WHO-AIMS

WHO-AIMS Report on Mental Health System in The Republic of Tajikistan

World Health Organization

Ministry of Health
Tajikistan

WHO-AIMS REPORT ON

MENTAL HEALTH SYSTEM

IN THE REPUBLIC OF TAJIKISTAN

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

(Dushanbe, Tajikistan)

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

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The WHO-AIMS project is coordinated by Shekhar Saxena.

Executive Summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Tajikistan. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Tajikistan to develop information-based mental health plans with clear baseline information and targets. It will also be useful for monitoring the progress of implementing reform policies, providing community services, and involving users, families, and other stakeholders in mental health promotion, prevention, care, and rehabilitation.

There is no mental health policy present in the country. There was no mental health legislation until 2002. Some practices and procedures have been active since the Soviet era. The country developed and adopted multiple mechanisms to implement the provision of mental health legislation (instructions, rules, and standards). The majority of these mechanisms were adopted for the centralized soviet type psychiatric system and require revision. However, the list of essential medicines is present.

There is no unified, detailed and well-defined mental health plan in the nation at present. The strategic and long-term disaster/emergency preparedness plan for mental health has not yet been developed.

Only one percent of health care expenditures by the government health department are directed towards mental health. Of all the expenditures spent on mental health, 84% are directed towards mental hospitals. For consumers that need to pay out of pocket for psychotropic medicines, the cost of antipsychotic medication is 18% and antidepressant medication is 10% (0.35 USD and 0.20 USD per day respectively).

A national human rights review body is in place (ombudsmen) that performs the human rights review and inspection of the patient and that can offer assistance with limits to those who appeal. Apart from that, inspection and monitoring of psychiatric institutions on a regular basis is performed by the Ministry of Health and legal proceedings. However, the supervision system on human rights of the patients requires improvements.

There is no Department of Mental Health or Mental Health Office in the Ministry of Health. Mental health data are not complete or properly analyzed. The collected data are

often not valuable enough to understand the full situation and there is no feedback system in place.

Primary health care staff receives no definitive training in mental health and interaction with mental health services is sporadic. There are 53 outpatient mental health facilities available in the country offering services for adults, children and adolescents. In Dushanbe city there is a separate facility that serves children and adolescents: The Children and Adolescent Mental Health Center. These facilities treat 629 users per 100,000 general population. There are three day-treatment facilities available in the country, of which one focuses on the treatment of children and adolescents. Furthermore, three community-based psychiatric inpatient units are available in the country for a total of 65 beds per 100,000 population.

In Tajikistan, psychiatric care is largely hospital-based and no functional community services exist in the mental health field.

There are 14 mental hospitals available in the country for a total of 22 beds per 100,000 population. Two percent of these beds in mental hospitals are reserved for children and adolescents only. In the last five years the number of beds did not change. A large reduction of beds took place from 1996 to 2000 due to the reform of the health care system. The number of beds was reduced, yet alternative means were not introduced and alternative methods for psychiatric care were not developed.

In addition to beds in mental health facilities, there are also 25 beds for persons with mental disorders in forensic inpatient units.

Two percent of training provided to medical doctors is devoted to mental health in comparison to one percent for nurses and zero percent for non-doctor/non-nurse primary health care workers.

The total number of human resources working in mental health facilities or private practice is 9.3 per 100,000 population. The distribution of human resources between urban and rural areas is disproportionate. There is also a lack of social workers, psychologists and occupational therapists. The interaction of mental health facilities with both consumers and family members is very weak. The coordinating body overseeing public education and awareness exists, but so far, no awareness campaigns have been conducted.

The legislative or financial provisions for employment, against discrimination at work, and provisions for housing exist but are not enforced.

Linkage of mental health services with other sectors is very limited and underused. The existing system of data collection does not fully reflect the real situation in mental health.

Introduction

Tajikistan is a country with an approximate geographical area of 143,100 square kilometres and a population of 7.2 million people[1]. Ninety percent of the population is Muslim. There are some people with other religious beliefs (primarily Russian Orthodox) in Dushanbe.

The country is a lower middle income group country based on World Bank 2007 criteria. Fifty three percent of the population lives below the poverty line, despite the turnaround in economic growth[2]. UNDP (United Nations Development Programme) human development index ranks Tajikistan 122 out of 177 countries[3]. The poverty and lack of employment opportunities remain the prime social concerns in this nation. Labor migration of about one million people, or 15% of the population to the Russian Federation and other countries, continues to be an important means of income for many households in Tajikistan. Thirty six % of the population is under the age of 15 and 5.1 percent of the population is over the age of 60. Seventy-four % of the population is rural. The life expectancy at birth for males is 56.0 years and 66.0 for females[4]. The healthy life expectancy at birth is 53.0 years for males and 56.0 for females. Total adult literacy rate is 99%.

In 2007, total health spending was estimated at 4.6 percent of Gross Domestic Product (GDP), with government expenditures on health representing only 1.2 percent of GDP, which is considerably less than the 4.5 percent in 1991. Tajikistan has a GDP per capita of 504 USD[5]. In 2007, hospitals accounted for 60 p% of total public health expenditure, while polyclinics and public health services received 17.1 % and 6.5 percent respectively.

Tajikistan has inherited the Soviet model of the medical system structured around a network of health facilities with emphasis on inpatient care. The system remains quite centralized with some variation of decentralization. There are 63 hospital beds per 100,000 population and 185 physicians. Zero-point-five percent of all hospital beds are in the private sector. In terms of primary care, there are 3343 physician-based primary health care clinics in the country (3281 in the public sector and 62 in the private) and 97 non-physician based primary health care clinics (all of them belong to public sector)[6].

The structure of Mental Health Services has not changed in the last decade. Tajikistan is facing major decline of the mental health services. It remains institutionalised and under-funded. To date, few to none have made mental health a priority.

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[1] State statistic committee
[2] For 2007 a complete poverty line was derived based on Tajik-specific consumption patters. The complete poverty line was estimated as 4.56 Somoni/day/person
[3] Human Development Report, 2006
[4] The World Health Report Statistical
[5] State statistic committee
[6] Health Information System, Ministry of Health

The WHO-AIMS Instrument

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) is a new WHO tool for collecting essential information on the mental health system of a country or region (WHO, 2005; Saxena et al. 2005). The goal of collecting this information is to improve mental health systems and to provide a baseline for monitoring the change. WHO-AIMS is primarily intended for assessing mental health systems in low and middle-income countries, but is also a valuable assessment tool for high resource countries. For the purpose of WHO-AIMS, a mental health system is defined as all the activities whose primary purpose is to promote, restore or maintain mental health. The mental health system includes all organizations and resources focused on improving mental health. WHO-AIMS 2.1 consists of 6 domains, 28 facets and 155 items created to cover the key aspects of mental health systems. In addition, it includes other resources, such as a data entry programme and a template for writing a country report, which allows countries to efficiently collect data and then quickly translate that information into knowledge that can assist planning. The implementation of WHO-AIMS can generate information on strengths and weaknesses to facilitate improvement in mental health services. WHO-AIMS will enable countries to develop information-based mental health plans with clear baseline information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families, and other stakeholders in mental health promotion, prevention, care and rehabilitation.

Data was collected in 2008 and is based on the year 2007.

Domain 1: Policy and Legislative Framework

Policy, plans, and legislation

There is no mental health policy present in the nation of Tajikistan. Before 2002, activities in the field of mental healthcare were regulated by the Soviet law on Psychiatric Care. On December 2, 2002 the law of the Republic of Tajikistan "On psychiatric care" was adopted. The law, however, requires follow up revision. Furthermore, the mechanisms to implement the law are currently not sufficient. The legislation is focused on the following components:

1. Access to mental health care including access to the least restrictive care.
2. Rights of mental health service consumers, family members, and other care givers.
3. Competency, capacity, and guardianship issues for people with mental illness.
4. Voluntary and involuntary treatment.
5. Accreditation of professionals and facilities.
6. Law enforcement and other judicial system issues for people with mental illness.
7. Mechanisms to oversee involuntary admission and treatment practices.

Some practices and procedures have been active since the Soviet times. The mechanisms to implement the provision of mental health legislation (instructions, rules and standards) are not sufficient. Sometimes the mechanisms are outdated and do not correspond to the legal requirements. The Ministry of Health needs technical assistance in this regard.

There is no unified policy for the human resource development component. Moreover, there is no unified, detailed, and well-defined mental health plan. Each institution has its own plans that are limited to that particular institution's area of work. The only document which has an element of strategy surrounding mental health in Tajikistan is the "Strategy of the RT on Protection of Health of the Population" for the period to 2010. Although a Declaration and Action Plan endorsed by all WHO European Member States prioritized mental health in Helsinki in 2005, Tajikistan has yet to introduce reforms. Additionally, despite the high burden of mental illness globally, the United Nations Millennium Development Goals do not directly include targets for mental disorders. Thus, these mental health programs attract little investment by international donors.

Currently, the strategic and long-term disaster/emergency preparedness plan for mental health is under development. The Ministry of Disaster Emergency Situation, together with the WHO and the International Federation of the Red Cross, signed an agreement to elaborate the overall disaster preparedness plan. There is no separate emergency response plan for Mental Health.

The list of essential medicines is present and updated on a regular basis. These medicines include antipsychotics, anxiolytics, antidepressants and antiepileptic drugs. Lithium has not been included into the essential medicines list.

Financing of mental health services

One percent of healthcare expenditures by the government health department are directed towards mental health. Of all the expenditures spent on mental health, 84% of them are directed towards mental hospitals. In terms of affordability of mental health services, all members of the population with psychiatric disorders at inpatient psychiatric facilities have free access to essential psychotropic medicines. According with Tajik law, patients with psychiatric problems (psychosis) are supposed to receive psychotropic treatment free of charge, as well as free treatment at outpatient facilities after discharge from the hospital. It is assumed that 100% of those consumers requiring psychotropic treatment should be receiving them free of charge, yet in reality this is not the case. Several reports reveal that there is a significant shortage of medications, in particular neuroleptics.

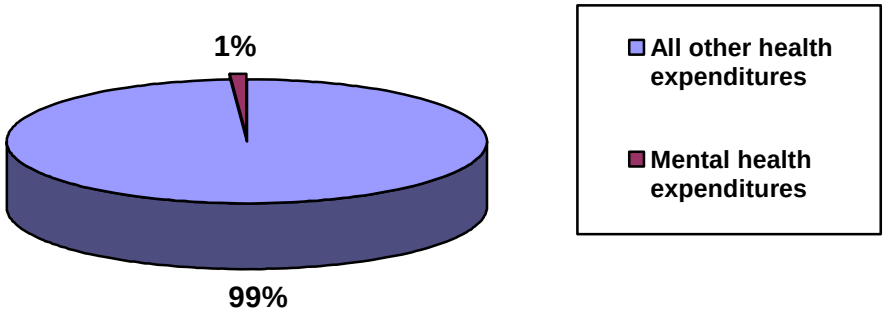
For those consumers that pay out of pocket, the cost of antipsychotic medication is 18% and the cost of antidepressant medication is 10% (0.35 USD and 0.20 USD per day respectively).

Currently, the health insurance system is in the pilot stage and does not include psychiatric care. There is lack of financing and absence of health insurance program.

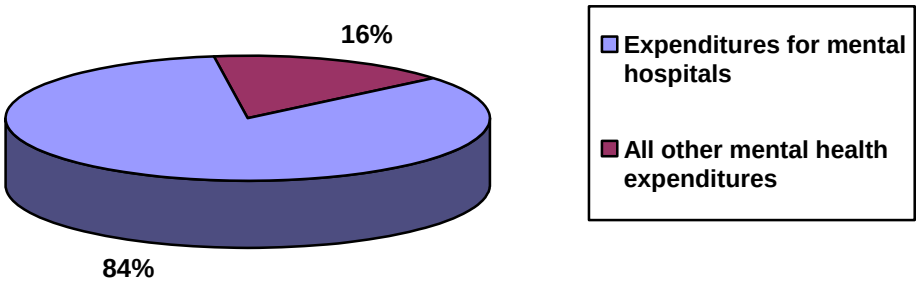
There is no separate budget line for psychiatric care. Allocated State budget resources were mainly intended to cover wages, food and medicines expenses. The State annual budget for psychiatric institutions is allocated by the Ministry of Health of the Republic of Tajikistan once a year. Allocation for the psychiatric institutions estimated according with the type of the hospital (psychiatric hospitals, psychoneurological dispensaries, psychoneurological centers and psychoneurological departments) and to its bed capacity as well as to the number of admitted patients per year. MoH receives budget requests from all the psychiatric institutions at the end of each year. However MoH is not able to provide funding for all the requests fully.

The Monitoring Report of the Bureau on Human Rights reveals that psychiatric hospitals are lacking sufficient medical supplies. If the appropriate medications are available in hospitals they are prescribed for free. In reality, there is a shortage of medicines in the hospitals therefore patients have to pay for treatment. The contributions from the State budget cover only about 22% of hospitals' needs in general medicines. Furthermore, psychiatric institutions still remain heavily dependant on humanitarian donations. All mental health institutions are regularly controlled by the State Research Center for Drugs Expertise.

GRAPH 1.1 HEALTH EXPENDITURE TOWARDS MENTAL HEALTH



GRAPH 1.2 MENTAL HEALTH EXPENDITURE TOWARDS MENTAL HOSPITALS



Human rights policies

The national human rights review body includes the Ministry of Justice, Ministry of Health, General Office of Public Prosecutor and Courts. The human rights review and inspection of the patients is completed on a regular basis, however improvements in inspections are required.

A system of compulsory treatment exists for individuals that have committed crimes and were recognized certifiable by the court based on the mental health conditions.
The involuntary hospitalization of individuals who may pose a hazard to themselves or surrounding individuals, is based on the decision of a committee of psychiatrists (no less than three doctors) with the subsequent requirement that this committee inform the appropriate prosecutorial powers within 24 hours.

Non-Governmental Organization (NGO) access to the aforementioned psychiatric facilities is possible with permission of the MoH. Media does not show interest until there is an emergency situation.

The training on human rights of patients includes only the issues of involuntary hospitalization during the undergraduate and postgraduate training program on psychiatry.

Domain 2: Mental Health Services

Organization of Mental Health Services

There is no Department of Mental Health or Mental Health Office within the Ministry of Health. Mental health is represented by a senior specialist at MoH who is responsible for the supervision of all non-communicable diseases, including mental health. There is also

a leading psychiatrist who is responsible for mental health issues. Mental health services are organized in terms of catchments/service areas.

Mental Health Outpatient Facilities

There are 53 outpatient mental health facilities available in the country, which provide services to adults, children and adolescents.

These facilities treat 629 users per 100,000 general population. For some of the users it was just a medical examination rather than treatment. Perhaps, some of them received recommendations and treatment from outpatient specialists (medication). Psychiatric cabinets exist within the district, however, not all the cabinets have psychiatrists. In some of the cabinets the psychiatrist function is performed by a neuropathologist.

Of all users treated in mental health outpatient facilities, 36% are female and 8% are children or adolescents. In Tajikistan, out of all mental disorders, retardation comprises 40% of 44,937 cases. Prevalence of retardation among males was 3.5 times higher than among females. Almost all retardation cases were detected during the army call-up, not at school. The utilization of mental health services is higher amongst males than females. This may be due in part to the higher employment rate among males in which diseases are diagnosed during a mandatory medical check up. There is one Republican Mental Health Centre for Children and Adolescents that offers outpatient services for children and adolescents for 30 beds. In average, each registered user referred 3 times in 2007. The calculation was done based on the data from the Republican clinical psychiatric centre and this figure represents only Dushanbe. It was not possible to calculate referrals for the whole country as the existing reporting system doesn't allow for extracting this figure out of data from outpatient's services.

After mental retardation, users treated in outpatient facilities are primarily diagnosed with schizophrenia, 26%, and neurotic disorders, 4%. According to procedure, mental and behavioural disorders due to substance use are observed at substance abuse institutions. There is a clear division among these services.

Currently, there is not a system of social workers set in place. In the past, there was a referral system set in place for home visits made by a nurse or doctor. These medical professionals observed whether the health care consumer was receiving the treatment necessary tend to his or her condition. The elements of this system remain up to the present. The follow-up system is in place only for those patients who are registered as so called "special cases" meaning those who have committed crimes, as the follow-up requirements for this category of patient are very strict. The psychological interventions are not performed.

Eleven percent of mental health outpatient facilities had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility or a nearby pharmacy all year round.

Day treatment facilities

There are three day treatment facilities available in the country, of which 33% are for children and adolescents only. These facilities were created during the Soviet era. Two facilities are located in the capital and one in the district near the capital. These facilities treat 5.9 users per 100,000 general population. This number is very small compared to Soviet times. The data on female users of day treatment facilities was not available at the national level as these data are not collected and analyzed. Of all users treated in day treatment facilities, nine percent are children or adolescents. On average, users spend 12.4 days in day treatment facilities.

Community-Based Psychiatric Inpatient Units

There are three community-based psychiatric inpatient units available in the country for a total of 65 beds per 100,000 population. In Tajikistan, psychiatric care is largely hospital-based and no functional community services exist in the mental health field. Currently, there are attempts to involve users of mental health care in processes and services as equal stakeholders and, according to the MoH, their opinions and preferences are taken into consideration. This activity has been supported by the Global Initiative for Psychiatry. Relatives of those receiving mental health care are reluctant to participate in such activities due to the stigma of acknowledging that a family member has a mental disorder. However, there have been attempts to involve family members despite the existing stigma. There are 30 beds reserved for children and adolescents. Apart from that, there are 30 beds for children and adolescents in day treatment facilities.

Forty-one percent of admissions to community-based psychiatric inpatient units are female. The diagnoses of admissions to community-based psychiatric inpatient were primarily from the following two diagnostic groups: schizophrenia 42% and neurotic disorders 17%.

On average patients spend 37.9 days per discharge. There is lack of primary health care specialists to continue provision of outpatient services, treatment and follow up. This number also includes the hospitalization of neglected cases. In addition, proper conditions often do not exist at home for the provision of appropriate patient care. No patients in community-based psychiatric inpatient units received psychosocial interventions in the last year.

Thirty three percent of community-based psychiatric inpatient units had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

Community Residential Facilities

There are residential facilities available in the country for the individuals with psychiatric disorders with a total number of 1060 beds. These facilities are under the Ministry of Labour and Social Protection.

Mental Hospitals

There are 14 mental hospitals available in the country for a total of 22 beds per 100,000 population. All of these facilities are organizationally integrated with mental health outpatient facilities. All hospitals are integrated with outpatient facilities since Soviet times and it still works like this at present. Psychiatric care is also linked with forensic procedures and legal issues. According with legislation, psychiatrists must interact with forensic system and keep mutual information and referral system. Two percent of beds in mental hospitals are reserved for children and adolescents only. In the last five years the number of beds did not change. A large reduction of beds took place from 1996 to 2000 due to the reform of the health system. The number of beds was reduced, but alternative resources were not introduced and community based psychiatric care was not developed.

The patients admitted to mental hospitals belong primarily to the following two diagnostic groups: schizophrenia (51%) and neurotic disorders (8%). Patients with substance abuse related disorders get treatment in substance abuse clinics.

The number of patients in mental hospitals is 66.9 per 100.000 population. The average number of days spent in mental hospitals is 87.

Ninety percent of patients spend less than one year, and 10 % of patients spend more than 10 years in mental hospitals. According to available sources of information it is possible to detect only the total number of patients that were in the hospital more than one year. This 10% includes all patients that were in the hospital for one year or more years without clear differentiation on the duration of stay. Patients in mental hospitals did not receive psychosocial interventions in the last year.

Sixty four percent of mental hospitals had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

Forensic and other Residential Facilities

In addition to beds in mental health facilities, there are also 25 beds for persons with mental disorders in forensic inpatient units and 1060 beds in other residential facilities such as homes for persons with mental retardation, detoxification inpatient facilities, homes for the destitute, etc. In forensic inpatient units 100% of patients spend less than one year.

Human Rights and Equity

Five percent of all admissions to community-based inpatient psychiatric units and seven percent of all admissions to mental hospitals are involuntary. This is preliminary estimate as it is not reflected in the official reports. In accordance with the law on psychiatric care, involuntary admissions are called emergency hospitalization, not involuntary hospitalization.

Between 6-10% of patients were restrained or secluded at least once within the last year in community-based psychiatric inpatient units, in comparison to 2-5% of patients in mental hospitals. Physical restraint and seclusion is applied in forensic departments and 8.2% out of the total number of patients admitted to the Republican psycho-neurological hospital are restrained or secluded. Physical restriction, or involuntary isolation, are only applied if a patient is violent, aggressive, causes problems for other patients, refuses to take medication as prescribed and does not yield to persuasion. In this case, the patient is fixed to the bed with the use of bed sheets and injected with medicine.

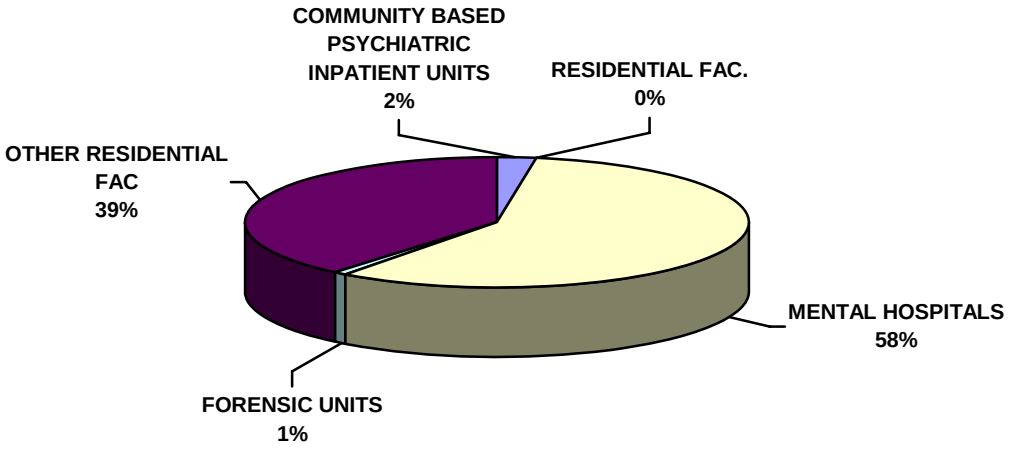
The density of psychiatric beds in or around the largest city is 4.55[7] times greater than the density of beds in the entire country. Such a distribution of beds prevents access for rural users. There is a large Republican psychiatric clinic that is placed near Dushanbe city with 700 beds.

Inequity of access to mental health services for other minority users (e.g., linguistic, ethnic, religious minorities) is a not an issue within the country. The mental health authorities stated that the access is there, but it's not reflected in any statistics. Customarily, people understand and speak several languages. Those, who don't understand, typically, have someone who can translate for them. Normally this consists of a relative, friend or medical worker. It was also stated that no restriction or barrier to any ethnic or religious groups exists. This is also not reflected in any statistics and is based on the conclusions of health professionals.

[7] The data were taken from the form #36 to identify proportion of rural users out of total number of users. The data do not reflect the real use of outpatient services but the number of users that are under dispensary observation (case follow-up). It would be appropriate to calculate the total referrals in one year, but the existing system does not allow this.

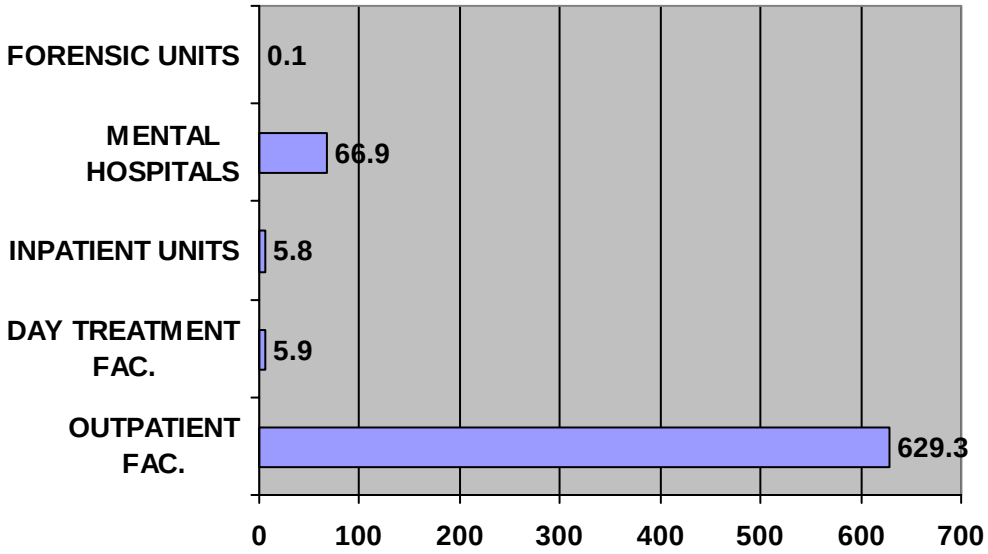
Summary Charts

GRAPH 2.1 - BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES



The majority of beds in the country are provided by mental hospitals, followed by residential units inside and outside the mental health system.

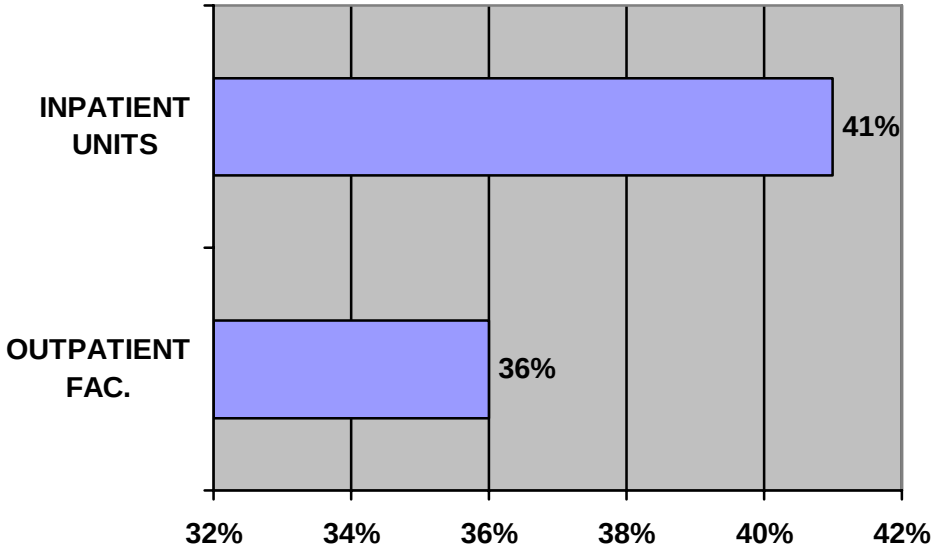
GRAPH 2.2 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES (rate per 100.000 population)



Note: In this graph the rate of admissions in inpatient units is used as proxy of the rate of users treated in the units. The majority of the users are treated in outpatient facilities and in mental

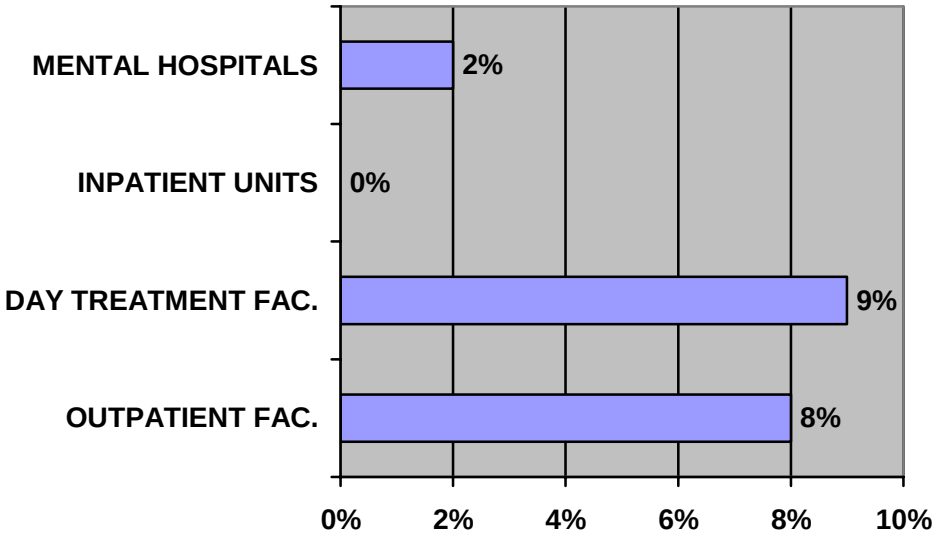
hospitals while the rate of users treated in inpatient units, day treatment facilities and community-based units is considerably lower.

GRAPH 2.3 - PERCENTAGES OF FEMALE USERS TREATED IN MENTAL HEALTH FACILITIES



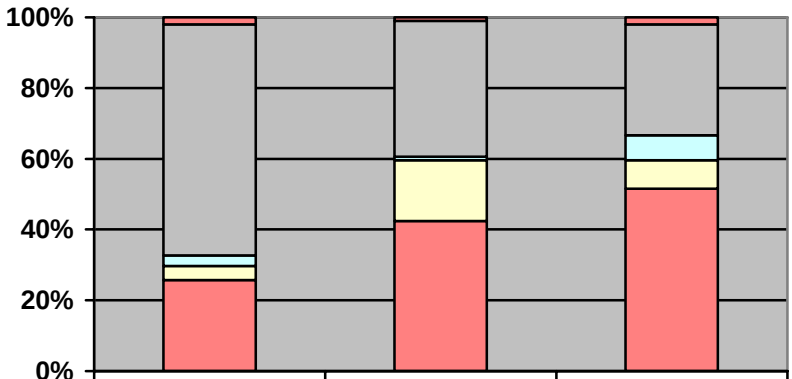
Note: In this graph the percentage of female users' admissions in inpatient units is used as proxy of the percentage of women treated in the units. The proportion of female users is highest in inpatient units and lowest in outpatient facilities.

GRAPH 2.4 - PERCENTAGE OF CHILDREN AND ADOLESCENTS TREATED IN MENTAL HEALTH FACILITIES AMONG ALL USERS



Note: The percentage of users that are children and/or adolescents varies substantially from facility to facility. The proportion of children users is highest in day treatment facilities, and mental health outpatient facilities and lowest in mental health hospitals. Services for children and adolescents are not provided at community-based inpatient units.

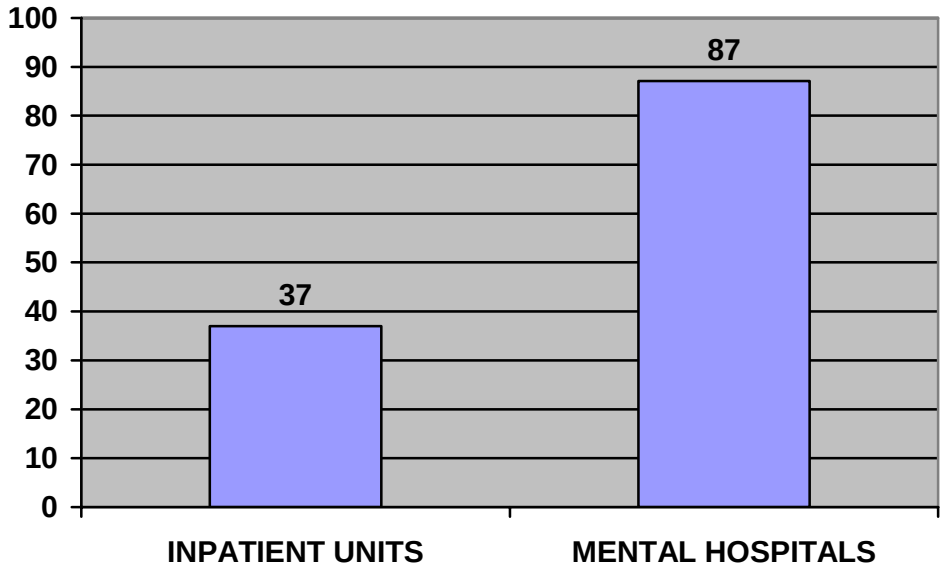
GRAPH 2.5 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS



	OUTPATIENT FAC.	INPATIENT UNITS	MENTAL HOSPITALS
MOOD DISORDERS	2%	1%	2%
OTHERS	66%	38%	31%
PERSONALITY DIS.	3%	1%	7%
NEUROTIC DIS.	4%	17%	8%
SCHIZOPHRENIA	26%	42%	51%
SUBSTANCE ABUSE	0%	0%	0%

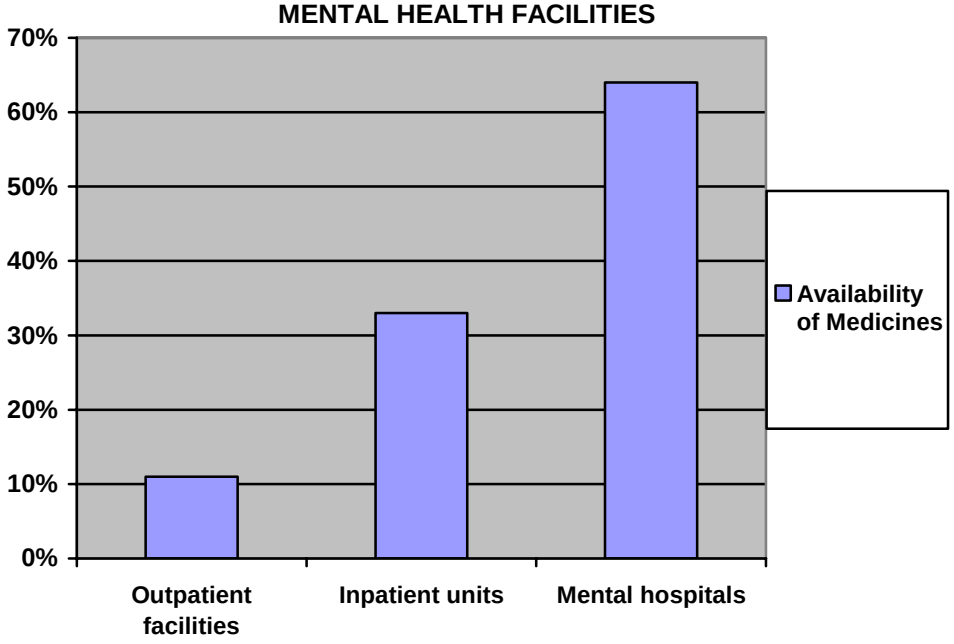
Note: The distribution of diagnoses varies across facilities: in all facilities schizophrenia and neurotic disorders and are most prevalent.

GRAPH 2.6 - LENGTH OF STAY IN INPATIENT FACILITIES
(days per year)



Note: The longest length of stay for users is in mental hospitals, followed by community-based psychiatric inpatient units.

GRAPH 2.7 - AVAILABILITY OF PSYCHOTROPIC DRUGS IN MENTAL HEALTH FACILITIES



Note: Psychotropic drugs are mostly widely available in mental hospitals, followed by inpatient units, and then outpatient mental health facilities.

Domain 3: Mental Health in Primary Health Care

Training in Mental Health Care for Primary Care Staff

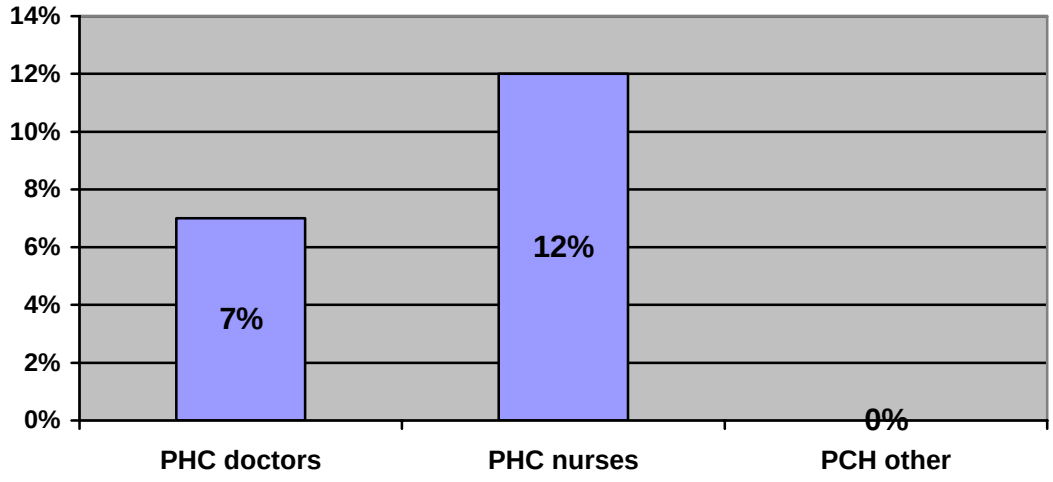
Two percent of training for medical doctors is devoted to mental health, in comparison to one percent for nurses and zero percent for non-doctor/non-nurse primary health care workers.

Two percent of the undergraduate training (first degree), training hours are devoted to psychiatry and mental health-related subjects for medical doctors. The duration of the graduate training is 2 years after the initial 5 years of general study. Internship training lasts for one year after six years of general study. The residency training lasts for two years.

In terms of refresher training, seven percent of primary health care doctors have received at least two days of refresher training in mental health, while 12% of nurses and 0% of non-doctor/non-nurse primary health care workers have received such training.

Family doctors and family nurses undergo six days of training on psychiatric disorders. There is a specialized training course for nurses at the Institute of Postgraduate Studies on psychiatric issues. The volume of the training is 312 hours (two months). The training courses for doctors during specialization comprise 1800 hours (two years).

GRAPH 3.1 - % OF PRIMARY CARE PROFESSIONALS WITH AT LEAST 2 DAYS OF REFRESHER TRAINING IN MENTAL HEALTH IN THE LAST YEAR



Mental Health in Primary Health Care

Both physician based primary health care (PHC) and non-physician based PHC clinics are present in the country. The treatment protocols are not available in both places.

From one to 20% of physician-based, primary healthcare doctors make an average of one referral per month to a mental health professional. Based on the results of the discussion with psychiatrists, patients do not refer to the psychiatrist every month. These are rather sporadic referrals and they comprise less than one percent as a rule. These referrals are not documented. There is an internal system of referrals in which the psychiatrist from an outpatient facility refers a patient to the hospital. The formal referral practice is not in place. The doctor gives only oral referral recommendations.

None of the non-physician based PHC clinics make a referral to a higher level of care. This is not documented anywhere and there are no instructions available. While this practice is not prohibited, this kind of referral is uncommon.

In terms of professional interaction between primary health care staff and other care providers, no primary care doctors interacted with a mental health professional a minimum of once in the last year. A lack of interaction is evidenced, with sporadic exceptions.

A lack of interaction between complimentary/alternative/traditional practitioners and mental health professionals exists. It is worth acknowledging the role of the Mullah - or religious healer -- as quite prominent. More than the half of population refers to this level of religious leader with various health problems, including psychiatric disorders, especially in the rural areas. The general population trusts the religious healer a great deal. The mental health professional's attitude towards religious and other healers is very negative. There is no formal interaction between psychiatrists and healers. As for other healers, such as herb healers, homoeopathists, *tabibs* (traditional healers), needle therapy etc., they are not that popular among the general population. There is an official department of Eastern medicine that is offering training sessions to doctors on alternative treatment methods[8].

Prescription in Primary Health Care

Non-doctor/non-nurse primary healthcare workers are not authorized to prescribe any psychotropic medications in any circumstances. The primary health doctors (general practitioners) prescribe psychotropic medicines and it is not forbidden. There is no formal restriction. However, general medical practitioners do not prescribe strong acting psychotropic medicines. Primary healthcare nurses are not authorized to prescribe psychotropic medicines. Nurses can prescribe only symptomatic treatment.

As for availability of psychotropic medicines, none of the clinics have psychotropic medicines. Both, physician-based and non-physician-based PHC clinics do not have psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic).

[8] Global Initiative for Psychiatry, Mental Health in Tajikistan, the country profile

Domain 4: Human Resources

Number of Human Resources in Mental Health Care

The total number of human resource officials working in mental health facilities or private practice per 100,000 population is 9.3. The breakdown according to profession is as follows: 1.12 psychiatrists, 0.29 other medical doctors (not specialized in psychiatry), 1.9 nurses, 0.1 psychologists, 0 social workers, 0 occupational therapists, and 6.0 other health or mental health workers (including auxiliary, non-doctor/non-physician primary health care workers, sanitary staff, logistics, guards etc.).

Ninety six percent of psychiatrists work only for government administered mental health facilities and four percent work for both the public and private sectors.

Thirty six percent of psychologists, social workers, nurses and occupational therapists work only for government administered mental health facilities, and 64% work only for NGOs/for-profit mental health facilities/private practice.

Regarding the workplace, 56 psychiatrists work in outpatient facilities, three in community-based psychiatric inpatient units and 12 in mental hospitals. Of other medical doctors not specialized in mental health, zero work in outpatient facilities, zero in community-based psychiatric inpatient units, and 12 in mental hospitals. As for nurses, zero work in outpatient facilities, 3 work in community-based psychiatric inpatient units and 40 work in mental hospitals. No psychosocial staff (psychologists, social workers and occupational therapists) works in outpatient facilities, zero in community-based psychiatric inpatient units and zero in mental hospitals. As regards other health or mental health workers, zero work in outpatient facilities, zero in community-based psychiatric inpatient units and 191 in mental hospitals.

In terms of staffing in mental health facilities, there are 0.05 psychiatrists per bed in community-based psychiatric inpatient units in comparison to 0.01 psychiatrists per bed in mental hospitals.

As for nurses, there are 0.05 nurses per bed in community-based psychiatric inpatient units, in comparison to 0.03 per bed in mental hospitals.

No psychosocial staff (clinical psychologists, social workers and occupational therapists) exists in this arena. Only mental hospitals include other staff (0.12 per bed).

Finally, for other mental healthcare staff (e.g., psychologists, social workers, occupational therapists, other health or mental health workers), there are zero per bed for community-based psychiatric inpatient units, and zero per bed in mental hospitals.

The distribution of human resources between urban and rural areas is disproportionate. The density of psychiatrists in or around the largest city is 4.13 times greater than the

density of psychiatrists in the entire country. The density of nurses is 4.09 times greater in the largest city than the entire country.

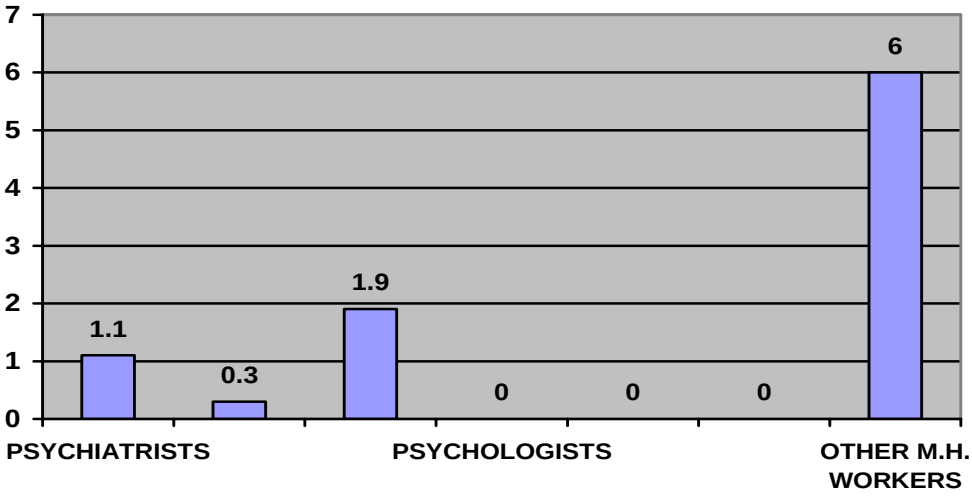
It's difficult to extract narcologists from psychiatrists. Normally they combine two jobs. This number includes all psychiatrists that are working in psychiatric wards and psychiatric cabinets.[9] Furthermore, the same specialists may work in different institutions. It is possible to extract only the number of positions, but not the concrete physical persons.

In the outpatient facilities, there are general practice nurses. As a rule the nurses receive general training on psychiatry within the training program at medical colleges.

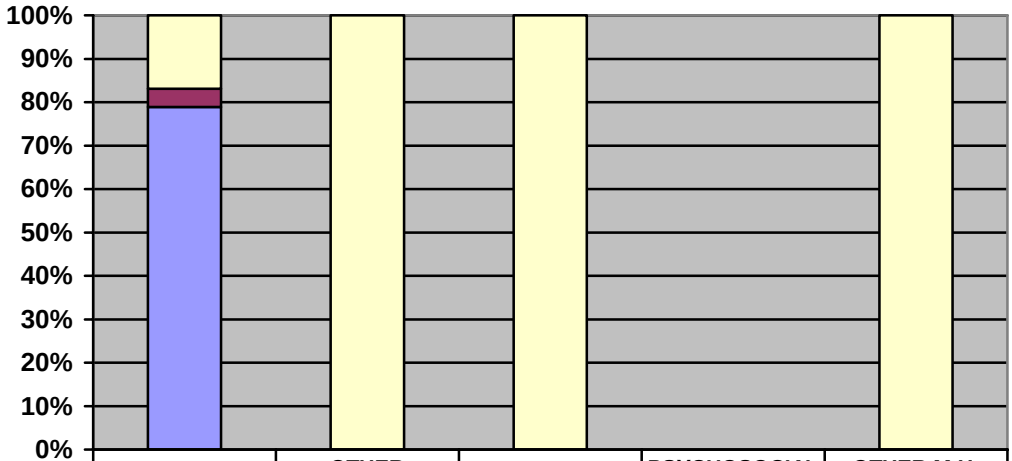
There are two institutions that train psychologists: State University and State Pedagogical University. The State University trained 25 psychologists in 2007. The State Pedagogical University trained 109 psychologists in 2007. The psychologists that graduated from the above institutions are not specialized in the provision of mental health services. Overall, there are six military psychologists, two in the Ministry of Internal Affairs. There are no psychologists within mental health services. There have been few projects funded by international organizations. There is also a lack of permanent personnel working for NGOs as the projects hire people when they need it. Once the funding is finished, the NGO doesn't function.

[9] These data were taken from the Form #30 from Health statistics information centre of the MoH. This number includes not only the psychiatrists, but also the other specialists such as neuropathologists that are working as psychiatrists due to the lack of cadres. According to the last assessment of psychiatric institutions in Tajikistan conducted by PSF in 2005 there were 75 psychiatrists and 27 narcologists (overall 102 doctors). In 2003 this figure was 190 and in 2004 - 179.

GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH
(rate per 100.000 population)

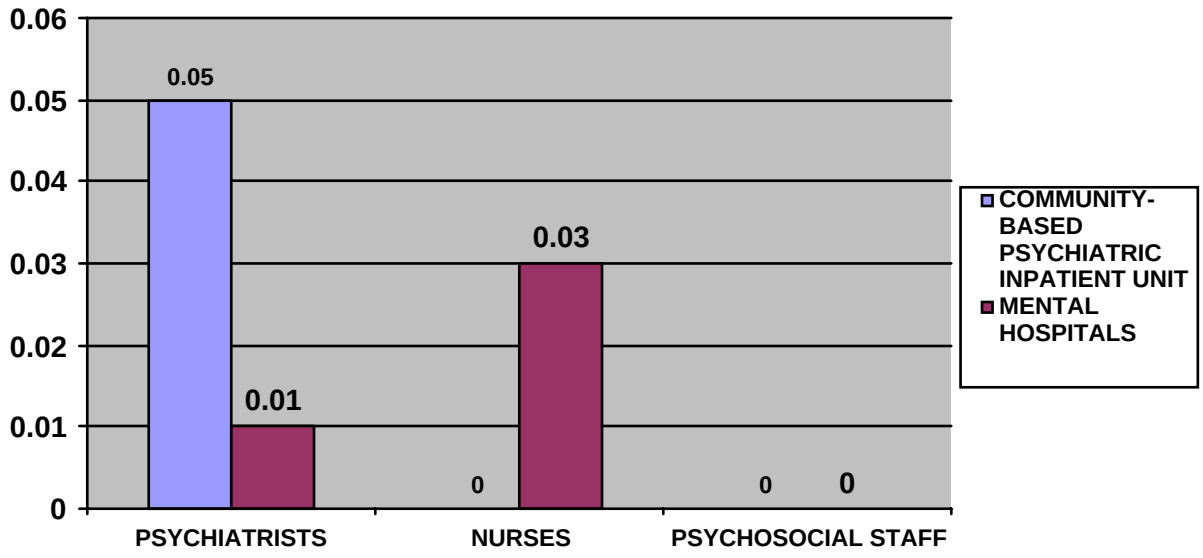


GRAPH 4.2 - STAFF WORKING IN MENTAL HEALTH FACILITIES
(percentage in the graph, number in the table)



	PSYCHIATRISTS	OTHER DOCTORS	NURSES	PSYCHOSOCIAL STAFF	OTHER M.H. WORKERS
MENTAL HOSPITALS	12	12	40	0	191
INPATIENT UNITS	3	0	0	0	0
OUTPATIENT FAC.	56	0	0	0	0

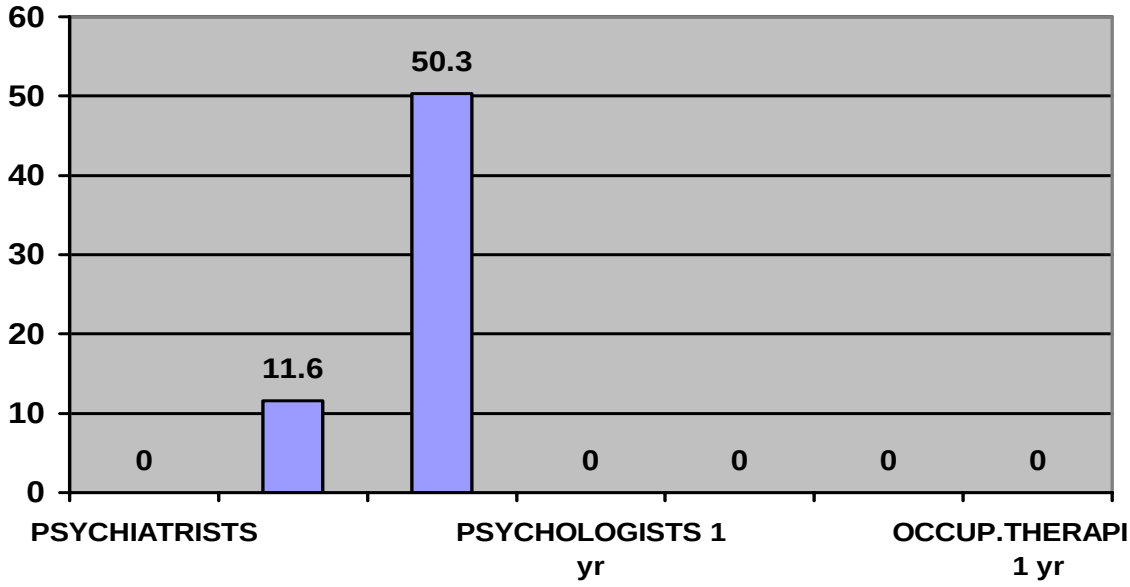
GRAPH 4.3 - AVERAGE NUMBER OF STAFF PER BED



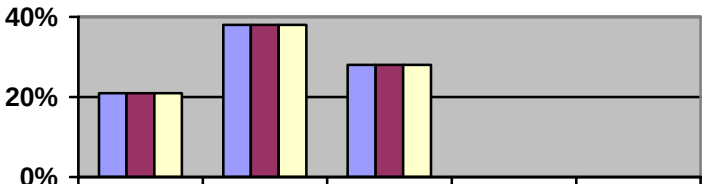
Training Professionals in Mental Health

The number of professionals who graduated last year in academic and educational institutions per 100,000 is as follows: 11.6 medical doctors (not specialized in psychiatry) 50.3 nurses (not specialized in psychiatry), 0 psychiatrists, 0 psychologists with at least one year of training in mental health care, 0 nurses with at least one year of training in mental health care, 0 social workers with at least one year of training in mental health care, and 0 occupational therapists with at least one year of training in mental health care. About 10% of psychiatrists immigrate to other countries within five years of the completion of their training.

GRAPH 4.4 - PROFESSIONALS GRADUATED IN MENTAL HEALTH (rate per 100.000 population)



GRAPH 4.5 - PERCENTAGE OF MENTAL HEALTH STAFF WITH TWO DAYS OF REFRESHER TRAINING IN THE PAST YEAR



	Psych.	MD	Nurses	Psychosocial	Other
Rational use of drugs	21%	38%	28%	NA	0%
Psychosocial interventions	21%	38%	28%	NA	0%
Child mental health	21%	38%	28%	NA	0%

Psych = psychiatrists; MD =other medical doctors not specialized in psychiatry; psychosocial staff = psychologists, social workers, and occupational therapists. Others = other health and mental health workers

Consumer and Family Associations

There are 14 users/consumers that are members of consumer associations, and 14 family members that are members of family associations.

The government does not provide direct financial support for either consumer or family associations.

The existing associations were recently registered therefore, they have not been involved in the development of policies, plans, or legislation. In addition, the policy form mental health program has been not elaborated yet. The interaction of the mental health facilities with both consumer and family is very weak.

In addition to consumer and family associations, there are more than 20 NGOs in the country involved in individual assistance activities such as counselling, housing, or support groups. The NGOs supported by various international organizations and donor agencies that are involved in provision of psychological support to the vulnerable groups of population. For instance these NGOs created day centers for children, trained social workers, and implemented methods of inclusive education. For the first time educational programs for parents with children of limited ability in the fields of legal literacy, consultation and psychological support have appeared. Several NGOs program activity is focused on protecting the rights of people with mental health problems, and also family

members and specialists working in the area. There are more than 20 NGOs which assist families with children of limited ability.

Activities of NGOs on mental health and HIV/AIDS

NGO "Center on Mental Health and HIV/AIDS" which was established with the support of the Global Initiative on Psychiatry (GIP Netherlands) in 2006 works on aspects of mental health and HIV / AIDS in Tajikistan. The organization has implemented 7 projects which address the mental health of drug users and HIV-infected people in the general population. During the last three years the Center conducted training on aspects of mental health and HIV / AIDS for over 120 health workers, psychologists, specialists of AIDS centers, journalists, religious leaders, people living with HIV and drug users. The center provides a variety of services for more than 2500 people every year.

Domain 5: Public Education and Links with Other Sectors

Public Education and Awareness Campaigns on Mental Health

There is a coordinating body to oversee public education and awareness campaigns on mental health and mental disorders. A Healthy Life Style Centre has been created in 2000. The centre is the main MoH body, intended to coordinate all health related public education and public campaigns, however, up to now no education and awareness campaign has taken place on mental health related subjects**.** The first public awareness campaign was the Mental Health Day in 2008 which was initiated and supported by WHO, with involvement of other NGOs, such as GIP, Mental Health Centre and HIV/AIDS, and other NGOs. The event covered the entire population, with emphasis on decision makers.

Legislative and Financial Provisions for Persons with Mental Disorders

Overall, legislative or financial provisions for employment, against discrimination at work, and provisions for housing exist but are not enforced. For instance, according to the law, all governmental organizations are bound to employ disabled persons, reserving 3% of all jobs for this anti-discriminatory employment practice. . These groups of the population are also entitled to use such benefits as 50% of communal services and taxes.

Links with Other Sectors

In addition to legislative and financial support, there are formal collaborations between the government department responsible for mental health and the departments/agencies responsible for primary health care (referral system), HIV/AIDS, Reproductive Health, Child and Adolescent Health, Substance abuse and Criminal justice.

In terms of support for child and adolescent health, 2% of primary and secondary schools have either a part-time or full-time mental health professional on site, and none of

primary and secondary schools have school-based activities to promote mental health and prevent mental disorders.

The percentage of prisoners with psychosis is less than 2 %, while the corresponding percentage for mental retardation is also about 2%. Regarding mental health activities in the criminal justice system, all or almost all (81-100%) of prisons have at least one prisoner per month in treatment contact with a mental health professional.

As for training, none of the police officers and very few judges and lawyers (about 1%) has participated in educational activities on mental health in the last five years. There is a compulsory training course on forensic psychiatry at the faculty of law at Tajik State University.

In terms of financial support for users, none of mental health facilities have access to programs outside the mental health facility that provide outside employment for users with severe mental disorders.

Finally, 11% of people who receive social welfare benefits do so for a mental disability. This is the official figure from the expert committee at Ministry of Labour and social protection. It is quite high, but this is the only info source. It requires monitoring, but the monitoring system is not in place.

Domain 6: Monitoring and Research

A formally defined list of individual data items that ought to be collected by all mental health facilities exists.

As shown in the table 6.1, the extent of data collection is consistent among mental health facilities.

The government health department received data from all mental hospitals, community based psychiatric inpatient units, and mental health outpatient facilities. However, the existing system of data collection does not fully reflect the real situation in mental health. The current AIMS assessment process showed that the information system requires considerable improvement in terms of revision of the data collection forms, flow of information, as well as analysis and feedback. A report was published on this data but did not include comments.

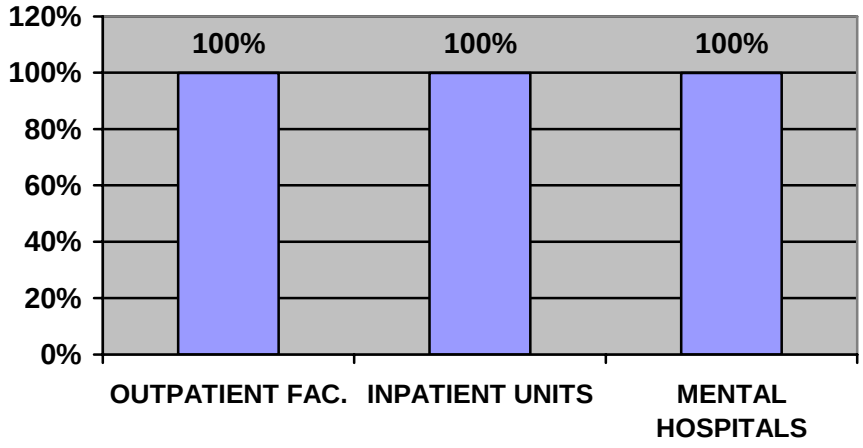
In terms of research, according to PubMed data, 1% of all health publications in the country were on mental health. There were very few studies conducted in the country. The institutions that are involved have limited funds for mental health professionals to compile research. In addition, mental health was not a “priority subject” for the last five years.

The limited number of research studies available includes: a study on the ethno-cultural characteristics of the mental health population of Tajikistan; a study on the causes of suicides in republic of Tajikistan; and a study of the differential diagnosis of schizophrenia and psychotic alcohol conditions.

Table 6.1 - Percentage of mental health facilities collecting and compiling data by type of information

TYPE OF INFORMATION COMPILED	MENTAL HOSPITALS	INPATIENT UNITS	OUTPATIENT FAC.
N° of beds	100%	100%	NA
N° inpatient admissions/users treated in outpatient facilities	100%	100%	100%
N° of days spent/user contacts	100%	100%	100%
N° of involuntary admissions	0%	0%	NA
N° of users restrained	0%	0%	NA
Diagnoses	100%	100%	100%

GRAPH 6.1 - PERCENTAGES OF MENTAL HEALTH FACILITIES TRANSMITTING DATA TO HEALTH DEPARTMENT



Strengths and Weaknesses of the Mental Health System in Tajikistan

Activities in the field of mental healthcare provision have not been specifically regulated up to 2002 from the legal point of view. At present, these are governed by Law of the Republic of Tajikistan. “On Psychiatric Care.” Although a Declaration and Action Plan endorsed by all WHO European Member States prioritized mental health in Helsinki in 2005, Tajikistan has not yet begun to introduce reforms. Moreover, despite the high burden of mental illness globally, the Millennium Development Goals do not directly include targets for mental disorders; thus these MH programs attract little investment by international donors.

Besides the decline of Mental Health cervices, Tajikistan also faces enormous economic, social, and political problems, including extreme poverty, drug trafficking, and the collapse of the Soviet-sponsored infrastructure. Tajikistan is dependent on other countries and governmental and nongovernmental organizations for support and development. To date, few to none have made mental health a priority.

Tajikistan remains the poorest NIS country and mental health receives very little priority. All mental healthcare in Tajikistan currently takes place in institutions. Being a doctor or nurse is not financially attractive and the younger generation of medical professionals will therefore not soon choose to work in mental health.

In Tajikistan, psychiatric care is largely hospital-based and no functional community services exist in the mental health field.

Tajik society has very little knowledge of the causes, possible treatments and needs of persons with psychiatric disorders. There is huge discrimination as far as employment and provision of services are concerned. In general, Tajik society has many prejudices, leading to stigmatization of those suffering from mental health problems.

Mental health policy development is another crucial area which needs to be improved. The process, entailing collaboration between various stakeholders including the traditional healers in Tajikistan, is equally important.

There is much gender-bias in mental health and psychiatric services and violence against women is widespread in Tajikistan. After 5 years of civil conflict and over a decade of economic transition following independence, Tajikistan's social sector is limping badly.

No reforms have been carried out to date in prison mental health or forensic psychiatry in Tajikistan.

The mental health services in Tajikistan need to train pediatric psychiatrists. There is no emergency psychiatry in the country.

HIV/AIDS is a very serious public health problem in Tajikistan. The general population stigmatizes and discriminates against HIV patients, and insufficient services exist to provide support for people living with HIV and their families. Importantly, according to mass media estimates more than 1 million of the working age Tajik male population migrates to Russia for employment.

The country plans to initiate the training of social workers within the Tajik National University.

As a result of the suspension of food supply provisions by international agencies, the psychiatric facilities became entirely dependent on State resources. The State health financing is far short of what is necessary to cover the needs of the patients. MoH is not able to provide funding for all the requests fully. The State budget resources are mainly intended to cover wages, food and medicines expenses.

Mental Health specialists in Tajikistan are paid the equivalent $20 a month. Unlike other medical specialties, mental health patients are mostly poor; they cannot afford to pay under the table for services

Mental Health services in Tajikistan have received little to no financial support from international community. Some NGOs have conducted trainings, in particular, MSF helped to carry out training on mental health laws, and the Global Initiative for Psychiatry provided technical support in the field of rehabilitation of patients. In addition, although the work of NGOs is critical in Tajikistan, the NGOs often do not have permanent staff, operate out of inadequate facilities and are dependent on donors. Also, there could be better coordination between the NGOs and between the NGOs and the government.

Next Steps in Strengthening the Mental Health System

Policy and Legislative Framework

Development of the comprehensive policy, national strategy and plan of action for mental health through promotion of the process of policy development in a participatory way involving all the stakeholders such as ministries and other governmental agencies, non-governmental organizations, users and their families and relatives based on the best use of experiences.

Mental Health Services

Creation of community-based facilities through establishing long-term, collaborative partnerships with psychiatric institutions with the assistance of leaders from countries with well-established, humane psychiatric practices and institutions.

Mental Health in Primary Health Care

Increasing the capacity of mental health professionals through: 1) training of healthcare providers with use of up to date training materials, guidelines and protocols 2) provision of supportive supervision practices 3) establishing a referral network between primary and specialized care.

Human Resources

Increasing the numbers of psychosocial staff through: 1) advocacy and motivation mechanisms for professionals 2) education of sufficient number of clinical psychologists, social workers, occupational therapists and psychiatric nurses 3) training of mental health managers and trainers.

Links with other Sectors

Increasing the mental health system's links with other key sectors through: 1) involvement of the key partners and stakeholders into the joint development and implementation of mental health policy 2) establishing interagency coordination committee on mental health.

Monitoring and Research

Development or improvement of the mental health information system through: 1) training on data collection and analysis of mental health data from all levels 2) establishing the feedback system.

The structure of the mental health services has not changed for the last two decades. Tajikistan is facing decline of the mental health services. It remains highly institutionalized and underfunded. Besides the decline of Mental Health services, Tajikistan also faces enormous economic, social, and political problems, including extreme poverty, drug trafficking, and the collapse of the Soviet-sponsored infrastructure. Tajikistan is dependent on other countries and governmental and nongovernmental organizations for support and development. To date, few to none have made mental health a priority.

Although a Declaration and Action Plan endorsed by all WHO European Member States prioritized mental health in Helsinki in 2005, Tajikistan has yet to introduce reforms. Moreover, despite the high burden of mental illness globally, the Millennium Development Goals do not directly include targets for mental disorders; thus MH programs attract little investment by international donors.

Being a doctor or nurse is not financially attractive and the younger generation of medical professionals will therefore not soon choose to work in mental health.

The current assessment was performed in 2008 and was based on data for the year 2007. The WHO Assessment Instrument for Mental Health Systems (WHOAIMS) was used to collect information on the mental health system in Tajikistan. The report includes data and analysis of the mental health system in Tajikistan and covers following topics: policy and legislative framework, mental health services, human resources, public education and links with other sectors, and monitoring and evaluation.

The goal of collecting this information is to enable policy makers to develop information-based mental health national policy and strategies with well defined targets and plan of action. These reforms should dramatically improve the lives of people with mental disorders in Tajikistan.