

Mental Health Challenges and Opportunities in Latvia

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Background

Latvia is among the small size countries in Europe with a population of 2.3 millions and a higher middle income group country based on World Bank 2004 criteria. About 15% of the population is under the age of 15 and 22% of the population are over the age of 60. The life expectancy at birth for males is 64.6 for males and 75.8 for females. The healthy life expectancy at birth is 58 for males and 68 for females (UNO, 2004, WHO 2004).

4.4% of Latvian residents are facing mental health problems. The number versus the average 7–9% showing in other countries is quite small due to recording problems as well as insufficient service accessibility.

The proportion of the health budget to GDP is relatively low (6.4%) with the per capita total expenditure on health of 509 international \$, and the per capita government expenditure on health of 267 international \$ (WHO, 2004). Psychiatry is 100 % publicly founded, however absolute pool of money available for mental health is small - 6.3% of the total health care expenditures. Of all mental health expenditures, about 80% were directed towards mental hospitals.

Mental health services are organized in terms of catchment/service areas. There are 13.8 psychiatric hospital beds per 100 000 population. The average number of days spent in mental hospitals was 67. Concerning the length of stay 66 % of patients spent less than one year and 9 % of patients spent more than 10 years in mental hospitals. The number of psychiatric hospitals beds decreased by 20% from 1997 to 2002. Over the last 4 years an additional 50 % of discharges with primary psychiatric diagnoses were coming from non-psychiatric hospital beds, mostly with somatoform and affective diagnoses.

There are only 5 day treatment facilities available in the country, none of which are available for children and adolescents only. These facilities treated 30.8 users per 100 000 general population. Children or adolescents were not treated in these facilities. On average, users spent 39.5 days per year in day treatment facilities.

There are 43 outpatient mental health facilities available in the country, of which 2% are for children and adolescents only. These facilities treated 2 681 users per 100 000 general population with an average number of contacts per user 3.

There are 1351 general practitioners and 515 primary health care facilities (praxis, ambulatory, health centre, primary health care centre) available in the country. They have carried out up to 1/3 of all outpatient visits (387 000) with primary F diagnosis in 2004. GP's have diagnosed mostly somatoform and affective diagnoses.

Strengths and weaknesses of the mental health care system in Latvia

The challenge facing the mental health care system in Latvia is how to shift the resources from mental hospitals to community mental health facilities. Mental hospitals still predominant in the

mental health system and almost all the financing and staff resources are concentrated in these institutions.

The network of mental health facilities in the community is not yet complete, as general hospital inpatient units for adults, day treatment facilities and community residential units are lacking. The absence of community residential facilities is critical, because it prevents the mental hospitals from downsizing through the dismissal of long stay patients (about a 1/3rd of all patients) into the community. Moreover, the lack of inpatient units for adults doesn't allow the shift of acute inpatient treatment from mental hospitals to general hospital. Community outpatient facilities are not well staffed; they particularly lack psychosocial staff (e.g., psychologists, social workers, etc). Outpatient facilities provided mainly psychotropic medication, while only few patients received psychosocial interventions.

In terms of coordination of care, only a half of the mental hospitals are organizationally integrated with mental health outpatient facilities, weakening the continuity of care. Without a clear shift of resources from mental hospitals towards community services, the extension of mental health cannot be increased and the continuity of care improved.

The diagnostic breakdown shows an intensive use of mental health facilities by users with organic mental disorders: characteristics of these needs should be assessed and appropriateness of their treatment in these facilities evaluated. Conversely there is an underutilization by users with affective disorders, possibly related to accessibility and stigmatization of community outpatient facilities. Patients with affective and somatoform disorders are often treated by non-specialists and without psychiatric backup, which question quality of care provided.

The last piece of mental health legislation was enacted in 1997, which focuses on access to mental health care, including access to the least restrictive care, rights of mental health service consumers and family members, voluntary and involuntary treatment, and accreditation of professionals and facilities. Mental health legislation issues were included in general health legislation, while a specific mental health law is under discussion in different governmental establishments and parliament for more than 4 years.

There was a lack of approved mental health plan from 2003. The new plan for 2006-2016 is already in the final stage of approval in the Council of Ministers. This plan includes following components: organization of services (development of community mental health services and downsizing large mental hospitals), developing a mental health component in primary health care, advocacy and promotion, human rights protection of users, equity of access to mental health services across different groups, quality improvement and monitoring system. It is meeting the standards of the European Council and the WHO.

The affordability of mental health care in Latvia is adequate: mental health treatments were covered in social insurance schemes and the reimbursement system for outpatients worked. However, 100% reimbursement for outpatient medication in 2005 was available only for children and for adults with schizophrenic disorders (F20) and 75 % for limited group of patients with diagnoses F 00, 06, 21, 22, 25, 31 and 33. A list of essential medicines is annually updated and it includes all the therapeutic classes of psychotropic medicines (antipsychotics, anxiolytics, antidepressants, mood stabilizers and antiepileptic drugs). However, the limited health budget does not allow to provide newest medication to all patients in need.

A national human rights review body does not exist. At the mental health services level, about two thirds of the mental hospitals had at least yearly one review/inspection of human rights protection of patients, while no community-based inpatient psychiatric units and community residential facilities had such a review. Moreover, no staff working in these facilities have had at least one day training, meeting, or other type of working session on human rights protection of patients.

The mental health information system is well developed and covers all mental health facilities. Its function in monitoring the development of community care is crucial and its utilization should be improved (e.g. disseminating a mental health report). It should include information on the number of involuntary admissions or secluded patients, because these are important indicators of human rights respect in mental health facilities.

The link between mental health services and primary care should be improved. Although referral to mental health services was frequent, only one-third of primary care doctors had monthly interactions with mental health staff, and only a few primary health doctors received refresher training in mental health. Without a stronger link between community outpatient facilities and primary care, common mental disorders, like affective disorders, are difficult to treat. The family and user associations are small in size and their opinion on mental health services, policies and plans was not encouraged.

From a larger point of view, the mental health issues should be tackled not only among professionals but in strong connection with the whole society. Downsizing the mental hospitals, promoting campaigns against stigma, and increasing the participation of users and families implies not only technical choices, but also a large participation of the stakeholders and of large sectors of the society to these choices.

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