to implement both criteria or just one of them.

as well the institutions surveyed (the Ombudsman's office and the Health Inspectorate) rated the adopted amendments as positive and consistent with human rights standards. For example, the response from *Ģintermuiža* hospital shows that the introduction of the amendments "helps the medical professionals a lot, because the responsibility for the decision of involuntary treatment has been 'transferred' from the doctor to the court."[164] In turn, a number of courts which are involved in the process of a person's involuntary admission expressed a negative opinion, indicating that "actually, judges are making only an additional formal confirmation of a medical opinion,"[165] also characterizing the amendments to the Medical Treatment Law as "deficient, contradictory and complicated to enforce."[166] However, the other courts rate the amendments to the Medical Treatment Law positively (for example, the Valka Regional Court,[167] Jelgava Court[168] and others).

One of the main problems connected with court proceedings mentioned by the judges is the doctors' "inability to assess objectively which of the Medical Treatment Law's criteria, defined in Article 68 (1) paragraph 1 or 2 (or even both) have been established in the patient's behaviour in the particular case".[169] Individual judges state that their inadequate knowledge of psychiatry makes it difficult to question the decisions of doctors,[170] and also draw attention to "inexplicable medical terminology" which is used in the decisions of the Council of Doctors.[171] However, in other courts judges had very positive opinions about the decisions of the Council of Doctors, indicating that "the information in the Council of Psychiatrists' decisions is sufficient, comprehensive"[172] and "objective."[173]

Communication between patients and judges also causes difficulties. Certain judges indicated that they lack the special knowledge of questioning of the patient and listening to him, as well they lack an understanding of the issues which can stimulate aggression of the patient.[174] The same problem was acknowledged also by doctors, who indicated that "the court usually asks the patient questions on their opinion on the necessity of treatment, but such questions can make the patient upset and can escalate their illness."[175] The Ombudsman mentioned complaints received from patients and recognized that during court hearings judges are reluctant to question the patient, and that for the greatest part only medical experts and invited representatives or counsel are addressed during the process.[176] Overall, the doctors indicated that "courts have an insufficient understanding of the patients' mental health condition."[177]

Opinions on holding the court hearing in the psychiatric hospital vary. Some judges rate this fact positively, indicating that in this way "the patient's view is heard in all the cases, which was not possible earlier when hearings took place in the premises of the courts."[178] However, a number of judges mentioned the issue of safety during the court hearing as problematic, as the majority of patients are aggressive and the law has not foreseen the involvement of police to ensure order

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164 Ģintermuiža hospital's opinion, 03.06.2009, Nr. 1-10/818. Available at RC "ZELDA".
165 Daugavpils Court's opinion provided by e-mail, 27.10.2009. Available at RC "ZELDA". A similar opinion was given to RC "ZELDA" in a telephone interview by City of Riga Northern District Court.
166 Jelgava Court's opinion, 14.08.2009, Nr. 1-18/188. Available at RC "ZELDA".
167 Valka District Court's opinion 29.05.2009. Available at RC "ZELDA".
168 Jelgava Court's opinion, 14.08.2009, Nr. 1-18/188. Available at RC "ZELDA".
169 Jelgava Court's opinion, 14.08.2009, Nr. 1-18/188. Available at RC "ZELDA".
170 Telephone interview with City of Riga Northern District Court's judge.
171 Jelgava Court's opinion, 14.08.2009, Nr. 1-18/188. Available at RC "ZELDA".
172 Valka District Court's opinion 29.05.2009. Available at RC "ZELDA".
173 Liepāja Court's opinion 27.05.2009, Nr.1-18/321. Available at RC "ZELDA".
174 Jelgava Court's opinion, 14.08.2009, Nr. 1-18/188. Available at RC "ZELDA".
175 Ģintermuiža hospital's opinion, 03.06.2009, Nr. 1-10/818. Available at RC "ZELDA".
176 Ombudsman's opinion 05.06.2009, Nr. 1-5/153. Available at RC "ZELDA".
177 Opinion given by the Riga Psychiatric and Narcology Centre 22.10.2009, Nr. 01-09/10054. Available at RC "ZELDA".
178 Jelgava Court's opinion, 14.08.2009, Nr. 1-18/188. Available at RC "ZELDA".

during the court session.[179] In turn, all the hospitals surveyed expressed satisfaction with having the court hearings in the hospital, as the process is then less traumatic for the patient.

Statistical data provided by courts on cases of involuntary admission:

	2007	2008	2009
Valka Regional Court	2	3	1
Liepāja Court	In total, 21 decisions of Council of Doctors approved, 4 decisions rejected in period of 2007 to 27 May 2009.		
Jelgava Court	10 patients in total involuntary admitted (2007 – 1 May 2009).		
Riga City Northern District Court	29 decisions of the Council of Doctors approved, 3 - rejected	All 27 decisions of the Council of Doctors approved	23 decisions of Council of Doctors approved, 1 - rejected
Daugavpils Court	9 cases considered in total from 2007 to 30 April 2009.		

The following suggestions have been received regarding necessary amendments to the Medical Treatment Law:

1. Liepāja Court indicated the necessity to clarify/amend sections 17 and 18 of Article 68 of the Law. The court doubted "if the frequent and repeated authorization of the Council's decision by a judge's decision is really necessary for seriously ill patients, who have had a psychiatric disorder for a long time, or since childhood or if they are incurable." The court believes that issues of this nature should be handled in a different way by the law.[180]
2. Jelgava Regional Court proposed "the amendment of section 11 of Article 68, to define the procedures by which other participants in the court hearing are heard, namely, hearing from the patient's representative or advocate should take place only after the patient's view has been heard."[181] The Court indicated that, "the order for the hearing of persons attending the hearing under section 11 of Article 68 is illogical."[182]
3. Jelgava Regional Court also referred to some other shortcomings in Article 68 of the Medical Treatment Law and indicated that the decision about a patient's admission in a psychiatric hospital should be made by the Council of Doctors. However, to ensure that the rights of the patient are ensured, the Law could allow for the right to challenge the decision of the Council of Psychiatrists in court, if the person so desires.[183] A similar view was expressed by the Daugavpils Psychiatric hospital, indicating that "practice shows that, according the Medical Treatment Law, not all the cases of emergency admission requires judicial review."[184]

The Ombudsman indicated that he does not see the necessity to amend Article 68 of the Medical Treatment Law and indicated the necessity of working on the aforementioned standards "to implement them into practice and to prevent the problems which are connected with ensuring professional legal representation in such cases, as well with training of judges in this area."[185]

Conclusions

1. Community-based mental health and social care services in Latvia, especially in rural regions, continue to be accessible only to a restricted number of people with mental disabilities. The

[179] Jelgava Court's opinion, 14.08.2009, Nr. 1-18/188. Available at RC "ZELDA".
[180] Liepāja Court's opinion, 27.05.2009, Nr.1-18/321. Available at RC "ZELDA".
[181] Jelgava Court's opinion,, 14.08.2009, Nr. 1-18/188. Available at RC "ZELDA".
[182] Ibid.
[183] Ibid.
[184] Daugavpils Psychiatric hospital's opinion, 24.08.2009, Nr. 01-08/220. Available at RC "ZELDA".
[185] Ombudsman's opinion, 05.06.2009, Nr. 1-5/153. Available at RC "ZELDA".

government continues to invest mainly in institutional care both in the health and the welfare sector.
2. At educational institutions which prepare mental health and social care specialists, training programs, and the preparing of community-based mental health care specialists, have not been developed and implemented.
3. Courts and doctors do not understand the court's role in the process of involuntary admission and treatment (often patients are "threatened" to be brought to the court, thus they do not perceive the court as a mechanism for protecting a person's rights). The necessity for a court procedure is often doubted – it means that there is a lack of knowledge regarding the case law of the European Court of Human Rights in regards to a person's rights to freedom.
4. Cooperation between doctors and the courts is problematic, both in relation to the opinion of the Council of Doctors (regarding the previously indicated problem of the doctors' inability to clarify which paragraph of Article 68 (1) of the Medical Treatment Law corresponds to the specific situation, as well as the problem indicated by the judges regarding complicated medical terminology), and in relation to court proceedings, especially in communicating with the patient. Both judges and doctors have outlined this problem and suggested organising a short course of lectures for judges, advocates and prosecutors about psychiatric illnesses.[186] Overall, the organization of such training is necessary in order for a person's rights to not be violated during the hearing due to a lack of understanding.
5. Taking into account the Ombudsman's opinion, it can be concluded that in cases of a person's involuntary admission in a psychiatric hospital, the effectiveness of state's provided legal assistance is questionable.

Recommendations

1. It is necessary to develop an implementation plan for the framework policy document "*Improvement of Inhabitants' Mental Health for 2009-2014"*, and also to allocate the necessary funding for the development of community-based mental health care services.
2. It is necessary to develop and introduce training programs for the preparation of community-based mental health care specialists.
3. It is necessary to organise teaching (by bringing in international experts in this field, as well as using the experience of other countries and the case laws of the European Court of Human Rights) for psychiatrists, judges, prosecutors and advocates on the nature of the court's procedure, as well on the effective representation of patients' rights in cases of involuntary admission in a psychiatric hospital.
4. It is necessary to implement measures in order to improve cooperation between psychiatrists and judges during court's procedures.
5. Taking into account the positive responses regarding court hearings being held in psychiatric hospitals and the objections expressed by the judges, it is worth considering how to ensure better security during court sessions.
6. It is recommended that the necessity of the procedural change endorsed by the judges should be evaluated (in relation to the hearing sequence of participants at court sessions).
7. Bearing in mind that Latvia has signed the UN Convention on the Rights of Persons with Disabilities and is currently preparing to ratify it, as well taking into account the Thematic Study of UN High Commissioner for Human Rights of 26 January 2009,[187] it is necessary to assess whether the involuntary admission criteria, defined in Article 68 (1) of the Medical Treatment Law, complies with Article 14 of the UN Convention.

[186] Riga Psychiatric and Narcology Centre's opinion, 22.10.2009, Nr. 01-09/10054. Available at RC "ZELDA".
[187] Thematic study by the Office of UN High Commissioner for Human Rights on enhancing the awareness and understanding of the Convention on the Rights of Persons with Disabilities, UN General Assembly, 26 January 2009, A/HRC/10/48, http://www2.ohchr.org/english/bodies/hrcouncil/docs/10session/A.HRC.10.48.pdf, [last accessed on 09.11.2009]

8. DEVELOPMENT OF INTER-SECTORAL COOPERATION

Inter-sectoral cooperation in developing and implementing mental health care policy has already been analysed in Section 2 of this report. As stated previously, at present the ministries of Health and Welfare have the closest cooperation on resolving mental health issues. For example, a working group, preparing the ratification of the UN Convention on the Rights of Persons with Disabilities, has been operating under the auspices of the Ministry of Welfare since August 2008. Ministries from a number of sectors, state and local governments' bodies, and NGOs representing disabled people are broadly represented in this working group.[188] Trilateral cooperation within this working group between the Ministry of Welfare, the Ombudsman's office and an NGO (RC "ZELDA") helped to identify problems in the regulations governing the legal capacity institute, which should be harmonised with Article 12 of the UN Convention on the Rights of Persons with Disabilities.

Inter-sectoral cooperation is also enabled by the Ministry of Welfare's National Council for Disabled Persons' Affairs (NCDPA), which was founded in 1997 as a consultative body and which takes part in developing and integrating policies for the integration of disabled people. The NCDPA consists of seven ministers, the chairman of the Latvian Local Governments' Association, the Ombudsman, the chairman of the Public Services' Regulation Commission, the director of the Social Integration Fund, the chairman of the Latvian Free Trade Unions' Confederation and representatives from a number of NGOs.[189] These NGOs include the association "*Rūpju bērns*", which represents intellectually disabled people, and RC "ZELDA", which represents both: people with psychiatric illnesses and people with intellectual disabilities.

In order to facilitate the exchange of views and information about policy planning documents in preparation and draft laws, the Ministry of Welfare has also strengthened collaboration with NGO's by signing cooperation agreements. The first contracts, with more than ten NGO's, including RC "ZELDA", was signed on 25 September 2009. To promote further exchange of information, the Ministry of Welfare's Department of Social Inclusion Policy organises monthly meetings with organisations representing disabled persons.[190]

The Ministry of Health also has a number of consultative councils and inter-sectoral committees,[191] but these do not include NGOs representing people with mental disabilities. Although the government approved the framework policy document "*Improvement of Inhabitants' Mental Health for 2009– 2014*" in August 2008, situational analysis reveals that there is "insufficient respect for the views of service users and their families regarding (mental health care) services, policy principles and objectives", and the promise to "involve organisations established by service users and their family members in resolving issues relating to developing and implementing mental health policy"[192] has not been kept to date.

Of the largest Latvian municipalities, mention must be made of the cooperation between the Riga City Council (as the service financer) and NGOs, resulting in the establishment in October 2007 of the Consultative Council of Disabled Persons' Non-governmental organisations, which currently

[188] Ministry of Welfare, Progress of the ratification of the UN Convention on the Rights of Persons with Disabilities, available at: http://www.lm.gov.lv/text/823, [last accessed on 09.11.2009]

[189] Information about the Ministry of Welfare NCDPA and minutes of the meetings are available at the Ministry of Welfare website, available at: http://www.lm.gov.lv/text/563, [last accessed on 09.11.2009]

[190] Minutes of the meetings are available at the Ministry of Welfare website, available at: http://www.lm.gov.lv/text/746, [last accessed on 09.11.2009]

[191] Information about cooperation between the Ministry of Health and NGOs is available at the website of Ministry of Health, available at: http://www.vm.gov.lv/index.php?id=527&top=92#SK, [last accessed on 09.11.2009]

[192] Approved by the Cabinet of Ministers on 6 August 2008, available at: http://polsis.mk.gov.lv/view.do?id=2753, [last accessed on 09.11.2009]

includes representatives from 20 disabled persons' organisations in Riga.

However, despite the efforts of ministries as well as state and municipal institutions to develop a dialogue with civil society, to date there has been a lack of systematic cooperation with psychiatric service users' organisations, and policymakers have not conducted regular studies of the needs of psychiatric service users and of their level of satisfaction with available services. The only quantitative users' needs assessment conducted up to now[193] was performed by the Latvian Centre for Human Rights, which published a study in 2006, reflecting the opinions of psychiatric service users about human rights issues as well as the availability, accessibility and quality of health and social care services. The study also provided recommendations regarding the involvement of psychiatric service users in policy planning and making.

Unfortunately, compared with the summer of 2005, when the aforementioned study was conducted, psychiatric service users' organisations are still only few and weak. Therefore, RC "ZELDA" is trying to increase the capacity of such organisations by holding regular discussions, at which views are exchanged about mental health issues and training is provided on matters of interest to psychiatric service users.[194] This collaboration with psychiatric service users' organisations also provides RC "ZELDA" with additional information about daily problems experienced by psychiatric service users.

Since 2004, the most active people with intellectual disabilities from various day centres and social care institutions have been joined in the Latvian Self-Defence movement, with support given to its members by the support person.

Cooperation between service providers

Another problematic area is cooperation between various service providers, which can often impact on a service user's quality of life. There have been some good projects where local governments and mental health care providers have sought cooperation with other service institutions, on their own initiative. For example, in autumn 2004 the Cēsis District Council cooperated with the Vecpiebalga Psychiatric hospital, with funding from the Soros Foundation-Latvia and the Open Society Institute, in order to create the Vidzeme Social Integration Program for People with Mental Disabilities.[195] Under the auspices of the Programme, cooperation was boosted between mental health and social care service providers in eight districts of Vidzeme. For example, a database of service providers in Vidzeme was set up.

Cooperation between seven psychiatric hospitals and branches of the State Employment Agency was also developed under the Riga Psychiatric and Narcology Centre's EQUAL Project "Integration of People with Mental Disturbances and Psychiatric Illnesses into the Labour Market," implemented in 2005-2007. However, it has been difficult to continue all these initiatives after the end of the projects' funding because the projects lacked follow-up financial support.

The lack of an information database available to all on support and social integration opportunities for people with mental disabilities was mentioned at a meeting organised by the Public Health

[193] Ieva Leimane-Veldmeijere, Uldis Veits, Needs Assessment of Users of Mental Health Care Services, Riga: Latvian Human Rights Centre, 2006, http://www.humanrights.org.lv/html/news/publications/index.html?yr=2006, [last accessed on 09.11.2009]

[194] For example, in 2008 RC "ZELDA" in collaboration with the Latvian Initiative Group on Psychiatry organised a three-day summer camp for users devoted to alternative therapies (art, music, dance and movement and drama therapies), while in 2009 RC "ZELDA" held two training seminars/discussions with users regarding the UN Convention on the Rights of Persons with Disabilities.

[195] Cēsis District Council, Vecpiebalga Psychiatric hospital, Vidzeme Social Integration Program for People with Mental Disabilities, 2004, available at: http://www.humanrights.org.lv/html/lv/jomas/28800.html, [last accessed on 09.11.2009]

Agency on 18 December 2009, to discuss support options for people with mental disabilities and their families. The participants in the meeting also stated that such an informative database would also be of use to psychiatrists by providing more options for informing the family members of patients. As a result of this discussion, in early 2009 the website of the now-defunct Public Health Agency (the archives of which are currently available at the address http://sva.vi.gov.lv/lv/garigaveseliba) created a list of mental health care service providers. However, this needs to be regularly updated, and both service recipients and providers should be informed about its existence.

Conclusions

1. Although there are some good examples of cooperation between ministries and disabled persons' organisations, these organisations are not involved in significant decisions affecting changes to mental health or social care policies for psychiatric service users.

2. Due to a lack of inter-sectoral cooperation, service providers are often not informed about services required by a particular client, which are offered by other institutions.

3. Psychiatric service users' organisations lack the resources and capacity to defend their interests.

Recommendations

1. Organisations defending the rights of people with mental disabilities must be involved in the decision-making on mental health and social care policies.

2. In implementing changes to mental health or social care policies, it is essential that periodic evaluations are made of the needs of people with mental disabilities and their satisfaction with the availability and quality of services.

3. It is recommended that local governments establish a database of mental health and social care service providers, including support groups, which is available to both - sector specialists and service users.

4. It is essential to continue increasing the advocacy capacity of organisations defending the rights of people with mental disabilities, to expand their knowledge on human rights issues and raise their skills in fighting against stigma and discrimination.

9. CREATION OF A SUFFICIENT AND COMPETENT WORKFORCE

The framework policy document "*Improvement of Inhabitants' Mental Health for 2009-2014*"[196] developed by the Ministry of Health finds that currently, mental health care is mainly oriented towards treatment and care for persons with mental and behavioural disorders. At present, the functions of the mental health care services revolve around the treatment of mental and behavioural disorders in acute cases in hospital wards and day care inpatient facilities in a small number of cases. State-funded services are provided to inhabitants with severe psychotic and behavioural disorders such as schizophrenia, organic psychotic disorders, mental retardation and severe depression, but

[196] Approved by the Cabinet of Ministers on 6 August 2008, available at: http://polsis.mk.gov.lv/view.do?id=2753, [last accessed on 09.11.2009]

the quality of state provided and funded services do not meet international standards. Work for the promotion of mental health, prevention of psychiatric disorders and rehabilitation is insignificant. At present Latvia does not have significant mental health care facilities where patients can be treated and rehabilitated with the aim of returning them to society. However, patients' rehabilitation is performed within the bounds of possibility in psychiatric hospitals. The rehabilitation, organisation of life and integration into society of mental health care users is also performed by social care institutions, but their main function is providing clients with places to live. Outpatient assistance is mainly carried out by psychiatrists and psychiatric nurses and consists mainly of dispensing medications. The offered state-funded services are not suitable for patients with less severe mental conditions and are, therefore, usually provided by mental health care specialists in private practice (psychiatrists, psychotherapists, psychologists, etc.).

At the end of 2008, there were eight psychiatric hospitals in Latvia providing mental health care, of which there was one children's psychiatric hospital; one children's psychiatric ward in a general hospital in Riga; three day inpatient facilities attached to psychiatric hospitals; one community-based mental health care centre in Riga; one community-based mental health centre attached to a primary health care centre in Riga; four outpatient facilities attached to specialised psychiatric hospitals (including children's care); one outpatient children's facility attached to a regional general hospital in Riga; 23 psychiatrists' offices attached to local governments' primary care centres (including children's care); and 61 psychiatrists' private practices, of which 16 had state funding for health care services. Inpatient psychiatric assistance for prisoners is provided by the Latvian Prisons' hospital, which has 30 psychiatric beds.

From 1998 to 2006, the average time spent for treatment in a psychiatric bed has fallen from 66 to 56 bed days, while over the same period the number of psychiatric hospital beds has been cut by 28.2%, (from 4,371 to 3,139 beds), according to the framework policy document "*Improvement of Inhabitants' Mental Health for 2009-2014*". This indicates that the psychiatric beds and human resources in hospitals is being used more efficiently, but still almost 15% of hospital beds in Latvia are psychiatric beds. This is a disproportionately high number of beds for one patient group and indicates the high level of institutionalisation in psychiatric care and the possible use of inpatient psychiatric resources for social objectives.

There is a range of policy documents directly or indirectly connected with mental health which will facilitate change towards the rational, effective development of the mental health care sector, improvement in the usage of human and other resources and better quality of services. There has been a shift in mental health care policy documents produced in recent years, urging a shift from institutional to community-based care, and from treating psychiatric disorders to prevention and reducing the impact of factors causing the disorders.

The number of professional psychiatric service providers has risen very slowly in recent years. Treatment and diagnosis are performed by psychiatrists, while social workers provide social support. Only one community-based mental health centre, an outpatient psychiatric assistance centre in Riga, has been opened up to date in Latvia, and there is also just one community-based mental health care service integrated into primary health care centre in Riga. These provide clients with multidisciplinary assistance, including determining of the client's needs and close cooperation between psychiatrists, psychiatric nurses, social workers and occupational therapists. Multidisciplinary teams ensure that patients receive qualitative, cost-effective assistance and that they can be reintegrated into society as soon as possible. The framework policy document "*Improving Inhabitants' Mental Health for 2009-2014*" found that only 17% of Latvia's residents have access to such care, and it is used by 10% of patients who are under state psychiatric care. A significant deficiency is that such community-based mental health care is not available outside of

Riga. Although the WHO recommends using multidisciplinary teams for providing mental health care, at present the personnel do not have the required level of skills to implement this advice. This situation has been further worsened by the current economic crisis.

Human resources play an important part in providing inhabitants with qualitative mental health care services, including the selection of specialists, their qualifications, sufficient numbers and rational disposition. A psychiatrist, a psychiatric nurse and an assistant nurse are the main persons involved in the psychiatric treatment process. Psychologists are mainly concerned with diagnostic methods. At present, Latvia has an insufficient number of social workers, occupational therapists and assistant nurses for maintaining for providing mental health care assistance. The number of occupational therapists working in Latvian psychiatric hospitals was two in 2002, four in 2004, and seven in 2006. There has been virtually no change in the number of psychiatrists, and this is the minimum the country requires to maintain mental health care at the present level. Although there has been a rise in the number of psychiatric nurses in recent years, there are still not enough of them.

According to the statistical year book *Psychiatric Health Care in Latvia in 2007*[197] published by the Public Health Agency in 2008, the number of adult and child psychiatrists and psychiatric nurses per 10,000 inhabitants was the following:

Speciality	2003	2004	2005	2006	2007
Adult psychiatrists	1.03	1.04	1.07	1.13	1.00
Child psychiatrists	0.03	0.06	0.09	0.10	0.20
Medical personnel with mid-level medical qualifications	3.4	3.5	3.7	3.8	3.5

The table shows that the number of psychiatrists and mid-level medical personnel per 1,000 inhabitants has been falling since 2007. Considering that over the last decade, Latvia's population has been declining by an average of 12,000 persons per year, this decline in the numbers of psychiatrists and nurses is significant. Given the current economic situation, due to a lack of funding, further reductions in the numbers of mental health care specialists can be expected in the next few years, and there is little hope for improvement in the situation. Given the difficult economic times, it is problematic merely to maintain existing human resources, improve competence and train and employ new specialists. The implementation of earlier mental health policy documents is under threat, covering reforms such as deinstitutionalising mental health care, introducing multidisciplinary teams, expanding alternative care options, developing community-based care, and including various types of rehabilitation services in state psychiatric inpatient facilities, as well in outpatient and social care services.

The Ministry of Health has developed the framework policy document *"Development of Human Resources in Health Care"*,[198] approved on 18 May 2005, by Cabinet of Ministers' Order No.326. The objective of the framework policy document is to provide inhabitants with qualitative health care services and to achieve effective usage of health care resources. The framework policy document

[197] Available at: http://sva.vi.gov.lv/files/anglu%20valoda/mental_health_care_2007_lv.pdf, [last accessed on 09.11.2009]

[198] Framework policy document "Development of Human Resources in Health Care", available at: http://phoebe.vm.gov.lv/misc_db/web.nsf/bf25ab0f47ba5dd785256499006b15a4/17cb8c1218bf81cdc2257313001f391a/$FILE/cilvekresursi.pdf, [last accessed on 09.11.2009]

identifies as the main problems: a lack of human resources, the uneven distribution of human resources across the country and deficiencies in the education system, meaning that growing demands for human resources are not being met and remuneration for existing health care personnel is inadequate. In order to implement the framework policy document, the Ministry of Health has prepared the Programme *"Development of Human Resources in Health Care for 2006 – 2015",*[199] which was approved by the Cabinet of Ministers in 2006 and anticipates a significantly increasing number of medical personnel and optimising their distribution between inpatient, outpatient and emergency care services. In light of the current economic situation, it is doubtful whether the provision for increasing the number of medical personnel (including mental health care specialists) in the human resources sections of the framework policy document and Program will be implemented over the next few years.

Despite the fact that there are not enough mental health care specialists, the education and suitability for practical work of psychiatrists and other mental health care specialists can be considered to be qualitative and appropriate. In Latvia, the core study programs for doctors are prepared by *Rīga Stradiņš University*[200] and the *Faculty of Medicine at University of Latvia.*[201] The implementation of medical study programs involves many factors, including changes to laws and regulations, licensing, accreditation for study programs, funding, efficient management of universities, etc. The framework policy document "Development of Human Resources in Health Care" finds that, due to the specific nature of medical study programs, students take part in the therapeutic process and 60% of studies are held outside of the universities in medical care institutions which are accepted as clinical bases. The study programs utilise the resources, treatment and diagnostic equipment available in medical care institutions. The linkage between the study program and practical work is also demonstrated through the fact that lecturers are involved in both teaching and research, in addition to being certified medical practitioners who actively practice medicine.

After completing the core study program, specialists in psychiatry are trained in a state-funded residency programme. The residents' training programme[202] in psychiatry runs for four-years and involves both lectures and practical sessions covering narcology, neurology, psychotherapy and other specialities. Every year, around four (three to five) residents graduate from the psychiatry resident program, and then they are posted by the state to workplaces. The assignment of residents is the responsibility of the Ministry of Health and is performed on the basis of set criteria.

To ensure that health care specialists in other disciplines have basic knowledge of mental health care and psychiatry and are able to deal with mental health issues, training in psychiatry is included in resident training programs for other specialisations. For example, narcology residents study psychiatry for two years; general practice residents undergo one month of psychiatry training, while resident programs for speech therapists, occupational therapists and public health specialists include five lectures (ten hours), eight classes (32 hours) and practical sessions devoted to psychiatry. Rīga Stradiņš University's Faculty of Rehabilitation runs bachelor and masters Social Work Study Programs including 14 days of training in clinical psychiatry, consisting of five lectures (ten hours), ten classes (50 hours) and e-learning materials.

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[199] Programme "Development of Human Resources in Health Care for 2006 – 2015", available at: http://phoebe.vm.gov.lv/misc_db/web.nsf/626e6035eadbb4cd85256499006b15a6/a0ef02442cc7b54cc225748800293375/$FILE/VMprogramma.doc, [last accessed 09.11.2009]

[200] Rīga Stradiņš University Studies Programme, available at: http://www.rsu.lv/studiju-iespejas/studiju-programmas/medicina, [last accessed on 09.11.2009]

[201] University of Latvia, Faculty of Medicine, available at: http://www.lu.lv/fakultates/medicinas-fakultate/, [last accessed 09.11.2009]

[202] Resident training programme, available at: http://www.rsu.lv/studiju-iespejas/studiju-programmas/rezidentura-medicina, [last accessed on 09.11.2009]

General practitioners can broaden their knowledge of psychiatry through courses at Rīga Stradiņš University's Faculty of Continuing Education. The course program includes lectures and practical work for one week per month, six months per year. Every year around 50-60 GPs attend these courses. In addition, GPs can broaden their knowledge of psychiatry and mental health issues through lectures held by the Latvian General Practitioners' Association[203] and the Latvian Rural General Practitioners' Association, where lectures of various aspects of psychiatry are presented by teaching staff from Rīga Stradiņš University's Department of Psychiatry and Narcology and other competent specialists with teaching credentials. The Latvian Doctors' Association[204] holds regular (five times per year) interdisciplinary conferences in which mental health care specialists present lectures.

Professional education in health care includes both theoretical and practical preparation for productive professional work, and includes obtaining professional qualifications and improving knowledge and skills by the bachelors and masters programs offered by Rīga Stradiņš University's Faculty of Nursing.[205] Most existing mid-level medical personnel have gained their medical education at medical schools. In 2004, the medical schools were reorganised as medical colleges, and these institutions were transferred from under the auspices of the Ministry of Health, to the Ministry of Education and Science. Well-trained, skilled and hard working mid-level medical staff play a vital role in mental health care, but in recent years there has been a continuing decline in the prestige of these professions. This might threaten the ability to provide qualitative mental health care in the near future due to a lack of mid-level personnel. The current proportion of 1:3.5 psychiatrists to mid-level medical staff involved in psychiatry, is satisfactory compared with other sectors, but due to the specific nature of mental health care the number of nurses should be increased. The additional mental health care training of mid-level personnel, which is organised by the Latvian Nurses' Association's Union of Psychiatric Nurses,[206] which attracts lecturers and runs courses and practical sessions on mental health subjects, is of great importance. To ensure the provision of qualitative mental health care, the Latvian Nurses' Association's Psychiatric Nurses' Certification Committee evaluates the knowledge and practical skills of nurses and issues relevant certificates.

An important means for improving the knowledge and skills of mental health care specialists and service providers is further education, which is the continuation and deepening of previously acquired education in accordance with the requirements of the particular profession. The content of continuing education is currently influenced by the labour market's demands, professional organisations and general requirements for medical personnel (communication skills, management, IT, legal, pedagogical, economic aspects, etc.). In accordance with legal requirements, continuing education providers must be accredited educational institutions, teaching medical care institutions or professional organisations. Continuing mental health care education is provided by Rīga Stradiņš University's Faculty of Continuing Education through the Department of Psychiatry and Narcology. Continuing education is supervised by the Ministry of Health and the Ministry of Education and Science. There is inadequate monitoring and coordination of continuing education, which takes the form of courses, seminars, distance learning, e-studies, etc. run by various bodies and organisations.

Teaching staff at Rīga Stradiņš University's Department of Psychiatry and Narcology teach basic study courses, hold resident training programs, present lectures and prepare informative materials.

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[203] Latvian General Practitioners' Association, available at: http://www.lgaa.lv/, [last accessed on 11.11.2009]

[204] Latvian Doctors' Association, available at: http://www.arstubiedriba.lv/, [last accessed on 11.11.2009]

[205] Nursing studies programme, available at: http://www.rsu.lv/studiju-iespejas/studiju-programmas/maszinibas, [last accessed on 09.11.2009]

[206] Available at: http://www.masas.lv/page.php?id=124, [last accessed on 09.11.2009]

They base their work on information and literature available throughout the world and improve their knowledge at international congresses and conferences. Each lecturer and professor in the department makes on average of three or four visits annually to congresses and conferences featuring workshop activities. In recent years, there has been regular exchange of knowledge and cooperation between the staff of Rīga Stradiņš University's Department of Psychiatry and Narcology and Bayreuth University Psychiatry and Psychotherapy Clinic[207] in Germany. There is also additional education provided in the sphere of psychotherapy, thanks to cooperation between the Latvian Psychiatrists' Association and the French professional association "The Field of Freud."

In addition to the aforementioned education and training opportunities for mental health care personnel, the RSU Department of Psychiatry and Narcology in cooperation with pharmaceuticals' producers has developed guidelines and other informative materials for general practitioners and other specialists for improving their practical work on relevant mental health care and psychiatry issues. In recent years, the following guidelines and informative materials have been prepared and distributed to specialists for practical work: "Bipolar affective disorders, clinic and treatment", developed in 2005; "The clinic of schizophrenia and treatment", developed in 2006; "Depressive disorders and their treatment", developed in 2008; "The course of depression and treatment possibilities", developed in 2009; "Practical psych-pharmacotherapy", developed in 2009.

The maintenance and improvement of mental health requires that specialists and service providers demonstrate both - professional and humanitarian qualities, such as responsiveness, tolerance and communication skills. Professional skills are improved by the regular exchange of knowledge and experience between the sector's professionals. Professional associations play an important role in maintaining skills and work's quality. They organise conferences, seminars, courses, and lectures where participants receive new information and handout materials and opinions and experiences are shared. An important task for professional associations is evaluating the compliance of specialists' knowledge and skills with professional standards, for which medical staff receive certificates from the Latvian Doctors' Association. Mental health care specialists have established many professional associations. The most important of these are the Latvian Psychiatrists' Association,[208] the Latvian Children's Psychiatrists' Association and the Latvian Psychotherapists' Association.[209] Specialists who work in multidisciplinary teams take part in interest groups organised by the Latvian Occupational Therapists' Association and the Latvian Physiotherapists' Association. Some mental health care specialists who require additional specific knowledge and skills for resolving issues relating to being expert witnesses, or being involved in health care situations of combined illnesses have formed the Forensic Psychiatry and Gerontology sections of the Latvian Psychiatrists' Association. The Rural Psychiatrists' Section has been established as a sub branch of the Latvian Psychiatrists' Association and concerns itself with mental health care in Latvia's small towns and rural areas. The Latvian Private Practice Psychiatrists' Union has also begun working.[210]

Mental health care specialists educate the public through radio and press interviews and take part in television programs in order to highlight the importance of mental health and in ascertaining and in averting risk factors for various psychiatric disorders.

In 2009, the Ministry of Health established a national institution of chief specialists, including the most responsible person in the field of mental health policy. It is anticipated that cooperation

[207] RSU in cooperation with Bayreuth Psychiatry and Psychotherapy Clinic, available at: http://www.rsu.lv/par-rsu/vesture-un-tradicijas/doctor-honoris-causa, [last accessed on 11.11.2009]

[208] Latvian Psychiatrists' Association, available at: http://www.psihiatru-asociacija.lv/index.php/lv/sertifikacija/, [last accessed on 09.11.2009]

[209] Latvian Psychotherapists' Association, available at: http://www.lpta.lv/, [last accessed on 09.11.2009]

[210] Latvian Private Practice Psychiatrists' Union, available at: http://www.privatpsihiatrija.lv/public/, [last accessed on 11.11.2009]

between the chief specialist on mental health issues and a representative on mental health from the Ministry of Health Strategy Council will significantly affect, and will speed up, the resolution of mental health problems in Latvia.

Conclusions

1. The developed mental health care policy documents acknowledge the advantages of the interdisciplinary approach, teamwork and community-based alternative forms of care, and indicate a readiness to introduce these forms of care and attract the necessary specialists to fulfil this task.
2. Training programs and continuing education courses provide general practitioners with opportunities to improve their overall knowledge and gain additional knowledge about mental health and mental health care.
3. The education of fully qualified and trainee staff is planned in conjunction with educational institutions, but the recession is threatening both existing education funding and future professional employment opportunities for graduates.
4. The distribution of residents is within the competency of the Ministry of Health.
5. Both university staff and medical care institution specialists with teaching credentials are involved in training and educating mental health care personnel.
6. In order to guarantee the quality of the education process, much attention is focussed on improving constantly the knowledge and skills of medical care institution specialists with teaching credentials.
7. Professional associations and their branches are dedicated to increasing the capacity of specialists, highlighting specific mental health care and expertise-related issues.

Recommendations

1. Ensure optimal use of available financial resources for developing human resource policy in a logical manner.
2. Motivate young specialists to provide health care services in regions where they are most needed.
3. Inform, motivate and raise interest of nurses, occupational therapists, physiotherapists, social care workers and other members of multidisciplinary teams about the possibility of reorienting their work to mental health care.
4. Continue developing informative and educational materials related to mental health for both professionals and the general public.

10. ACCESS TO INFORMATION AND DATA ON MENTAL HEALTH

Until 1 October 2009, the acquisition, summarising, processing and analysis of public health and health care statistical information were performed by the National Agency for Health Statistics and Medical Technologies. The Agency also gathered data on mental health. By a governmental decision[211] the National Agency of Health Statistics and Medical Technologies has been closed down, and its functions have been taken over by the Health Economics' Centre.

[211] Cabinet of Ministers' Order No. 509 of 29 July 2009 "On the reorganisation of state administrative institutions under the supervision of the Ministry of Health", http://www.vsmtva.gov.lv/, [last acccessed on 11.11.2009]

Latvia implements its international commitments in the field of health care statistics and provides the World Health Organisation, Eurostat and other institutions with necessary information. Historically, there has been a register of patients with specific illnesses in Latvia (part of the national information system), which contains data about patients with specific illnesses.[212] A similar register contains information about patients with mental and behavioural disorders. It contains information about:

1. the number of patients undergoing treatment in outpatient psychiatric facilities, hospital outpatient and inpatient wards and who are diagnosed for the first time with:
    a) organic mental disorders (also symptomatic);
    b) schizophrenia, schizotypical disorders;
    c) (affective) mood disorders;
    d) neurotic, stress related and somatoform disorders;
    e) adult personality and behavioural disorders;
    f) mental retardation, intellectual developmental disorders;
    g) behavioural and emotional disorders that have begun in childhood and teenage years;
2. the number of patients diagnosed for the first time with the disability group;
3. the number of patients hospitalised for attempted suicide;
4. patients, who are dangerous to society, characterisation of the danger to society if the patient is dangerous to the society or if information about the patient's health creates suspicion that the patient might be dangerous to society;
5. the number of patients subjected to compulsory measures of a medical nature;
6. information on factors and problems that can influence patients' health status and care.

Inpatient and outpatient medical treatment institutions and doctor's practices provide the necessary information for the creation, expansion and maintenance of the register. Each patient's personal information (first name, surname, identity number, declared domicile and actual domicile) is kept encoded in the data processing system separately from the rest of the information in the register. The link between the patient's personal information and the rest of the information enclosed in the register is encoded. The supervisor of the register was previously the National Agency for Health Statistics and Medical Technologies, and since 1 October 2009, is supervised by the Health Economics' Centre.

The attitude towards the register in society and among patients is ambiguous, because, on the one hand it provides information about the situation on mental health in Latvia, while on the other hand, persons with mental health problems often avoid seeing a doctor because they do not wish that information about their problems is sent to the register.

Although a wide range of information on mental health is available, information about involuntary admission and treatment is still not gathered systematically. Since 2001, the year book *Mental Health Care* has been published annually based on the gathered data. In different periods the Psychiatric Centre, the National Agency of Mental Health and the Public Health Agency have published it. The handbook analyses available data on mental health care in Latvia.

Conclusions:

1. A system of mental health data collection and distribution has been established in Latvia, which is based on international, standardised and comparable results.

[212] The Register is governed by Cabinet of Ministers' Regulation No. 746 of 15 September 2008 "Procedures for the creation, improvement and maintenance of a register of patients with specific illnesses," http://www.likumi.lv/doc.php?id=181288&from=off, [last accessed on 11.11.2009]

2. The compliance of gathered data with the real situation is in doubt, because many patients avoid giving their data to the official data registration sources because of stigmatisation fears.

Recommendations:

1. Data collection mechanisms must be improved by ensuring more precise data collection on the situation in mental health care.
2. It is necessary to collect data on the number of people admitted and treated involuntarily.
3. It is necessary to provide access to information on mental health, particularly emphasizing the issue of stigmatisation and the prevalence of mental illnesses in society.

11. PROVISION OF APPROPRIATE FUNDING

In 2002, 6% of state health spending was shifted to mental health and 80% of this went to psychiatric hospitals,[213] but in 2008, 5.9% of the state health care expenses were channelled to mental health and 74% of this went to psychiatric hospitals.

The proportional decrease of inpatient funding can be explained by an increase in outpatient medication financing, but overall the bulk of resources is still channelled to inpatients. If state guaranteed loans to psychiatric hospitals were added in, it could be said that the situation has not changed significantly and the institutional care model is still dominant. Alternative ways of providing and financing services are still in evolution.

According to data of State Compulsory Health Insurance Agency,[214] on medications reimbursed by the state were spent:

- 9.54% of all resources in 2006, thus providing medications to 17,509 patients in amount of 4,243,376.15 lats (6,037,780 Euros) or approximately 242.35 lats (345 Euros) per patient;
- 7.94% of all resources in 2007, thus providing medications to 18,130 patients in amount of 5050,910.51 lats (7186,798 Euros) or approximately 282.84 lats (402 Euros) per patient;
- 6.35% of all resources in 2008, thus providing medications to 19,142 patients in amount of 4,883,084.59 lats (6,948,003 Euros) or approximately 255.10 lats (363 Euros) per patient.

The largest amount of prescribed medication (83% of the total) went to patients with:
blood circulation illnesses – 2,813,427 prescriptions;
endocrinal, dietary and digestive illnesses – 644,600 prescriptions;
mental and behavioural disorders – 319,130 prescriptions.

The largest amount of funding for reimbursed medications in 2008 was used for:

1. the treatment of blood circulation illnesses – 18,461,790.54 lats (26,268,760 Euros);
2. the treatment of endocrinal, dietary and digestive illnesses – 14,226,034.14 lats (20,241,822 Euros);
3. the treatment of tumours – 9,772,983.60 lats (13,905,702 Euros);
4. the treatment of nervous system illnesses – 5,343,505.70 lats (7,603,122 Euros);
5. the treatment of mental and behavioural disorders – 4,934,192.72 lats (6,968,804 Euros) or 6.35% of the total (9.54% in 2006 and 7.94% in 2007).

In 2008, the state paid 1,664,363 lats (2,368,175 Euros) for outpatient psychiatric consultations,

[213] WHO AIMS report on the Mental Health care System in Latvia, Riga, 2006, p 11.
[214] State Compulsory Health Insurance Agency Gazette No. 17, available at: http://www.voava.gov.lv/files/VOAVA_Vestis_Nr_17_par_2008_gadu.pdf, [last accessed on 11.11.2009]

which is 1.17% of all spending on outpatient healthcare services. In the diagnosis group "Mental and Behavioural Disorders", 28.53% of visits, according to initial diagnosis, were made to GPs and 71.47% to specialists in 2008.

In 2008, 9.5% of total resources allocated for outpatient services was spent on psychiatric treatment, and 7.26% of all patients in inpatient facilities were psychiatric patients (in 2007 this figure was 8.58%). Spending in 2008 was 21,623,903 lats (30,768,042 Euros), compared with 16,459,137 lats (23,419,242 Euros) in 2007. In 2008, 35,656 patients received state funded outpatient treatment. By comparison in 2008, 9.67% (22,002,528 lats – 31,306,776 Euros) of all resources was spent on invasive cardiology, covering 1.9% of all patients receiving inpatient treatment. Haematology and oncology received 6.82% (15,526,503 lats – 22,092,223 Euros) of total resources, covering 5.21% of all patients receiving inpatient treatment.

Schizophrenia was the eighth most commonly treated disorder in 2008, with 6,934 patients (5,606 patients in 2006, 6,297 in 2007), and also had the largest number of bed days. Mental disorders take the first five places among diagnoses with the longest average treatment duration. Furthermore, schizophrenia is the second most expensive diagnose with 11,213,311 lats (15,955,104 Euros) spent on inpatient treatment in 2008 (4,978,437 lats (7,083,677 Euros) in 2006, and 8,855,841 lats (12,600,726 Euros) in 2007).

Since 2005, mentally ill persons have been exempted from patient payments when receiving state-funded psychiatric treatment.[215] Psychiatric expenses are completely covered by the state and are free of charge for the patient. This applies to cases where the primary diagnosis of the patient is a mental illness, but does not apply to cases if the patient needs different help, for example a surgical consultation. The patient has to pay the full patient payment for the surgical consultation. However, should the patient belong to another category that does not have to pay patient payments, (for example if the patient is under the care of a state social care home or local government's elderly home, or he or she has the status of low-income as defined by laws and regulations), the other specialist services for this person is covered by the state in the full amount, from 1 October 2009.[216]

The state does not pay for psychotherapeutic and psychological help (except assistance provided in psychiatric wards or specialised hospitals, treatment in drug and alcohol rehabilitation programs and outpatient palliative care for children). Although the state does not pay for specialist home visits, one of the two exceptions to this rule is state-funded psychiatrist's home visits to psychiatric patients chosen by the psychiatrist.

Although Latvia's healthcare system is based on a network of GPs who "open the gates" to secondary health care, a person can turn directly to a psychiatrist if he or she has a mental illness (diagnose codes in accordance with ICD-10: F00-F09; F20-F62; F63.1-F99).

The cost for the psychiatrist for an appointment of is 2.49 lats (3.54 Euros) and 4.28 lats (6.08 Euros) for a children's psychiatrist. The tariif for other specialists ranges from 2.22 lats (3.16 Euros) to 3.04 lats (4.29 Euros). An additional 5 lats (7.11 Euros) for the patient's payment has to be added to this sum, which is reimbursed to the doctor by the state and is free for the patient, thus the total fee the state pays to the psychiatrist for one appointment is 7.49 lats (10.66 Euros).

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[215] Cabinet of Ministers' Regulation No. 1046 of 19 December 2006, "Procedures for organising and funding", Paragraph 10, http://www.likumi.lv/doc.php?id=150766&from=off, [last accessed on 09.11.2009]

[216] Up to 1 March 2009 persons with low-income were exempted from patient payments. Due to a decline in state budget revenues, from 1 March 2009 to 1 October 2009 persons with low income also had to pay 50% of the patient's payment set by the state.

In 2006, seven medical treatment institutions and Rīga Stradiņš University received state guaranteed loans for the development of the services provided by these institutions. These state guaranteed loans totalled 73,290,000 euros, or 51.5 million lats. The following psychiatric hospitals were among the treatment institutions that received state guaranteed loans:

1. State Ltd. "*Ģintermuiža* hospital" received approximately 10 million lats (14.23 million Euros),
2. State Ltd. "Streči Psychiatric hospital" – approximately 1.8 million lats (2.56 million Euros),
3. State Ltd. "Ainaži Psychiatric Children hospital" – approximately 1.2 million lats (1.7 million Euros),
4. State Ltd. "Daugavpils Psychiatric hospital" – approximately 10 million lats (14.23 million Euros),
5. State Ltd. "Aknīste Psychiatric hospital" – approximately 3.3 million lats (4.7 miilion Euros).[217]

The Riga Psychiatry and Narcology Centre also received a state guaranteed loan of 18.5 million lats (26.32 million Euros). Psychiatric hospitals have received state guaranteed loans totalling 44.8 million lats (63.74 million Euros) since 2006.

Funding for non-institutional care is also important. An allowance of 100 lats (142.28 Euros) per month was introduced on 1 January 2008, for caring for a disabled person, and the amount of the allowance for a disabled child was raised from 50 lats (71.14 Euros) to 150 lats (213.43 Euros) per month.[218] Psychiatrists working in hospitals have indicated that these allowances encourage patients' relatives to take care of these patients outside institutions and reduce the need for hospitals and social care institutions.

Conclusions:

1. The proportion of mental health care funding compared to total state funding of health care is decreasing.
2. Most of the resources are being channelled to inpatient healthcare.
3. Huge investments have been channelled to the development of inpatient facilities, while funding for alternative, community-based care services is insufficient.
4. People with the most severe problems and from the poorest parts of society receive relatively the largest privileges, because people with mental illnesses do not have to pay the patient's co-payment or patient's charges for other healthcare services. However, the threshold to receive the status of low-income is very low.
5. The development of community-based services has virtually stopped.

Recommendations:

1. It is necessary to channel proportionally more funding to outpatient and community-based mental health services.
2. It is necessary to maintain patients' access to existing reimbursed medications.
3. Funding for mental health promotion measures should be provided.

[217] Several medical institutions will receive state-guaranteed loans, 2006.09.26, information available at: http://www.vm.gov.lv/?id=122&sa=121&top=121&rel=1704, [last accessed on 09.11.2009]

[218] Ministry of Welfare, Public report of 2008, available at: http://www.lm.gov.lv/upload/gada_parskats/publ_parskats_2008_4_1.doc.pdf, [last accessed on 09.11.2009]

12. EVALUATION OF THE EFFICIENCY AND THE CREATION OF NEW EVIDENCE

In 2004, the National Mental Health Agency was created by reorganising the Riga Psychiatry Centre. In addition to outpatient and inpatient treatment for psychiatric patients, the Agency had to develop methodical recommendations for the treatment and diagnosis of mental illnesses and behavioural disorders, produce informative and consultative support on mental health care issues for state institutions, conduct research in the field of mental health, ensure cooperation with mass media and international representatives from the mental health care field, and ensure the clinical basis for the training of specialists in different treatment sectors in the field of mental health.[219]

On 1 March 2007, the National Mental Health Agency was again reorganised as the Riga Psychiatric and Narcology Centre Ltd.[220] The regulation on reorganization stipulated that the state agency - Public Health Agency (under the supervision of the Ministry of Health) - should take over functions from the National Mental Health Agency in the following fields:

1. creation, development and coordination of interdisciplinary information and the monitoring system in the field of mental health care;
2. development of methodological recommendations for the treatment and diagnosis of mental illnesses and behavioural disorders;
3. administration of the state mental health care program.

The Public Health Agency was closed down on 1 September 2009.[221] The Agency's functions, which were connected with the implementation of public health promotion policy, development of the health promotion program and implementation of methodological administration, has been taken over by the Ministry of Health; illness supervision (excluding infectious illnesses), supervision of environmental factors that cause illness and supervision of the implementation of health promotion at the regional level has been taken over by the Health Inspectorate; methodological support to treatment institutions on clinical guideline implementation issues and monitoring of public health have been taken over by the Health Economics' Centre.

Doctors are trained at two universities in Latvia – Rīga Stradiņš University and the University of Latvia. Rīga Stradiņš University has created a separate Psychiatry and Narcology Department. Professors Raisa Andrēziņa, Elmārs Rancāns, Māris Taube, Elmārs Tērauds and others are active in the research and publication of results of psychiatric issues.

Latvia's psychiatrists are united in a professional association. Professor H.Buduls created the Latvian Association of Psychiatrists and Neurologists in 1924. It operated until 1940 and was renewed in 1947. It later added neurosurgeons and then split off in 1989 as the Scientific Association of Latvian Psychiatrists and Narcologists, uniting 481 colleagues. The Latvian Psychiatrists' Association replaced it in 1990.[222] It regularly organises scientific conferences and provides cooperation in the exchange of information about the latest scientific developments in the field of mental health by cooperating with foreign professional associations.

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[219] Cabinet of Ministers' Regulation No. 186 of 15 March 2005 "Bylaws of the State Mental Health Agency," available at: http://www.likumi.lv/doc.php?id=103989&from=off, [last accessed on 09.11.2009]

[220] Cabinet of Ministers' Order No. 54 of 18 January 2007 "On the reorganisation of the State Mental Health Agency," available at: http://www.likumi.lv/doc.php?id=151747, [last accessed on 09.11.2009]

[221] Cabinet of Ministers' Order No. 509 of July 29, 2009 "On the reorganisation of state administrative institutions under the supervision of the Ministry of Health," available at: http://www.likumi.lv/doc.php?id=195595&from=off, [last accessed on 09.11.2009]

[222] Prof. Arnis Vīksna, The roots of psychiatry in Latvia, available at: http://www.psihiatru-asociacija.lv/index.php/lv/psihiatrija-latvija/, [last accessed on 09.11.2009]

Research in the field of mental health care has been conducted in Latvia, including assessment on other policies which are not linked to the sphere of health, but have the potential to improve mental health. For example, as a response to the World Health Organisation's report on violence and health (World Report on Violence and Health 2002), Latvia developed a report on violence and health[223] in 2007, where a more active participation by the health care sector in the fight against violence is urged.

Under the auspices of an agreement between the Ministry of Health and the World Health Organisation, the Public Health Agency with the support of the World Health Organisation have prepared the report "Suicides in Latvia – Situation, Perspectives and Solutions" in 2009.[224] The document analysed the situation in Latvia, Europe and the world. The report examined the causes and main risk factors of suicide, existing policy initiatives to reduce suicides and recommendations for the further improvement of the situation in Latvia.

Clinical research of medications in the field of psychiatry is also carried out in Latvia, with seven clinical research projects out of a total of 87 involved in psychiatry in 2008.[225] Five research projects out of 62 were in psychiatry in 2005.[226]

Conclusions:

1. The Public Health Agency which had the central role in research on mental health issues has been closed down and its functions divided among numerous organisations.
2. Due to the economic crisis, funding for research, science and education has been reduced.

Recommendations:

1. To endow further implementation of the functions of the former Public Health Agency, especially systematic support for the implementation of community-based mental health services.
2. To support and plan funding for research, science and education at a level that would allow implementation of the framework policy document "*Improvement of Inhabitants' Mental Health for 2009-2014*" and evaluation of the impact of changes in mental health policy.

FINAL CONCLUSIONS OF THE REPORT

1. Evaluating the implementation of the WHO Mental Health and Declaration and Action Plan over the last five years in Latvia, it can be concluded that policy makers and other involved specialists have shown great willingness to make improvements in mental healthcare, as shown by the development and adoption of policy in different spheres based on the world's best practices. At present, the necessary theoretical base is acquired for implementation of the adopted plans and policy documents.

2. Evaluating the implementation of the respective policy documents, unfortunately it must be concluded that this has been delayed as a result of insufficient purposeful action, partially completed implementation or a lack of leadership. There is no common implementing and/or

[223] Report "Violence and Health," available at: http://phoebe.vm.gov.lv/misc_db/web.nsf/626e6035eadbb4cd85256499006b15a6/d607bf50bd8d4113c22573f000498c25/$FILE/Summary_iekslapas_v4.pdf, [last accessed on 09.11.2009]

[224] Information available at: http://www.sva.lv/pashnavibas_latvija_2009_lv.pdf, [last accessed on 09.11.2009]

[225] State Agency of Medicines of Latvia, Public report of 2008, p. 21-23, available at: http://www.vza.gov.lv/index.php?id=304&sa=304&top=298, [last accessed on 09.11.2009]

[226] State Agency of Medicines of Latvia, Public report of 2005, p. 15-16, available at: http://www.zva.gov.lv/doc_upl/Gada-Publiskais-Parskats-2005.pdf, [last accessed on 09.11.2009]

supervising institution for implementation of policy planning documents. Different functions are carried out by dividing them among many ministries and institutions, thus creating difficulties in assessment of the common positive results and flaws concerning persons with mental disabilities.

3. It is positive that many important laws and regulations in this field have been improved in the last years, but there are numerous problems with their implementation. In evaluating the implementation of the diverse laws and regulations that have been adopted, it can be concluded that the necessity for such norms is often unclear and a common understanding of internationally adopted human rights standards regarding persons with mental disabilities is missing.

4. Unfortunately, users of mental health care services still are not involved in policy making and the implementation and evaluation of policy documents, despite the fact that service users could provide very important information to help improve the accessibility and quality of mental health care services. Discussions with users in the course of this study revealed that many activities that were implemented did not reach the target audience and that there exists an information vacuum for users regarding the planned policy activities that directly affect persons with mental disabilities.

5. This study represents the work accomplished up to the end of 2009, but work with many important activities in the field of mental health must be continued. Therefore, the authors hope that this study will be a foundation for understanding what has been accomplished, to refine what has been initiated and to continue the improvement of mental health in Latvia.

APPENDIX I

Helsinki, Finland, 12–15 January 2005
EUR/04/5047810/6
14 January 2005
52667
ORIGINAL: ENGLISH

MENTAL HEALTH DECLARATION FOR EUROPE

PREAMBLE

1. We, the Ministers of Health of Member States in the European Region of the World Health Organization (WHO), in the presence of the European Commissioner for Health and Consumer Protection, together with the WHO Regional Director for Europe, meeting at the WHO Ministerial Conference on Mental Health, held in Helsinki from 12 to 15 January 2005, acknowledge that mental health and mental well-being are fundamental to the quality of life and productivity of individuals, families, communities and nations, enabling people to experience life as meaningful and to be creative and active citizens. We believe that the primary aim of mental health activity is to enhance people's well-being and functioning by focusing on their strengths and resources, reinforcing resilience and enhancing protective external factors.

2. We recognize that the promotion of mental health and the prevention, treatment, care and rehabilitation of mental health problems are a priority for WHO and its Member States, the European Union (EU) and the Council of Europe, as expressed in resolutions by the World Health Assembly and the WHO Executive Board, the WHO Regional Committee for Europe and the Council of the European Union. These resolutions urge Member States, WHO, the EU and the Council of Europe to take action to relieve the burden of mental health problems and to improve mental well-being.

3. We recall our commitment to resolution EUR/RC51/R5 on the Athens Declaration on Mental Health, Man-made Disasters, Stigma and Community Care and to resolution EUR/RC53/R4 adopted by the WHO Regional Committee for Europe in September 2003, expressing concern that the disease burden from mental disorders in Europe is not diminishing and that many people with mental health problems do not receive the treatment and care they need, despite the development of effective interventions. The Regional Committee requested the Regional Director to:

- give high priority to mental health issues when implementing activities concerning the update of the Health for All policy;
- arrange a ministerial conference on mental health in Europe in Helsinki in January 2005.

4. We note resolutions that support an action programme on mental health. Resolution EB109. R8, adopted by the WHO Executive Board in January 2002, supported by World Health Assembly resolution WHA55.10 in May 2002, calls on WHO Member States to:

- adopt the recommendations contained in *The world health report 2001;*
- establish mental health policies, programmes and legislation based on current knowledge and considerations regarding human rights, in consultation with all stakeholders in mental health;

- increase investment in mental health, both within countries and in bilateral and multilateral cooperation, as an integral component of the well-being of populations.

5. Resolutions of the Council of the European Union, recommendations of the Council of Europe and WHO resolutions dating back to 1975 recognize the important role of mental health promotion and the damaging association between mental health problems and social marginalization, unemployment, homelessness and alcohol and other substance use disorders. We accept the importance of the provisions of the Convention for the Protection of Human Rights and Fundamental Freedoms, of the Convention on the Rights of the Child, of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment and of the European Social Charter, as well as the Council of Europe's commitment to the protection and promotion of mental health which has been developed through the Declaration of its Ministerial Conference on Mental Health in the Future (Stockholm, 1985) and through its other recommendations adopted in this field, in particular Recommendation R(90)22 on protection of the mental health of certain vulnerable groups in society and Recommendation Rec(2004)10 concerning the protection of the human rights and dignity of persons with mental disorder.

SCOPE

6. We note that many aspects of mental health policy and services are experiencing a transformation across the European Region. Policy and services are striving to achieve social inclusion and equity, taking a comprehensive view of the balance between the needs and benefits of diverse mental health activities aimed at the population as a whole, groups at risk and people with mental health problems. Services are being provided in a wide range of community-based settings and no longer exclusively in isolated and large institutions. We believe that this is the right and necessary direction. We welcome the fact that policy and practice on mental health now cover:

I. the promotion of mental well-being;
II. the tackling of stigma, discrimination and social exclusion;
III. the prevention of mental health problems;
IV. care for people with mental health problems, providing comprehensive and effective services and interventions, offering service users and carers[227] involvement and choice;
V. the recovery and inclusion into society of those who have experienced serious mental health problems.

PRIORITIES

7. We need to build on the platform of reform and modernization in the WHO European Region, learn from our shared experiences and be aware of the unique characteristics of individual countries. We believe that the main priorities for the next decade are to:

I. foster awareness of the importance of mental well-being;
II. collectively tackle stigma, discrimination and inequality, and empower and support people with mental health problems and their families to be actively engaged in this process;
III. design and implement comprehensive, integrated and efficient mental health systems that

[227] The term "carer" is used here to describe a family member, friend or other informal care-giver.

cover promotion, prevention, treatment and rehabilitation, care and recovery;

IV. address the need for a competent workforce, effective in all these areas;

V. recognize the experience and knowledge of service users and carers as an important basis for planning and developing mental health services.

ACTIONS

8. We endorse the statement that there is no health without mental health. Mental health is central to the human, social and economic capital of nations and should therefore be considered as an integral and essential part of other public policy areas such as human rights, social care, education and employment. Therefore we, ministers responsible for health, commit ourselves, subject to national constitutional structures and responsibilities, to recognizing the need for comprehensive evidence-based mental health policies and to considering ways and means of developing, implementing and reinforcing such policies in our countries. These policies, aimed at achieving mental well-being and social inclusion of people with mental health problems, require actions in the following areas:

I. promote the mental well-being of the population as a whole by measures that aim to create awareness and positive change for individuals and families, communities and civil society, educational and working environments, and governments and national agencies;

II. consider the potential impact of all public policies on mental health, with particular attention to vulnerable groups, demonstrating the centrality of mental health in building a healthy, inclusive and productive society;

III. tackle stigma and discrimination, ensure the protection of human rights and dignity and implement the necessary legislation in order to empower people at risk or suffering from mental health problems and disabilities to participate fully and equally in society;

IV. offer targeted support and interventions sensitive to the life stages of people at risk, particularly the parenting and education of children and young people and the care of older people;

V. develop and implement measures to reduce the preventable causes of mental health problems, comorbidity and suicide;

VI. build up the capacity and ability of general practitioners and primary care services, networking with specialized medical and non-medical care, to offer effective access, identification and treatments to people with mental health problems;

VII. offer people with severe mental health problems effective and comprehensive care and treatment in a range of settings and in a manner which respects their personal preferences and protects them from neglect and abuse;

VIII. establish partnership, coordination and leadership across regions, countries, sectors and agencies that have an influence on the mental health and social inclusion of individuals and families, groups and communities;

IX. design recruitment and education and training programmes to create a sufficient and competent multidisciplinary workforce;

X. assess the mental health status and needs of the population, specific groups and individuals in a manner that allows comparison nationally and internationally;

XI. provide fair and adequate financial resources to deliver these aims;

XII. initiate research and support evaluation and dissemination of the above actions.

9. We recognize the importance and the urgency of facing the challenges and building solutions based on evidence. We therefore endorse the Mental Health Action Plan for Europe and support its implementation across the WHO European Region, each country adapting the points appropriate to its needs and resources. We are also committed to showing solidarity across the Region and to sharing knowledge, best practice and expertise.

RESPONSIBILITIES

10. We, the Ministers of Health of the Member States in the WHO European Region, commit ourselves to supporting the implementation of the following measures, in accordance with each country's constitutional structures and policies and national and subnational needs, circumstances and resources:

I. enforce mental health policy and legislation that sets standards for mental health activities and upholds human rights;
II. coordinate responsibility for the formulation, dissemination and implementation of policies and legislation relevant to mental health within government;
III. assess the public mental health impact of government action;
IV. eliminate stigma and discrimination and enhance inclusion by increasing public awareness and empowering people at risk;
V. offer people with mental health problems choice and involvement in their own care, sensitive to their needs and culture;
VI. review and if necessary introduce equal opportunity or anti-discrimination legislation;
VII. promote mental health in education and employment, communities and other relevant settings by increasing collaboration between agencies responsible for health and other relevant sectors;
VIII. prevent risk factors where they occur, for instance, by supporting the development of working environments conducive to mental health and creating incentives for the provision of support at work or the earliest return for those who have recovered from mental health problems;
IX. address suicide prevention and the causes of harmful stress, violence, depression, anxiety and alcohol and other substance use disorders;
X. recognize and enhance the central role of primary health care and general practitioners and strengthen their capacity to take on responsibility for mental health;
XI. develop community-based services to replace care in large institutions for those with severe mental health problems;
XII. enforce measure that end inhumane and degrading care;
XIII. enhance partnerships between agencies responsible for care and support such as health, benefits, housing, education and employment;
XIV. include mental health in the curricula of all health professionals and design continuous professional education and training programmes for the mental health workforce;
XV. encourage the development of specialized expertise within the mental health workforce, to address the specific needs of groups such as children, young people, older people and those with long-term and severe mental health problems;
XVI. provide sufficient resources for mental health, considering the burden of disease, and make investment in mental health an identifiable part of overall health expenditure, in order to achieve parity with investments in other areas of health;
XVII. develop surveillance of positive mental well-being and mental health problems, including risk factors and help-seeking behaviour, and monitor implementation;
XVIII. commission research when and where knowledge or technology is insufficient and disseminate findings.

11. We will support nongovernmental organizations active in the mental health field and stimulate the creation of nongovernmental and service user organizations. We particularly welcome organizations active in:

I. organizing users who are engaged in developing their own activities, including the setting up and running of self-help groups and training in recovery competencies;
II. empowering vulnerable and marginalized people and advocating their case;
III. providing community-based services involving users;
IV. developing the caring and coping skills and competencies of families and carers, and their active involvement in care programmes;
V. setting up schemes to improve parenting, education and tolerance and to tackle alcohol and other substance use disorders, violence and crime;
VI. developing local services that target the needs of marginalized groups;
VII. running help lines and internet counselling for people in crisis situations, suffering from violence or at risk of suicide;
VIII. creating employment opportunities for disabled people.

12. We call upon the European Commission and the Council of Europe to support the implementation of this WHO Mental Health Declaration for Europe on the basis of their respective competences.

13. We request the Regional Director of WHO Europe to take action in the following areas:

(a) Partnership

I. encourage cooperation in this area with intergovernmental organizations, including the European Commission and the Council of Europe.

(b) Health information

I. support Member States in the development of mental health surveillance;
II. produce comparative data on the state and progress of mental health and mental health services in Member States.

(c) Research

I. establish a network of mental health collaborating centres that offer opportunities for international partnerships, good quality research and the exchange of researchers;
II. produce and disseminate the best available evidence on good practice, taking into account the ethical aspects of mental health.

(d) Policy and service development

I. support governments by providing expertise to underpin mental health reform through effective mental health policies that include legislation, service design, promotion of mental health and prevention of mental health problems;
II. offer assistance with setting up "train the trainer" programmes;
III. initiate exchange schemes for innovators;
IV. assist with the formulation of research policies and questions;
V. encourage change agents by setting up a network of national leaders of reform and key civil servants.

(e) Advocacy

I. inform and monitor policies and activities that will promote the human rights and inclusion of people with mental health problems and reduce stigma and discrimination against them;
II. empower users, carers and nongovernmental organizations with information and coordinate activities across countries;
III. support Member States in developing an information base to help empower the users of mental health services;
IV. facilitate international exchanges of experience by key regional and local nongovernmental organizations;

V. provide the media, nongovernmental organizations and other interested groups and individuals with objective and constructive information.

14. We request the WHO Regional Office for Europe to take the necessary steps to ensure that mental health policy development and implementation are fully supported and that adequate priority and resources are given to activities and programmes to fulfil the requirements of this Declaration.

15. We commit ourselves to reporting back to WHO on the progress of implementation of this Declaration in our countries at an intergovernmental meeting to be held before 2010.

APPENDIX II

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MENTAL HEALTH ACTION PLAN FOR EUROPE

This Action Plan is endorsed in the Mental Health Declaration for Europe by ministers of health of the Member States in the WHO European Region. They support its implementation in accordance with each country's needs and resources.

The challenges over the next five to ten years are to develop, implement and evaluate policies and legislation that will deliver mental health activities capable of improving the well-being of the whole population, preventing mental health problems and enhancing the inclusion and functioning of people experiencing mental health problems. The priorities for the next decade are to:

I. foster awareness of the importance of mental well-being;
II. collectively tackle stigma, discrimination and inequality, and empower and support people with mental health problems and their families to be actively engaged in this process;
III. design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery;
IV. address the need for a competent workforce, effective in all these areas;
V. recognize the experience and knowledge of service users and carers[228] as an important basis for planning and developing services.

This Action Plan proposes ways and means of developing, implementing and reinforcing comprehensive mental health policies in the countries of the WHO European Region, requiring action in the 12 areas as set out below. Countries will reflect these policies in their own mental health strategies and plans, to determine what will be delivered over the next five and ten years.

1. PROMOTE MENTAL WELL-BEING FOR ALL

CHALLENGE

Mental health and well-being are fundamental to quality of life, enabling people to experience life as meaningful and to be creative and active citizens. Mental health is an essential component of social cohesion, productivity and peace and stability in the living environment, contributing to social capital and economic development in societies. Public mental health and lifestyles conducive to mental well-being are crucial to achieving this aim. Mental health promotion increases the quality of life and mental well-being of the whole population, including people with mental health problems and their carers. The development and implementation of effective plans to promote mental health will enhance mental well-being for all.

[228] The term "carer" is used here to describe a family member, friend or other informal care-giver.

ACTIONS TO CONSIDER

I. Develop comprehensive strategies for mental health promotion within the context of mental health, public health and other public policies that address the promotion of mental health across the lifespan.
II. Adopt promotion of mental health as a long-term investment and develop education and information programmes with a long time frame.
III. Develop and offer effective programmes for parenting support and education, starting during pregnancy.
IV. Develop and offer evidence-based programmes that foster skills, provide information and focus on resilience, emotional intelligence and psychosocial functioning in children and young people.
V. Improve access to healthy diets and physical activity for older people.
VI. Promote community-based multilevel interventions involving public awareness campaigns, primary care staff and community facilitators such as teachers, clergy and the media.
VII. Integrate mental health promotion components into existing generic health promotion and public health policies and programmes, such as those supported by WHO health promoting networks.
VIII. Encourage the consumption of healthy products and reduce the intake of harmful products.
IX. Create healthy workplaces by introducing measures such as exercise, changes to work patterns, sensible hours and healthy management styles.
X. Offer effective mental health promotion activities to groups at risk such as people with enduring mental or physical health problems and carers.
XI. Identify clear mechanisms for empowering the population to take responsibility for health promotion and disease prevention targets, for example by heightening public awareness of the importance of life choices.

2. DEMONSTRATE THE CENTRALITY OF MENTAL HEALTH

CHALLENGE

Mental health is central to building a healthy, inclusive and productive society. Sound and integrated public policies, such as those on labour, urban planning and socioeconomic issues, also have a positive impact on mental health and reduce the risk of mental health problems. The mental health implications of all public policy, and particularly its potential impact on groups at risk, therefore need to be considered. Mental health policy requires intersectoral linkages and should incorporate multisectoral and multidisciplinary approaches.

ACTIONS TO CONSIDER

I. Make mental health an inseparable part of public health.
II. Incorporate a mental health perspective and relevant actions into new and existing national policies and legislation.
III. nclude mental health in programmes dealing with occupational health and safety.
IV. Assess the potential impact of any new policy on the mental well-being of the population before its introduction and evaluate its results afterwards.
V. Give special consideration to the relative impact of policies on people already suffering from mental health problems and those at risk.

3. TACKLE STIGMA AND DISCRIMINATION

CHALLENGE

Mental health policy development and implementation must not be jeopardized by the widespread stigma attached to mental health problems that leads to discrimination. In many instances, people with mental health problems suffer from a lack of equal opportunities because of such discrimination. Human rights and respect for people with mental health problems must be protected. Empowerment is a crucial step towards meeting these objectives, as it enhances integration and social inclusion. The lack of empowerment of service users' and carers' organizations and poor advocacy hinder the design and implementation of policies and activities that are sensitive to their needs and wishes. The exclusion experienced by mental health service users, whether in asylums and institutions or in the community, needs to be tackled in a variety of ways.

ACTIONS TO CONSIDER

I. Instigate activities to counter stigma and discrimination, emphasizing the ubiquity of mental health problems, their general good prognosis and treatability, and the fact that they are rarely associated with violence.
II. Introduce or scrutinize disability rights legislation to ensure that it covers mental health equally and equitably.
III. Develop and implement national, sectoral and enterprise policies to eliminate stigma and discrimination in employment practices associated with mental health problems.
IV. Stimulate community involvement in local mental health programmes by supporting initiatives of nongovernmental organizations.
V. Develop a coherent programme of policy and legislation to address stigma and discrimination, incorporating international and regional human rights standards.
VI. Establish constructive dialogue with the media and systematically provide them with information.
VII. Set standards for representation of users and their carers on committees and groups responsible for planning, delivery, review and inspection of mental health activities.
VIII. Stimulate the creation and development of local and national nongovernmental and service user-run organizations representing people with mental health problems, their carers and the communities they live in.
IX. Encourage the integration of children and young people with mental health problems and disabilities in the regular educational and vocational training system.
X. Establish vocational training for people suffering from mental health problems and support the adaptation of workplaces and working practices to their special needs, with the aim of securing their entry into competitive employment.

4. PROMOTE ACTIVITIES SENSITIVE TO VULNERABLE LIFE STAGES

CHALLENGE

Infants, children and young people, and older people are particularly at risk from social, psychological, biological and environmental factors. Given their vulnerability and needs, young and older people should be a high priority for activities related to the promotion of mental health and the prevention and care of mental health problems. However, many countries have inadequate capacity in this area, and services and staff are often poorly prepared to deal with developmental and age-related problems. In particular, disorders in childhood can be important precursors of adult mental disorders. Supporting the mental health of children and adolescents should be seen as a strategic investment which creates many long-term benefits for individuals, societies and health systems.

ACTIONS TO CONSIDER

I. Ensure that policies on mental health include as priorities the mental health and wellbeing of children and adolescents and of older people.
II. Incorporate the international rights of children and adolescents and of older people into mental health legislation.
III. Involve young people and older people as much as possible in the decision-making process.
IV. Pay special attention to marginalized groups, including children and older people from migrant families.
V. Develop mental health services sensitive to the needs of young and older people, operated in close collaboration with families, schools, day-care centres, neighbours, extended families and friends.
VI. Promote the development of community centres for older people to increase social support and access to interventions.
VII. Ensure that age- and gender-sensitive mental health services are provided by both primary care and specialized health and social care services and operate as integrated networks.
VIII. Restrict institutional approaches for the care of children and adolescents and older people that engender social exclusion and neglect.
IX. Improve the quality of dedicated mental health services by establishing or improving the capacity for specialized interventions and care in childhood and adolescence and old age, and by training and employing adequate numbers of specialists.
X. Improve coordination between organizations involved in alcohol and drugs programmes and children's and adolescents' health and mental health at national and international levels, as well as collaboration between their respective networks.
XI. Ensure parity of funding in relation to comparable health services.

5. PREVENT MENTAL HEALTH PROBLEMS AND SUICIDE

CHALLENGE

People in many countries are exposed to harmful stress-inducing societal changes that affect social cohesion, safety and employment and lead to an increase in anxiety and depression, alcohol and other substance use disorders, violence and suicidal behaviour. The social precipitants of

mental health problems are manifold and can range from individual causes of distress to issues that affect a whole community or society. They can be induced or reinforced in many different settings, including the home, educational facilities, the workplace and institutions. Marginalized and vulnerable groups, such as refugees and migrant populations, the unemployed, people in or leaving prisons, people with different sexual orientations, people with physical and sensorial disabilities and people already experiencing mental health problems, can be particularly at risk.

ACTIONS TO CONSIDER

I. Increase awareness of the prevalence, symptoms and treatability of harmful stress, anxiety, depression and schizophrenia.
II. Target groups at risk, offering prevention programmes for depression, anxiety, harmful stress, suicide and other risk areas, developed on the basis of their specific needs and sensitive to their background and culture.
III. Establish self-help groups, telephone help-lines and websites to reduce suicide, particularly targeting high-risk groups.
IV. Establish policies that reduce the availability of the means to commit suicide.
V. Introduce routine assessment of the mental health of new mothers by obstetricians and health visitors and provide interventions where necessary.
VI. For families at risk, provide home-based educational interventions to help proactively to improve parenting skills, health behaviour and interaction between parents and children.
VII. Set up in partnership with other ministers evidence-based education programmes addressing suicide, depression, alcohol and other substance use disorders for young people at schools and universities and involve role models and young people in the making of campaigns.
VIII. Support the implementation of community development programmes in high-risk areas and empower nongovernmental agencies, especially those representing marginalized groups.
IX. Ensure adequate professional support and services for people encountering major crises and violence, including war, natural disasters and terrorist attacks in order to prevent post-traumatic stress disorder.
X. Increase awareness among staff employed in health care and related sectors of their own attitudes and prejudices towards suicide and mental health problems.
XI. Monitor work-related mental health through the development of appropriate indicators and instruments.
XII. Develop the capacities for protection and promotion of mental health at work through risk assessment and management of stress and psychosocial factors, training of personnel, and awareness raising.
XIII. Involve mainstream agencies responsible for employment, housing and education in the development and delivery of prevention programmes.

6. ENSURE ACCESS TO GOOD PRIMARY CARE FOR MENTAL HEALTH PROBLEMS

CHALLENGE

For many countries in the European Region, general practitioners (GPs) and other primary care staff are the initial and main source of help for common mental health problems. However, mental health problems often remain undetected in people attending GPs or primary care services and treatment is not always adequate when they are identified. Many people with mental health problems, particularly those who are vulnerable or marginalized, experience difficulties in accessing and

remaining in contact with services. GPs and primary care services need to develop capacity and competence to detect and treat people with mental health problems in the community, supported as required as part of a network with specialist mental health services.

ACTIONS TO CONSIDER

I. Ensure that all people have good access to mental health services in primary health care settings.
II. Develop primary care services with the capacity to detect and treat mental health problems, including depression, anxiety, stress-related disorders, substance misuse and psychotic disorders as appropriate by expanding the numbers and skills of primary care staff.
III. Provide access to psychotropic medication and psychotherapeutic interventions in primary care settings for common as well as severe mental disorders, especially for individuals with long-term and stable mental disorders who are resident in the community.
IV. Encourage primary health care staff to take up mental health promotion and prevention activities, particularly targeting factors that determine or maintain illhealth.
V. Design and implement treatment and referral protocols in primary care, establishing good practice and clearly defining the respective responsibilities in networks of primary care and specialist mental health services.
VI. Create centres of competence and promote networks in each region which health professionals, service users, carers and the media can contact for advice.
VII. Provide and mainstream mental health care in other primary care services and in easily accessible settings such as community centres and general hospitals.

7. OFFER EFFECTIVE CARE IN COMMUNITY-BASED SERVICES FOR PEOPLE WITH SEVERE MENTAL HEALTH PROBLEMS

CHALLENGE

Progress is being made across the Region in reforming mental health care. It is essential to acknowledge and support people's right to receive the most effective treatments and interventions while being exposed to the lowest possible risk, based on their individual wishes and needs and taking into account their culture, religion, gender and aspirations. Evidence and experience in many countries support the development of a network of community-based services including hospital beds. There is no place in the twenty-first century for inhumane and degrading treatment and care in large institutions: an increasing number of countries have closed many of their asylums and are now implementing effective community-based services. Special consideration should be given to the emotional, economic and educational needs of families and friends, who are often responsible for intensive support and care and often require support themselves.

ACTIONS TO CONSIDER

I. Empower service users and carers to access mental health and mainstream services and to take responsibility for their care in partnership with providers.
II. Plan and implement specialist community-based services, accessible 24 hours a day, seven days a week, with multidisciplinary staff, to care for people with severe problems such as schizophrenia, bipolar disorder, severe depression or dementia.
III. Provide crisis care, offering services where people live and work, preventing deterioration or

hospital admission whenever possible, and only admitting people with very severe needs or those who are a risk to themselves or others.

IV. Offer comprehensive and effective treatments, psychotherapies and medications with as few side effects as possible in community settings, particularly for young people experiencing a first episode of mental health problems.
V. Guarantee access to necessary medicines for people with mental health problems at a cost that the health care system and the individual can afford, in order to achieve appropriate prescription and use of these medicines.
VI. Develop rehabilitation services that aim to optimize people's inclusion in society, while being sensitive to the impact of disabilities related to mental health problems.
VII. Offer services for people with mental health needs who are in non-specialist settings such as general hospitals or prisons.
VIII. Offer carers and families assessment of their emotional and economic needs, and involvement in care programmes.
IX. Design programmes to develop the caring and coping skills and competencies of families and carers.
X. Scrutinize whether benefit programmes take account of the economic cost of caring.
XI. Plan and fund model programmes that can be used for dissemination.
XII. Identify and support leaders respected by their peers to spearhead innovation.
XIII. Develop guidelines for good practice and monitor their implementation.
XIV. Introduce legal rights for people subject to involuntary care to choose their independent advocate.
XV. Introduce or reinforce legislation or regulations protecting the standards of care, including the discontinuation of inhuman and degrading care and interventions.
XVI. Establish inspection to reinforce good practice and to stop neglect and abuse in mental health care.

8. ESTABLISH PARTNERSHIPS ACROSS SECTORS

CHALLENGE

Essential services which in the past were routinely provided in large institutions or were not considered as relevant to the lives of people with mental health problems are nowadays often fragmented across many agencies. Poor partnership and lack of coordination between services run or funded by different agencies lead to poor care, suffering and inefficiencies. The responsibilities of different bodies for such a wide range of services need coordination and leadership up to and including government level. Service users and their carers need support in accessing and receiving services for issues such as benefits, housing, meals, employment and treatment for physical conditions, including substance misuse.

ACTIONS TO CONSIDER

I. Organize comprehensive preventive and care services around the needs of and in close cooperation with users.
II. Create collaborative networks across services that are essential to the quality of life of users and carers, such as social welfare, labour, education, justice, transport and health.
III. Give staff in mental health services responsibility for identifying and providing support for needs in daily living activities, either by direct action or through coordination with other services.
IV. Educate staff in other related services about the specific needs and rights of people with

mental health problems and those at risk of developing mental health problems.

V. Identify and adjust financial and bureaucratic disincentives that obstruct collaboration, including at government level.

9. CREATE A SUFFICIENT AND COMPETENT WORKFORCE

CHALLENGE

Mental health reform demands new staff roles and responsibilities, requiring changes in values and attitudes, knowledge and skills. The working practices of many mental health care workers and staff in other sectors such as teachers, benefit officers, the clergy and volunteers need to be modernized in order to offer effective and efficient care. New training opportunities must respond to the need for expertise in all roles and tasks to be undertaken.

ACTIONS TO CONSIDER

I. Recognize the need for new staff roles and responsibilities across the specialist and generic workforce employed in the health service and other relevant areas such as social welfare and education.

II. Include experience in community settings and multidisciplinary teamwork in the training of all mental health staff.

III. Develop training in the recognition, prevention and treatment of mental health problems for all staff working in primary care.

IV. Plan and fund, in partnership with educational institutions, programmes that address the education and training needs of both existing and newly recruited staff.

V. Encourage the recruitment of new mental health workers and enhance the retention of existing workers.

VI. Ensure an equitable distribution of mental health workers across the population, particularly among people at risk, by developing incentives.

VII. Address the issue of lack of expertise in new technologies of present trainers, and support the planning of "train the trainers" programmes.

VIII. Educate and train mental health staff about the interface between promotion, prevention and treatment.

IX. Educate the workforce across the public sector to recognize the impact of their policies and actions on the mental health of the population.

X. Create an expert workforce by designing and implementing adequate specialist mental health training for all staff working in mental health care.

XI. Develop specialist training streams for areas requiring high levels of expertise such as the care and treatment of children, older people and people suffering from a combination of mental health problems and substance use disorder (comorbidity).

10. ESTABLISH GOOD MENTAL HEALTH INFORMATION

CHALLENGE

In order to develop good policy and practice in countries and across the Region, information has to be available about the current state of mental health and mental health activities. The impact of any implementation of new initiatives should be monitored. The mental health status and the help-seeking behaviour of populations, specific groups and individuals should be measured in a manner that allows comparison across the WHO European Region. Indicators should be standardized and comparable locally, nationally and internationally in order to assist in the effective planning, implementation, monitoring and evaluation of an evidence-based strategy and action plan for mental health.

ACTIONS TO CONSIDER

I. Develop or strengthen a national surveillance system based on internationally standardized, harmonized and comparable indicators and data collection systems, to monitor progress towards local, national and international objectives of improved mental health and well-being.
II. Develop new indicators and data collection methods for information not yet available, including indicators of mental health promotion, prevention, treatment and recovery.
III. Support the carrying out of periodic population-based mental health surveys, using agreed methodology across the WHO European Region.
IV. Measure base rates of incidence and prevalence of key conditions, including risk factors, in the population and groups at risk.
V. Monitor existing mental health programmes, services and systems.
VI. Support the development of an integrated system of databases across the WHO European Region to include information on the status of mental health policies, strategies, implementation and delivery of evidence-based promotion, prevention, treatment, care and recovery.
VII. Support the dissemination of information on the impact of good policy and practice nationally and internationally.

11. PROVIDE FAIR AND ADEQUATE FUNDING

CHALLENGE

Resources dedicated to mental health are often inadequate and inequitable compared to those available to other parts of the public sector, and this is reflected in poor access, neglect and discrimination. In some health care systems, insurance coverage of access and rights to treatment discriminate severely against mental health problems. Within the mental health budget, resource allocation should be equitable and proportionate, i.e. offering greatest relative share and benefits to those in greatest need.

ACTIONS TO CONSIDER

I. Assess whether the proportion of the health budget allocated to mental health fairly reflects the needs and priority status of the people with needs.
II. Ensure that people with the most severe problems and the poorest in society receive the largest relative benefits.

III. Assess whether funding is allocated efficiently, taking into account societal benefits, including those generated by promotion, prevention and care.
IV. Evaluate whether coverage is comprehensive and fair in social and private insurancebased systems, on an equal level to that for other conditions, not excluding or discriminating against groups and particularly protecting the most vulnerable.

12. EVALUATE EFFECTIVENESS AND GENERATE NEW EVIDENCE

CHALLENGE

Considerable progress is being made in research, but some strategies and interventions still lack the necessary evidence base, meaning that further investment is required. Furthermore, investment in dissemination is also required, since the existing evidence concerning effective new interventions and national and international examples of good practice are not known to many policy-makers, managers, practitioners and researchers. The European research community needs to collaborate to lay the foundations for evidence-based mental health activities. Major research priorities include mental health policy analyses, assessments of the impact of generic policies on mental health, evaluations of mental health promotion programmes, a stronger evidence base for prevention activities and new service models and mental health economics.

ACTIONS TO CONSIDER

I. Support national research strategies that identify, develop and implement best practice to address the needs of the population, including groups at risk.
II. Evaluate the impact of mental health systems over time and apply experiences to the formulation of new priorities and the commissioning of the necessary research.
III. Support research that facilitates the development of preventive programmes aimed at the whole population, including groups at risk. Research is needed on the implications of the interrelated nature of many mental, physical and social health problems for effective preventive programmes and policies.
IV. Promote research focused on estimating the health impacts of non-health sector policies, as there is a clear potential for positive mental health to be improved through such policies.
V. Bridge the knowledge gap between research and practice by facilitating collaboration and partnerships between researchers, policy-makers and practitioners in seminars and accessible publications.
VI. Ensure that research programmes include long-term evaluations of impact not only on mental health but also on physical health, as well as social and economic effects.
VII. Establish sustainable partnerships between practitioners and researchers for the implementation and evaluation of new or existing interventions.
VIII. Invest in training in mental health research across academic disciplines, including anthropology, sociology, psychology, management studies and economics, and create incentives for long-term academic partnerships.
IX. Expand European collaboration in mental health research by enhancing networking between WHO's European collaborating centres and other centres with research activities in the field of prevention.
X. Invest in regional collaboration on information and dissemination in order to avoid the duplication of generally applicable research and ignorance of successful and relevant activities elsewhere.

MENTAL HEALTH FOR EUROPE: FACING THE CHALLENGES

MILESTONES

Member States are committed, through the Mental Health Declaration for Europe and this Action Plan, to face the challenges by moving towards the following milestones. Between 2005 and 2010 they should:

1. prepare policies and implement activities to counter stigma and discrimination and promote mental well-being, including in healthy schools and workplaces;
2. scrutinize the mental health impact of public policy;
3. include the prevention of mental health problems and suicide in national policies;
4. develop specialist services capable of addressing the specific challenges of the young and older people, and gender-specific issues;
5. prioritize services that target the mental health problems of marginalized and vulnerable groups, including problems of comorbidity, i.e. where mental health problems occur jointly with other problems such as substance misuse or physical illness;
6. develop partnership for intersectoral working and address disincentives that hinder joint working;
7. introduce human resource strategies to build up a sufficient and competent mental health workforce;
8. define a set of indicators on the determinants and epidemiology of mental health and for the design and delivery of services in partnership with other Member States;
9. confirm health funding, regulation and legislation that is equitable and inclusive of mental health;
10. end inhumane and degrading treatment and care and enact human rights and mental health legislation to comply with the standards of United Nations conventions and international legislation;
11. increase the level of social inclusion of people with mental health problems;
12. ensure representation of users and carers on committees and groups responsible for the planning, delivery, review and inspection of mental health activities.