WHO-AIMS

WHO-AIMS REPORT ON

MENTAL HEALTH SYSTEM IN THE REPUBLIC OF AZERBAIJAN

World Health Organization

MINISTRY OF HEALTH
THE REPUBLIC OF AZERBAIJAN

WHO-AIMS REPORT ON

MENTAL HEALTH SYSTEM

IN THE REPUBLIC OF AZERBAIJAN

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

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The World Health Organization Assessment Instrument for Mental health Systems (WHO-AIMS) has been conceptualized and developed by the Mental Health Evidence and Research team (MER) of the Department of Mental Health and Substance Abuse (MSD), World Health Organization (WHO), Geneva, in collaboration with colleagues inside and outside of WHO.

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.

LIST OF ABBREVIATIONS

AIMS	Assessment Instrument for Mental Health Systems
AzPA	Azerbaijan Psychiatric Association
CMC	Baku Clinical Medical Center
EBM	Evidence-based Medicine
FIU	Forensic Inpatient Unit (Inpatient unit for compulsory treatment)
CFPA	Center for Forensic-Psychiatric Assessment
IDP	Internally Displaced Person
MH	Mental Health
MHS	Mental Health System
MoH	Ministry of Health
PH	Public Health
PHC	Primary Health Care
PND	Psychoneurologic Dispensary
PSD	Psychosomatic Department
PsH	Psychiatric Hospital
SU	Soviet Union
SW	Social Worker
WB	World Bank
WHO	World Health Organization

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 the Republic of Azerbaijan for the year of 2006. 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 Azerbaijan to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

Azerbaijan has no mental health policy present in the country. A mental health strategic plan and an emergency/disaster preparedness plan for mental health are also lacking. Due to development of the system of social insurance mental health services are not fully covered by social insurance. Although there is a human rights review body in the country, this authority does not consider issues related to the human rights protection of mentally ill people on a regular basis.

There is no mental health authority body in the country. Eleven outpatient mental health facilities treat 1092 users per 100,000 general population. Day treatment facilities are underutilized and they treat 24.9 users per 100,000 general population. There are two community-based psychiatric inpatient units in the country for a total of 0.71 beds per 100,000 population. None of these beds in community-based inpatient units are reserved for children and adolescents. There are nine mental hospitals (MHs) in the country for a total of 48.9 beds per 100,000 population. The patients admitted to mental hospitals belong primarily to schizophrenia, schizophreniform and delusional disorders (36%). Violation of human rights is practiced in some inpatient psychiatric institutions. Due to cultural features, women in Azerbaijan do not seek help from mental health providers that often as men do. In comparison to western societies women in Azerbaijan are mostly supported in the framework of their families. None of users receive any psychosocial interventions in mental health facilities. 100% percent of mental health facilities had at least one free psychotropic medicine of each therapeutic class available in the facility.

Primary health care staff receive no training in mental health and interaction with mental health services is rare.

There are 22 human resources working in mental health for 100,000 population. Rates are particularly low for social workers and clinical psychologists. There are no occupational therapists working in mental health. Most psychiatrists work for governmental facilities. There is an uneven distribution of human resources in favour of mental hospitals and the capital city. There are no consumer and family associations in mental health (MH).

There is no coordinating body to oversee publication and awareness campaigns in the field of MH. Legislation provisions for employment and housing, as well as countering discrimination at work and in housing exist but are not enforced. There is formal interaction between MH service and departments/agencies responsible for HIV/AIDS, reproductive health, substance abuse, military and criminal justice.

Data are collected and complied by facilities to a variable extent. Facilities produce internal reports based on the information, but no official report has been published and distributed by the government based on these data or internal reports. Limited number of the research carried out in the country focused on non-epidemiological clinical/questionnaires assessments of mental disorders, services research, psychosocial interventions/psychotherapeutic interventions, and pharmacological interventions.

INTRODUCTION

Azerbaijan is a country with area of 86,600 square kilometers. According to the government of the Azerbaijan Republic and UN resolutions[1], about 20% of Azerbaijan's territory in and around Nagorny Karabakh region of the Azerbaijan Republic has been occupied by the Armenian military forces. The country population is 8,436,400 and more than 10% of the population is refugees and Internally Displaced People (IDPs). On a world scale this is one of the highest refugee-per-person indicators. The main languages used in the country are Azerbaijani and Russian. The largest religious group is Muslim (96%), and the other religious groups are Russian Orthodox, Armenian Apostolic and Judaism. The largest ethnic groups are Azerbaijani 90.6%, Dagestani 2.2%, Russian 1.8%, Armenian 1.5% (majority of Armenians live in the Nagorno-Karabakh region, which is under Armenian occupation; over 30,000 of Armenians live in other parts of Azerbaijan); other ethnic groups include Talishs, Tatars, Turks, Ukrainians, Kurds, Georgians, Tats, Jews and Udins. According the World Bank 2006 criteria, Azerbaijan is a lower middle income country.

The proportion of population under the age of 15 years is 25.4%, and 7% of the population is above the age of 60 years. The percentage of the rural population is 49%. The life expectancy at birth is 65.9 years for the total population (61.8 years for males and 70.6 years for females). Information on healthy life expectancy is unavailable. The literacy rate is 98.8% total: 99.5% for males and 98.2% for females.

Proportion of the government's health budget to GDP is 0.6%. According to the World Bank (WB), only 20% of total health expenditures are public, and 78% are private, mostly through unofficial out-of-pocket system. Per capita government expenditure on mental health is 0.34 $ a year.

The healthcare system of the country is a legacy of the Soviet Union (SU) and it has been in transition since the collapse of the SU. It became unsustainable in meeting the challenges of political and economic changes.

According to research of the International Consortium for Mental Health Policy and Services conducted in 2000-2002 in Azerbaijan the cultural significance attached to health/mental health is considered in the view of family values, financial well-being or adhering to customs. A positive mental health is conceived as an inner balance, ability to manage the everyday deals and to choose a correct solution of personal problems, as well as to adhere to the conventional behavioral standards. Some psychiatric disorders such as mild or moderate depression or anxiety are not perceived as serious emotional problems, whilst the concept of "mental illness" is attributed to severe psychiatric disorders. Due to stigma accompanying psychiatric disorders patients and their families try to hide mental problems and avoid applying to the official Mental Health System (MHS). The structure of the MHS has not changed for the last decades. It remains institutionalized and restricted in terms of provided services. In addition to relatively insufficient number of psychiatric institutions their conditions and equipment do not meet modern standards for a medical facility. Almost all of them are located in very old and decrepit buildings, without satisfactory water and heat supply.

[1] 1993 UN Security Council Resolutions on Nagorno-Karabakh (No. 822, 853, 874, 884)

Total number of beds in hospitals per 100,000 population is 829 and approximately 2% of them are in the private sector. There are 6041 general practitioners in the country. In terms of primary care, there are 1595 physician-based primary health care clinics in the country.

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 to cover the key aspects of mental health systems. In addition, it includes other resources, such as a data entry programme and a template for writing a country report, which allows countries to efficiently collect data and then quickly translate that information into knowledge that can assist planning.

The implementation of WHO-AIMS can generate information on strengths and weaknesses to facilitate improvement in mental health services. WHO-AIMS will enable countries to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

Data for the report were collected in 2007 and based on the year 2006.

POLICY AND LEGISLATIVE FRAMEWORK

Policy, plans, and legislation

There is no mental health policy in terms of a particular document which is intended to set a clear direction of future development of mental health services in the country. Both a mental health plan and an emergency/disaster preparedness plan for mental health are not present in the country.

The first piece of mental health legislation was enacted in 2001 and at the present time it is the only available legal act regulating mental health care provision. This 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.

Mental health issues are also covered in both criminal and civil legislation. In addition, there is a few regulations issued by the Cabinet of Ministers of the Azerbaijan Republic to implement some aspects of mental health legislation, but the majority of them remain uncovered. Standardized documentation and procedures for implementing mental health legislation do not exist for the most of components of mental health legislation. Psychiatrists, lawyers and consumers are not sufficiently informed about the existent norms of mental health legislation.

The list of essential medicines is present and was updated in 2005. These medicines include antipsychotics, anxiolytics, antidepressants and antiepileptic drugs. Lithium has not been included into the essential medicines list. Anticonvulsants such as carbamazepine and valproats are used as mood stabilizers.

Financing of mental health services

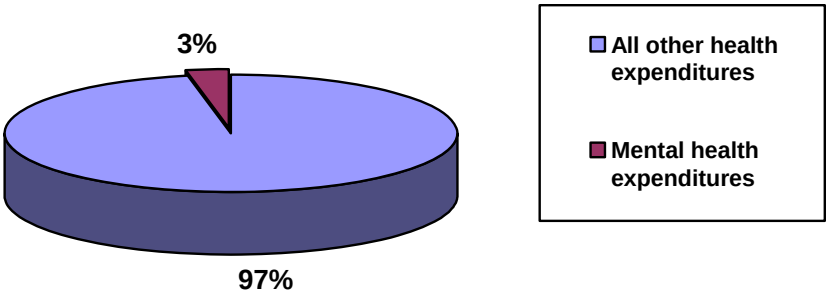
3% of health care expenditures by the MoH are devoted to mental health. Of all the expenditures spent on mental health, 85% are allocated to mental hospitals. The biggest share for mental health expenditures lays on out-of-pocket payments by mental health consumers to providers. Since this practice is unofficial it is not calculated and reported.

People with schizophrenia and epilepsy as well as people with first and second group of disability due to mental illnesses who are registered in mental health outpatient facilities have free access to essential psychotropic medicines. During the period of assessment, less than 1% of population of the country was registered and entitled to these free medicines. At least one free psychotropic medicine from each category is available for registered patients. The majority of patients applying for mental health

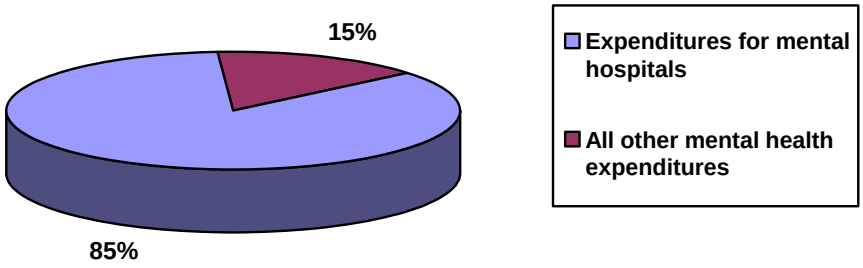
care avoid registration in mental health facilities due to stigma, thus they are not eligible for free psychotropic medication and they have to purchase medicines at their own expense. For those who pay out of pocket, the cost of the least expensive antipsychotic medication is 3% and the cost of the least expensive antidepressant medication is also 3% of the minimum daily wage (0.06 USD and 0.07 USD per day respectively).

Mental health services are not covered in social insurance schemes. The government covers expenses for treatment (e.g. some medication, lab tests) and care (e.g. some consumables) in mental hospitals.

GRAPH 1.1 STATE HEALTH EXPENDITURE TOWARDS MENTAL HEALTH



GRAPH 1.2 STATE MENTAL HEALTH EXPENDITURE TOWARDS MENTAL HOSPITALS



Human rights policies

Although there is a human rights review body (office of Ombudsman), it does not consider issues related to rights protection of mentally ill people on a regular basis. Thus, none of mental hospital and community-based inpatient psychiatric units have had at least one yearly external review/inspection of human rights protection of patients. None of the staff of mental hospitals and community-based inpatient psychiatric units have ever had at least one-day training, meeting or other type of working ses-

sion on human rights protection of patients. However, in the last two years, nongovernmental and professional organizations have provided training on patients' human rights to approximately 40 hospital staff.

According to the expert opinion of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, there are some violations of human rights in certain psychiatric institutions.

MENTAL HEALTH SERVICES

Organization of mental health services

There is no mental health authority in the country. There is a consultancy position of the Head Psychiatrist of the Ministry of Health. However, the formal scope of work for the position is defined by regulations elaborated during times of the Soviet Union (Order # 225, issued in 1985 by the MoH of the USSR).

Mental health services are governed by the Ministry of Health and organized in terms of catchment/service areas. An office of a psychiatrist is presented in each administrative district polyclinic to offer its services for 50,000 to 150,000 people. The psychiatrist's offices are subordinated both to the district health administration and to interregional Psychoneurologic dispensaries (PND), with a catchment area of 300,000-600,000 population. Reports from the psychiatrists are submitted to interregional PNDs.

Mental health outpatient facilities

There are 11 outpatient mental health facilities (PNDs) available in the country, of which one facility (9%) is for children and adolescents only. Nine out of 11 outpatient mental health facilities have beds for inpatient care. However, bed-related data of outpatient facilities are presented in the section "Mental Hospitals" (page 14). These facilities treat 1092 (1.1%) users per 100,000 general population.

Of all users treated in mental health outpatient facilities, about 25% are female and approximately 16% are children and adolescents. Due to cultural features, women in Azerbaijan do not seek help from mental health providers that often as men do, and women get more support by their families and relatives. In contrast to men women at younger ages are also less socially involved in terms of vocational and leisure activities. Another reason for the phenomenon is the fact that women have fewer chances to be in the scope of MH services unlike men, who are conscripted into military services: men have to pass psychiatric examination for the purpose of fitness to army. Finally, stigma attached to women with regard to metal disorders is higher than among men and their complaints are often not taken seriously.

The users treated in outpatient facilities are primarily diagnosed with mental and behavioral disorders due to neurotic, stress-related and somatoform disorders (25%) and schizophrenia, schizophreniform and delusional disorders (19%). Based on the conducted assessment, the statistical break down of mental disorders in Azerbaijan significantly differs from the one in European countries because mild and moderate

mood disorders are under-diagnosed by psychiatrists. The average number of contacts per user was 3.48 in the assessed year.

Follow-up community care is provided mainly by PNDs. Visits for follow-up care to PNDs is prevalent practice. According to the legislation, home visits are permitted in case of preliminary content of the patient. The main reason of limited home visits is absence of transportation for staff to see patients at home. None of PNDs have mental health mobile teams, because a mobile psychiatric team is a part of Emergency Medical Services.

None of users receive any psychosocial interventions in PNDs as services are limited to psychopharmacotherapy only. 100% percent of mental health outpatient facilities had at last one psychotropic medicine of each therapeutic class (anti-psychotics, antidepressants, mood stabilizers, anxiolytics, and antiepileptic medicines) available in the facility or a near-by pharmacy all year round.

Day treatment facilities

There are five “day care departments” available in the country. Four of them are located in the capital city: two of them are a part of mental hospitals, while the other two ones are integrated into a mental health outpatient facility (Adult and Child PNDs). One of the existing day treatment facilities (20%) is for children and adolescents. See appendix A for the organigram of the country MHS.

These departments are underutilized and they treat 24.9 users per 100,000 general population. No data on female users of day treatment facilities is available. Of all users treated in day treatment facilities, 17% are children or adolescent

Community-based psychiatric inpatient units

Community-based psychiatric inpatient units are called “psychosomatic departments” in general hospitals. There are two of them in the country with 60 beds in total (0.71 per 100,000 population). None of these beds in community-based inpatient units are reserved for children and adolescents. Children and adolescents are not admitted to community-based psychiatric inpatient units. Information on gender distribution of patients admitted to community-based psychiatric inpatient units is not available.

The diagnoses of admissions to community-based psychiatric inpatient were primarily from the following two diagnostic groups: schizophrenia, shizophreniform and delusional disorders (38%) and mood disorders (7%). On average patients spend 30.8 days per discharge. Like in PNDs, treatment in community-based psychiatric inpatient units did not include psychosocial interventions and focused on pharmacotherapy only.

100% 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.

One of the community-based psychiatric inpatient units has not been operating for more than a year as the hospital where it is situated is under renovation. So the data collected for the unit reflects statistics for the first quarter of the year 2006.

Community residential facilities

There are no community residential facilities available for mentally ill people in the country.

Mental hospitals

There are nine mental (psychiatric) hospitals (PsH) in the country for a total of 4,125 beds (48.9 beds per 100,000 population). This number of beds also includes the number of beds in mental health outpatient facilities (PNDs). The largest hospital in the country has a mental health outpatient facility in its structure. In addition, only this hospital has one child department (50 beds) and one adolescent department (50 beds). Thus only 2% of beds in mental hospitals are reserved for children and adolescents. The number of beds in PsHs has increased by 1% in the last five years (this data is based on the official statistics and the number of beds in facilities under renovation is not considered).

The patients admitted to mental hospitals belong primarily to schizophrenia, shizophreniform and delusional disorders (36%). In addition, people undergoing psychiatric examination often reveal disorders of adult personality and behavior (8%). The number of patients in PsHs is 107.4 per 100.000 population. The average number of days spent mental hospitals was 64.5 in the assessed year.

One of imperfections of the existing inpatient facilities is an absence of differentiation of MHs as short- or long-term institutions. Yet information on proportion of long-stay patients is not available since existing system of patients' registration in terms of length of stay is not considered. Patients stay in the similar conditions in PsHs regardless severity and course of their illnesses. Similar to other mental health facilities, treatment in PsHs focused on pharmacotherapy only. While some of the PsHs provide limited number of initiatives related to psycho-social rehabilitation, this practice is not common in the country. All PsHs had at least one psychotropic medicine of each therapeutic class (anti-psychotics, antidepressants, mood stabilizers, anxiolytics, and antiepileptic medicines) available in the facility. Drug provision is irregular and number of medicines is limited both in range and quantity. Treatment is not based on adopted guidelines or protocols of Evidence-based Medicine (EBM).

Forensic and other residential facilities

In addition to beds in mental health facilities, there are also 370 beds for persons with mental disorders in forensic inpatient units and 1617 beds in other residential facilities such as homes for persons with mental retardation, elderly, homes for the destitute, etc. These are closed institutions with insufficient observance and monitoring of human and social rights for their residents. There is no available information on proportion of long-stay patients by length of stay in forensic and other facilities.

Human rights and equity

Information on involuntary admissions to community-based inpatient psychiatric units as well as involuntary admissions to mental hospitals is not available, since there are

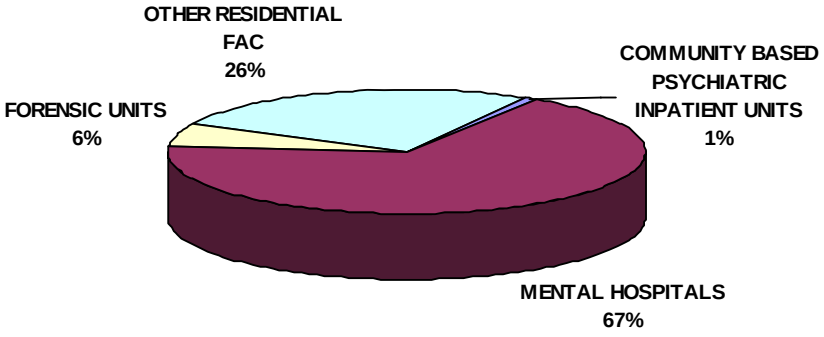
no procedures that provide implementation of the existing legislation on involuntary admissions, and there are no statistical forms to register such admissions. In addition, information on patients who were restrained or secluded at least once within the last year both in community-based psychiatric inpatient units and in mental hospitals was not kept. Yet these practices happen in inpatient psychiatric institutions. Human rights compliance is still an issue in most of mental health institutions in terms of unauthorized admissions and confinement, malpractice in inpatient facilities, and relatives' refusal to take patients back home after completion of their treatment.

The density of psychiatric beds in or around the largest city is 2.75 times greater than the density of beds in the entire country. Such distribution of beds limits access for rural users. Inequity of access to mental health services for other minority users (e.g., linguistic, ethnic, religious minorities) is a not an issue in the country.

PsHs in the country are in a bad condition and very poorly equipped, so people tend to avoid admitting to these facilities and forced to apply in cases of severe or acute disorders.

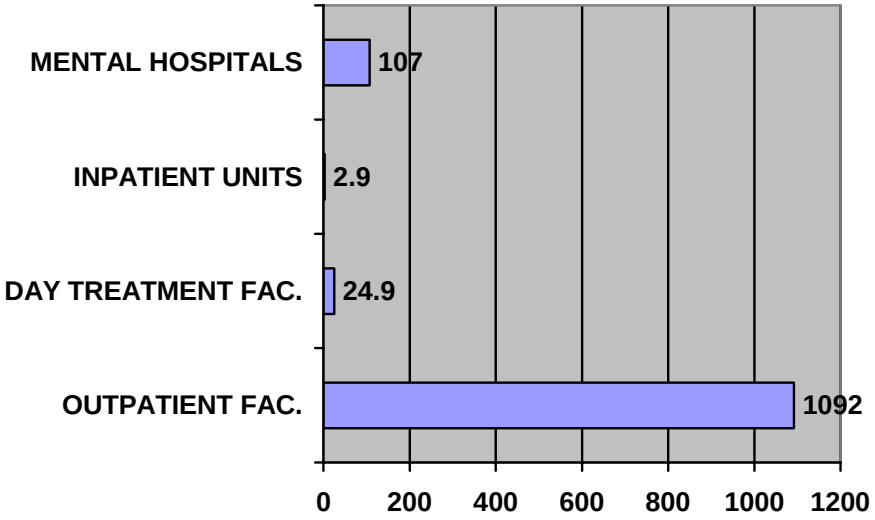
Summary Charts

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



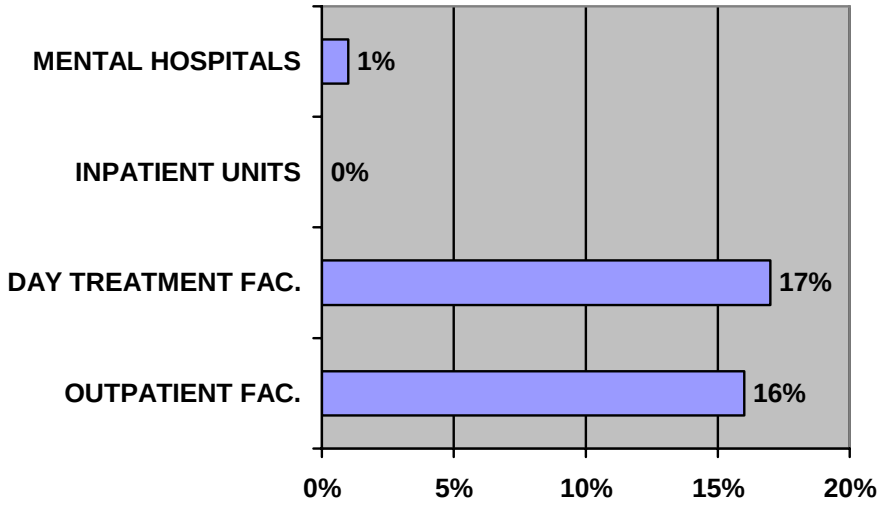
The majority of beds in the country are provided by mental hospitals, followed by other residential facilities inside and outside the mental health system.

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



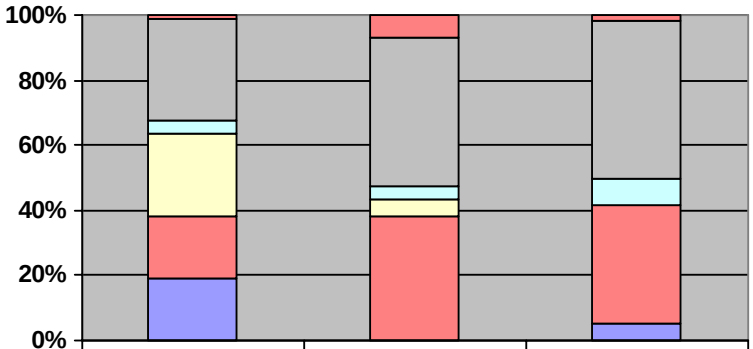
Note: In this graph the rate of admissions in inpatient units is used as proxy of the rate of users treated in the units. The majority of the users are treated in outpatient facilities and in mental hospitals, while the rate of users treated in community-based inpatient units, day treatment facilities is significantly lower.

GRAPH 2.3 - PERCENTAGE OF CHILDREN AND ADOLESCENTS TREATED IN MENTAL HEALTH FACILITIES AMONG ALL USERS



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 hospitals. Children are not served in community-based inpatient units.

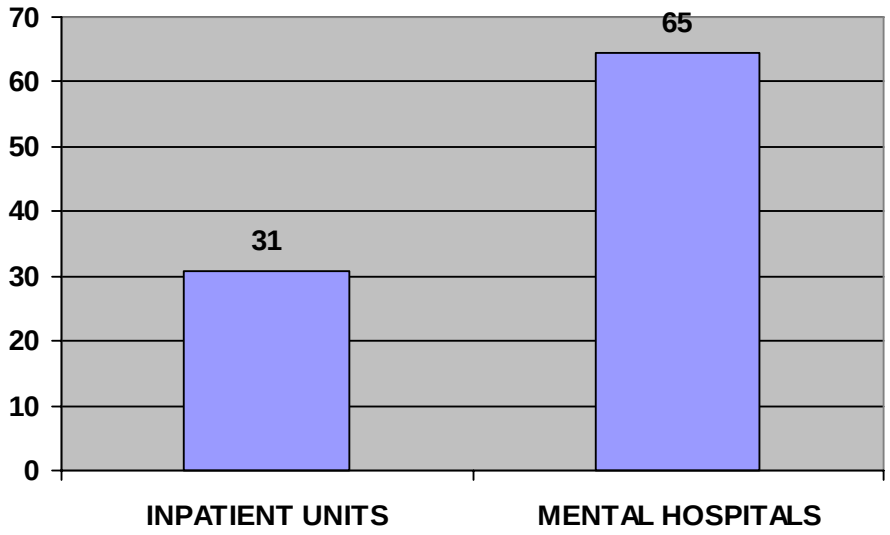
GRAPH 2.4 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS



	OUTPATIENT FAC.	INPATIENT UNITS	MENTAL HOSPITALS
MOOD DISORDERS	1%	7%	2%
OTHERS	31%	45%	48%
PERSONALITY DIS.	4%	4%	8%
NEUROTIC DIS.	25%	5%	0%
SCHIZOPHRENIA	19%	38%	36%
SUBSTANCE ABUSE	19%	0%	5%

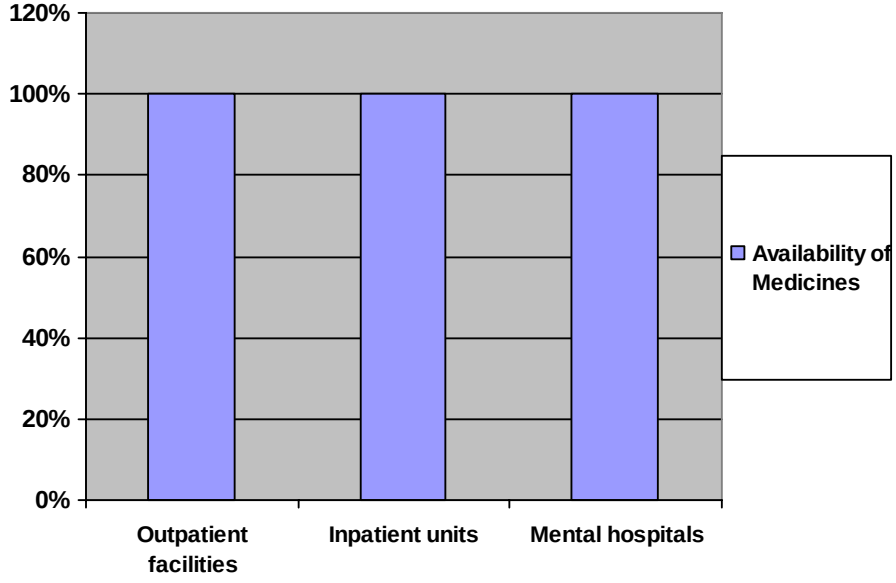
The distribution of diagnoses varies across facilities: in outpatients facilities neurotic disorders and schizophrenia are most prevalent; within inpatient units schizophrenia and affective disorders diagnoses are most common; and in mental hospitals schizophrenia and “other” diagnoses are most frequent. Organic mental disorders and epilepsy are the most frequent diagnoses in the “other category”.

GRAPH 2.5 - LENGTH OF STAY IN INPATIENT FACILITIES (days per year)



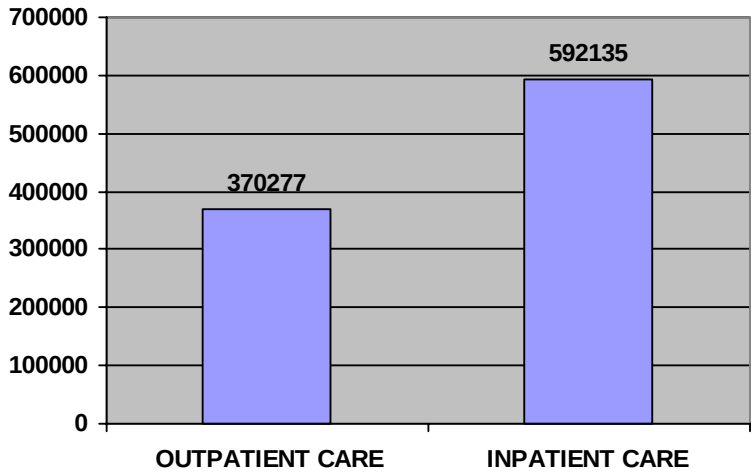
The longest length of stay for users is in mental hospitals, followed by community-based psychiatric inpatient units.

GRAPH 2.6 - AVAILABILITY OF PSYCHOTROPIC DRUGS IN MENTAL HEALTH FACILITIES



Note: the format of the data in the graph is "percentage"; please remember to enter a % sign after the data.

GRAPH 2.7 INPATIENT CARE VERSUS OUTPATIENT CARE



The ratio between outpatient/day care contacts and days spent in all the inpatient facilities (mental hospitals and general hospital units) is an indicator of extent of community care: in this country the ratio is 1:1.6.

MENTAL HEALTH IN PRIMARY HEALTH CARE

Training in mental health care for primary care staff

Approximately 1% of the training for medical doctors is devoted to mental health, in comparison to 5% for nurses. Medical doctors study Medical Psychology (16% of training in mental health) in the second year and Psychiatry (84% of training in mental health) in the forth and fifth years of the medical school. Education on mental health for nurses also consists of two classes: i) Psychoneurological Disorders (82% of training in mental health); this class is focused mostly on neurological disorders and less on psychiatric disorders, and ii) Medical Psychology (18% of training in mental health). Non-doctor/non-nurse primary health care workers do not study mental health subjects. Neither primary health care doctors nor nurses receive at least two days of refresher training in mental health. In order to specialize in Psychiatry a medical doctor is required to undergo one-year internship, whish is not sufficient enough for proper training.

Mental health in primary health care

Both physician based primary health care (PHC) and non-physician based PHC clinics are present in the country. Neither of these clinics have assessment and treatment protocols for key mental health conditions. Information on physician-based primary health care doctors making on average at least one referral per month to a mental health professional is not countable, as this information is not registered.

At the same time, approximately 21-50% of non-physician based primary health care clinics make a referral to a higher level of care. Information on primary care doctors

interacting with a mental health professional at least once in the last year is not available, as this information is not registered either. Staff at physician-based PHC facilities, non-physician-based PHC clinics and mental health facilities have unofficial interaction with complimentary/alternative/traditional practitioners, but information on this is not registered, thus is unavailable.

Care in mental health is predominantly specialized and institutionalized. Patients have to apply to mental health institutions directly, because mental health services at PHC level are underdeveloped.

Prescription in primary health care

Physicians of all specialties including PHC physicians are allowed to prescribe psychotropic medications in any circumstance without restrictions. Both nurses and non-doctor/non-nurse PHC workers are not eligible to do so. As for availability of psychotropic medicines, 100% of both physician-based and non-physician-based PHC clinics have at least one psychotropic medicine of each therapeutic category (anti-psychotics, antidepressants, mood stabilizers, anxiolytics, and antiepileptics). There are no either guidelines or treatment protocols for rational use of psychotropic drugs in PHC facility. Besides, there are pharmaceutical companies that aggressively promote psychotropic drugs and provide financial incentives to physicians who prescribe psychotropic drugs produced by them.

HUMAN RESOURCES

Number of human resources in mental health care

The total number of human resources working in state mental health facilities and private practice per 100,000 population is 22.2. The breakdown according to profession is as follows: 5.2 psychiatrists, 0.8 other medical doctors (not specialized in psychiatry), 8.4 nurses, 0.2 psychologists, 0.3 social workers, 7.4 other health or mental health workers that include auxiliary staff and medical assistants. Other specialists related to mental health such as occupational therapists, non-doctor/non-physician primary health care workers, health assistants, professional and paraprofessional psychosocial counselors do not exist in the country.

92% of psychiatrists work only for government administered mental health facilities, none work only for NGOs/for profit mental health facilities/private practice, while 8% work for the both sectors. 99% of nurses work only for government administered mental health facilities, while 1% work only for NGOs/for profit mental health facilities/private practice. Both psychologists and social workers (SWs) are not employed in the framework of the health system. SWs (50%) are employed by the Ministry of Labor and Social Protection of Population, while the majority of clinical psychologists work for NGOs (94%).

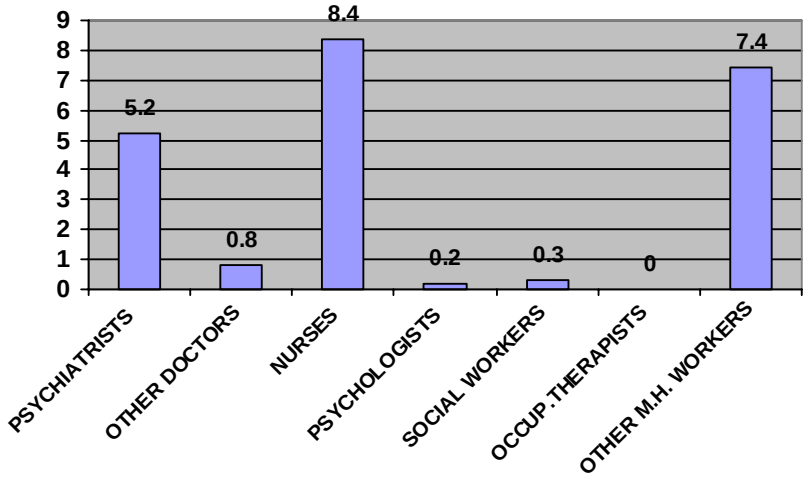
Regarding the workplace, 158 psychiatrists work in outpatient facilities, 11 in community-based psychiatric inpatient units and 133 in mental hospitals. 18 other medical doctors, not specialized in mental health, work in outpatient facilities, none in com-

munity-based psychiatric inpatient units and 47 in mental hospitals. As for nurses, 313 work in outpatient facilities, 17 in community-based psychiatric inpatient units and 393 in mental hospitals. There are no psychosocial staff (clinical psychologists, social workers and occupational therapists) that work either in outpatient facilities or in community-based psychiatric inpatient units and only one psychologist works in the Republican Psychiatric Hospital. As regards to other health or mental health workers 273 work in outpatient facilities, 16 in community-based psychiatric inpatient units and 334 in mental hospitals.

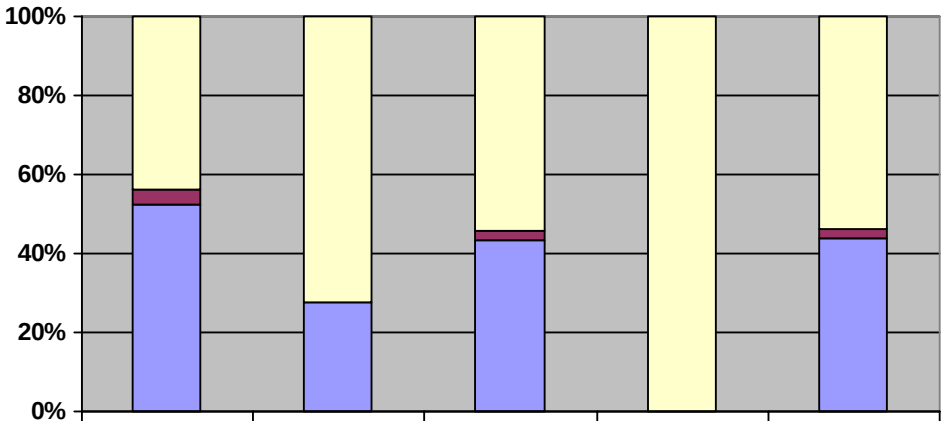
In terms of staffing in mental health facilities, there are 0.18 psychiatrists per bed in community-based psychiatric inpatient units, in comparison to 0.03 psychiatrists per bed in mental hospitals. As for nurses, there are 0.3 nurses per bed in community-based psychiatric inpatient units, in comparison to 0.1 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 1.6 times greater than the density of psychiatrists in the entire country. The density of nurses is 2 times greater in the largest city than the entire country. The number of clinical psychologists and clinical social workers is limited in the country, and they do not provide services for the rural population.

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



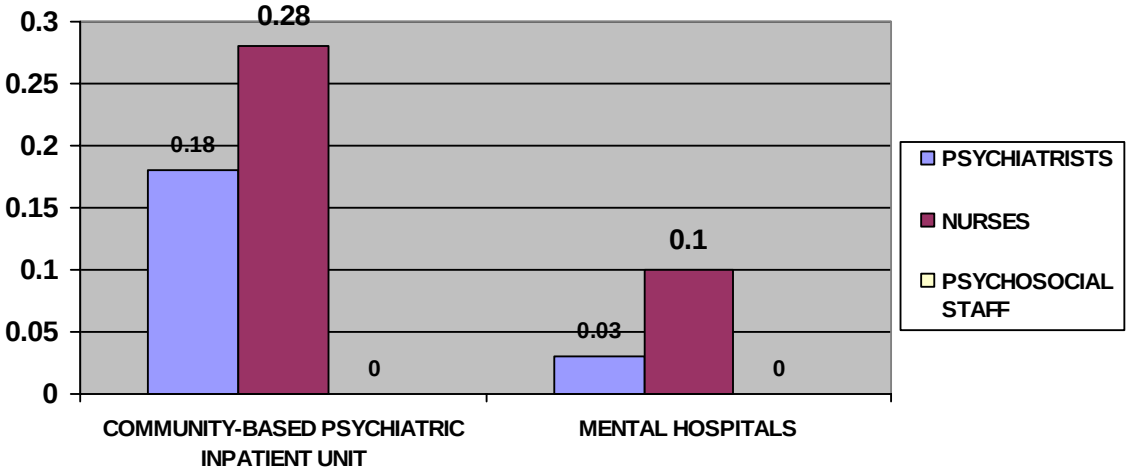
GRAPH 4.2 - STAFF WORKING IN MENTAL HEALTH FACILITIES
(percentage in the graph, number in the table)



	PSYCHIATRISTS	OTHER DOCTORS	NURSES	PSYCHOSOCIAL STAFF	OTHER M.H. WORKERS
MENTAL HOSPITALS	133	47	393	1	334
INPATIENT UNITS	11	0	17	0	16
OUTPATIENT FAC.	158	18	313	0	273

Note: diagram 4.2 does not include number of psychiatrists employed in district policlinics and other sectors (Ministry of Defense, Ministry of Justice, etc.)

GRAPH 4.3 - AVERAGE NUMBER OF STAFF PER BED



Training professionals in mental health

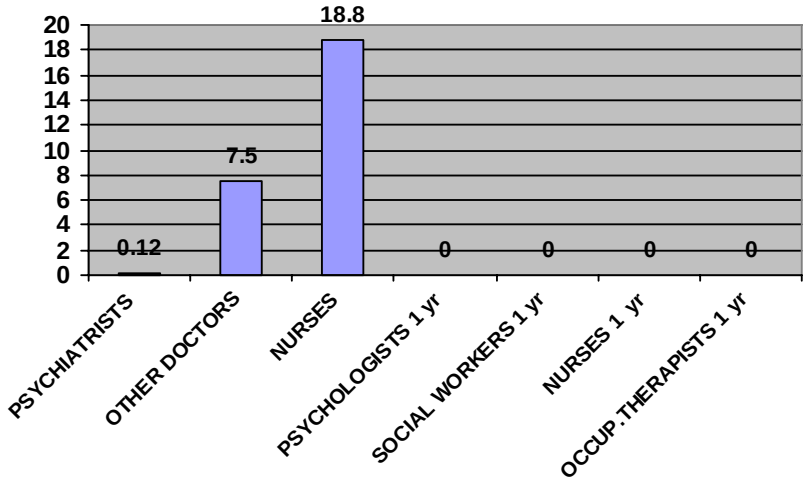
The number of professionals graduated in 2006 from academic and educational institutions per 100,000 is as follows: medical doctors (not specialized in psychiatry) 7.5, nurses (not specialized in psychiatry) 19, psychiatrists 0.1. Neither psychologists nor

nurses nor social workers nor occupational therapists have had at least 1 year training in mental health care. Up to 20% of psychiatrists emigrate to other countries within five years of the completion of their training.

None of mental health care staff have undergone at least two days of refresher training in the rational use of drugs and child/adolescent mental health issues. Undergraduate education of physicians is limited to 20 hours of Medical Psychology and 130 hours of Psychiatry. Specialization in Psychiatry is gained after one-year internship. The internship is not systematically organized, is limited in terns of duration and there are no programs for sub-specialization (child psychiatry, substance abuse, etc.). According to legislation, each psychiatrist has to have a re-fresher course not less than every five years. Re-fresher courses are provided by the State Institute for Further Education of Physicians and include five different topics (diagnoses and treatment of personality and behavioral disorders; modern aspects of medical psychology and psychotherapy, etc.). Topics of the courses are reconsidered from year to year (20% annually). Course duration is one and a half or two months. Along with psychiatrists other health professionals participate in the courses. Due to the fact that most of physicians' incomes are unofficial. Postgraduate education health care does not encompass short-term courses (CME) and does not consider the accreditation system. It should be noted that neither Medical University nor the State Institute for Further Education of Physicians have university clinics for education. Baku city PsH # 1 and #2 are used for education purposes.

Some NGOs in the country conducted short-term training on psychosocial intervention in the recent years but these training are not acknowledged in formal refresher/continuous education.

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



Consumer and family associations

There are no psychiatric patients that are members of consumer associations, as well as no family members that have joined family associations. The government does not provide economic support for consumer, family or professional associations.

There are about 14 NGOs in the country involved in individual assistance activities such as counseling, psychoeducation or support. An association such as the Azerbaijan Psychiatric Association has conducted several activities related to development of mental health legislation, training, campaigning, advocacy and international cooperation.

PUBLIC EDUCATION AND LINKS WITH OTHER SECTORS

Public education and awareness campaigns on mental health

There is no coordinating body to oversee publication and awareness campaigns in MHS. NGOs, professional associations, and international agencies have promoted public education and awareness campaigns in the last five years. These activities have been carried out irregularly and on a small scale. The campaigns have targeted the following groups: children, adolescents, women, trauma survivors and other vulnerable groups (refugees and IDPs). In addition, there have been public education and awareness campaigns targeting professional groups including health care providers, teachers and other professional groups linked to the health sector.

Legislative and financial provisions for persons with mental disorders

Legislation provisions for employment, against discrimination at work, provision for housing exist but are not enforced.

Links with other sectors

In addition to legislative and financial support, there is formal interaction between the government bodies responsible for mental health and the departments/agencies responsible for HIV/AIDS, reproductive health, substance abuse, military and criminal justice.

In terms of support for child and adolescent health, 100% of primary and secondary schools should have either a part-time or full-time psychologist. These psychologists have graduated from the Department of Social Psychology at Baku State University and do not have skills in Clinical Psychology. About 20% of primary and secondary schools have school-based activities to promote mental health and prevent mental disorders.

As for penitentiary system, the percentage of prisoners with psychosis is less than 2%, while the corresponding percentage for mental retardation is unknown. People with moderate and severe mental retardation are not imprisoned in case of crime, as they are considered with diminished legal responsibility or irresponsible. Regarding mental health activities in the criminal justice system, up to 80% of prisons have at least one prisoner per month in treatment contact with a mental health professional. As for

training, none of police officers and none of judges and lawyers have participated in educational activities on mental health in the last five years. Yet health care personnel of penitentiary system has various training courses provided by the State Institute for Further Education of Physicians.

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, 1% of people who receive social welfare benefits do so for a mental disability.

Links with other sectors are established poorly and uncoordinated.

MONITORING AND RESEARCH

A formally defined list of individual statistical 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. Data do not fully reflect the real situation in mental health, as it is underestimated, because the majority of patients applies unofficially. Thus, these patients are not included in the data provided to the government.

According to PubMed data, in terms of research, 6% of all internationally published health publications in the country were on mental health. The limited number of studies that were carried out in the country focused on epidemiological studies in clinical samples, non-epidemiological clinical/questionnaires assessments of mental disorders, services research, psychosocial interventions/psychotherapeutic interventions, and pharmacological interventions. At the same time, these researches do not completely meet criteria for evidence-based studies, they are under-funded and formal training for researchers is not available in the country.

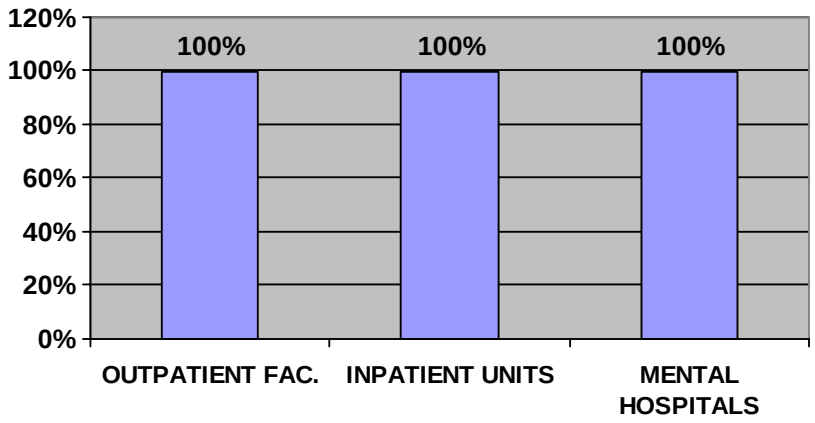
Table 6.1 - Percentage of mental health facilities collecting and compiling data by type of information

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%	0%
N° of days spent/user contacts in outpatient facili-	100%	100%	100%

ties.			
N° of involuntary admissions	0%	0%	NA
N° of users re-strained	0%	0%	NA
Diagnoses	100%	100%	100%

* Some outpatient facilities (PNDs) have integrated inpatient wards and provide 100% data on beds

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



STRENGTHS AND WEAKNESSES OF THE MENTAL HEALTH SYSTEM IN AZERBAIJAN

Based on the old Soviet model, mental health care in Azerbaijan is characterized by an institutional approach, over centralized services and segregation of psychiatric facilitates from the general health system and the other sectors (social welfare, housing services, educational system, judicial system, etc.). Almost all kinds of services are available at the level of specialist care while mental health care at primary level is underdeveloped. The principal mental care providers are psychiatrists' offices in policlinics, PNDs, and MHs. An office of a psychiatrist is presented in each administrative district polyclinic to offer its services for 50-150 thousand people. The psychiatrist's offices are subordinated to interregional PND, with a catchment area of 300-600 thousand population. Most of PNDs have both outpatient and inpatient facilities and inpatient treatment is also available in psychiatric hospitals. In addition, three large cities of the country have round-the-clock psychiatric out-reach teams working within an Emergency Ambulance Service.

In spite of sufficient number of psychiatrists and psychiatric nurses their training does not meet contemporary requirements for professional education at both undergraduate and post-graduate levels. Special educational programs in child/adolescent, geriatric or forensic psychiatry or psychotherapy are absent and system of continuous education is failed. Other mental health professionals such as clinical psychologists, social workers, occupational therapists, etc. are not involved in mental health care provision. Thus psychosocial interventions are rarely used in Azerbaijan and almost all services are focused on psychotropic medication. Moreover, there are no adopted standards of care including guidelines and treatment protocols to monitor treatment process.

The significant restriction to mental health care in Azerbaijan is financial. The proportion of mental health expenditures is only 3% from the general health budget and there is an obvious disbalance in financing because 85% of funds are allocated to inpatient services. In absence of health insurance system the most common financing way is out-of-pocket and physicians unofficially require a fee for their services as their salary is very low (about USD 73 a month).

In 2001 the National Parliament adopted Mental Health Law which regulates such issues as informed consent, anonymity and confidentiality, involuntary admission and treatment (only after court decision), as well as advocacy and rights protection of persons with mental illness. However there is very little awareness about the norms of the legislation among mental health professionals, jurists and consumers. Meanwhile the relevant bylaws and mechanisms of its implementation are not elaborated yet and there is no any review body responsible for mentally ill people rights' protection.

The National Mental Health Policy and Mental Health Strategic Plan are not available in the country as well as the consumers have no opportunity to participate in policy formulation, planning or evaluation. The mental health information system does not operate with reliable data on psychiatric epidemiology and statistics because most of patients apply unofficially and they are not included in official statistics. In addition, all information obtained is related to input or intermediate indicators while outcome evaluation is not provided.

In the second half of 2005, significant changes took place in the Ministry of Health and the new administration has started the work to straighten out the public health sector. This work provides opportunity for reforms in mental health in terms of policy development, increased service financing, deinstitutionalization, implementation of primary and community-based services, and improvement of professional education.

NEXT STEPS IN STRENGTHENING THE MENTAL HEALTH SYSTEM

Next steps in strengthening the mental health system in Azerbaijan should focus on the following objectives:

Policy and Legislative Framework: Development of a mental health policy and a national strategic plan. This policy and plan should:

- Describe the vision, principles and objectives of the future mental health system
- Determine strategies, timeframes, activities, budget, targets and responsibilities
- Develop specific programs on suicide prevention, child mental health, work stress management, violence reduction, etc.
- Set standards and quality assurance procedures
- Improve organizational structure and governance of mental health services
- Improve the finance allocation in mental health

Mental Health Services Creation of community-based psychiatric inpatient units and strengthening of existing community-based facilities.

- Integrate mental health services into general health system
- Conduct deinstitutionalization with parallel development of alternative services (crisis interventions, rehab program, sheltered residence and workplaces, assertive outreach, case management, etc).
- Conduct decentralization of services with empowerment of local health/mental health services
- Establish community-based facilities meeting consumers needs and demands

Mental Health in Primary Health Care Increasing the training in mental health for primary care staff.

- Develop educational programs on mental health for primary care staff
- Implement guidelines and treatment protocols for primary care practitioners
- Provide supervision of primary care providers by mental health professionals
- Establish referral network between primary and specialized care

Human Resources Increasing human resources for mental health (e.g., social workers, psychologists, etc.).

- Educate sufficient number of clinical psychologists, social workers, occupational therapists, psychiatric nurses
- Implement multidisciplinary team approach in mental health
- Involve patients' families in mental health service planning, provision and evaluation
- Conduct trainings for mental health managers, trainers, researchers
- Implement system of short-term trainings for CME in mental health

Links with other Sectors Increasing the mental health system's links with other key sectors (e.g. education, social welfare, justice, etc.).

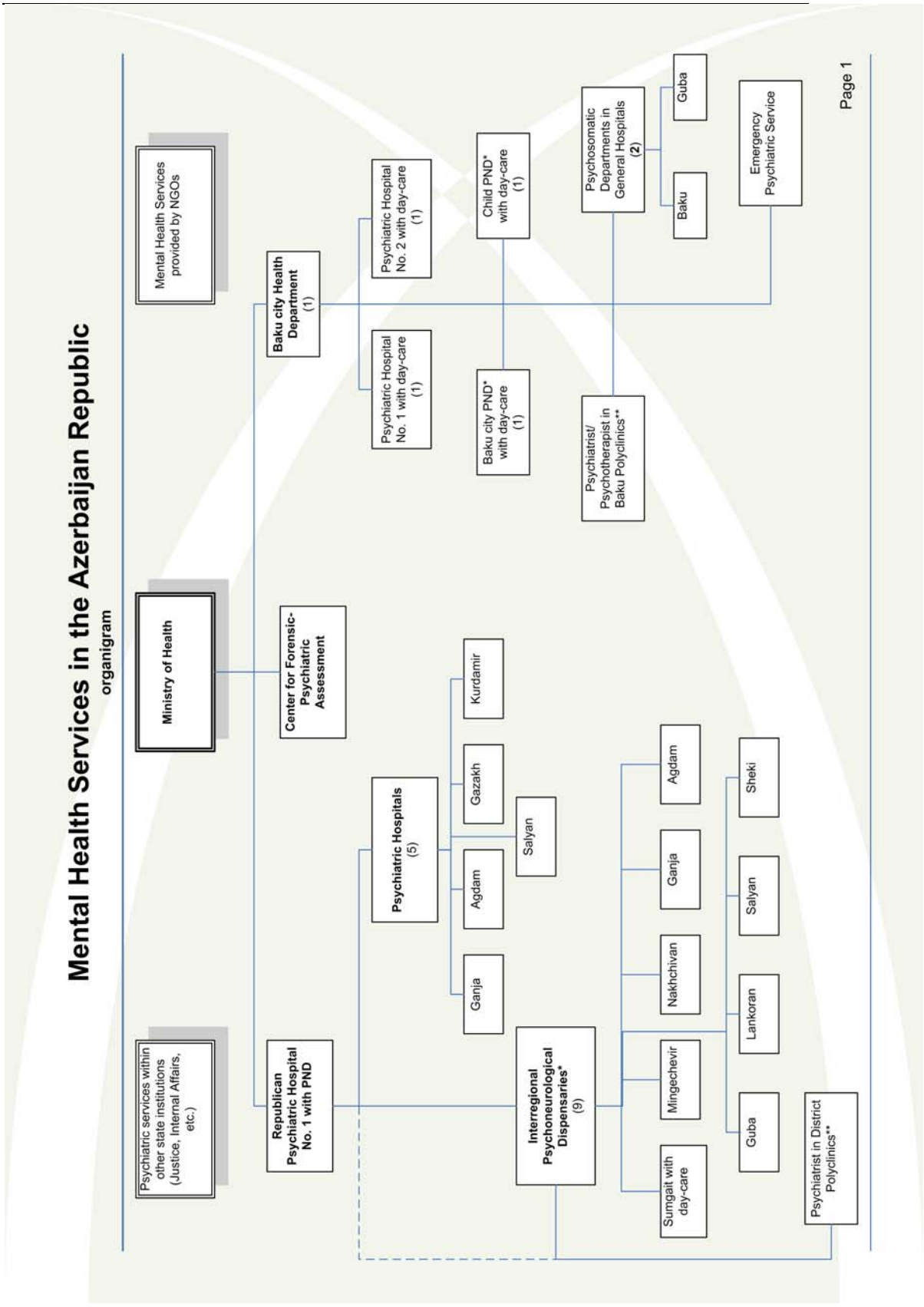
- Achieve understanding of importance of mental health issues in key stakeholders and encourage them to have join agreement on mental health policy implementation

- Appoint in each sector a representative responsible for coordination of mental health issues
- Establish Coordination/Advisory Board on mental health with participation of representatives from governmental, international and non-governmental organizations

Monitoring and Research Improvement of the mental health information system.

- Define the main indicators to be considered in the mental health information system
- Provide regularly mental health data collection, proceeding, analysis and distribution
- Educate specialists on clinical epidemiology and biostatistics
- Focus on outcomes rather than on input or process information
- Develop electronic database on mental health

APPENDIX A


Mental Health Services in the Azerbaijan Republic
organigram
Page 1
Ministry of Health
Mental Health Services provided by NGOs
Psychiatric services within other state institutions (Justice, Internal Affairs, etc.)
Republican Psychiatric Hospital No. 1 with PND
Center for Forensic-Psychiatric Assessment
Baku city Health Department (1)
Psychiatric Hospitals (5)
Ganja
Agdam
Gazakh
Kurdamir
Salyan
Interregional Psychoneurological Dispensaries* (9)
Sumgait with day-care
Mingechevir
Guba
Nakhchivan
Lankoran
Ganja
Salyan
Agdam
Sheki
Psychiatrist in District Polyclinics**
Psychiatric Hospital No. 1 with day-care (1)
Psychiatric Hospital No. 2 with day-care (1)
Baku city PND* with day-care (1)
Child PND* with day-care (1)
Psychiatrist/ Psychotherapist in Baku Polyclinics**
Psychosomatic Departments in General Hospitals (2)
Baku
Guba
Emergency Psychiatric Service

The WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Azerbaijan including the policy and legislative framework, mental health services, mental health in primary health care, human resources, public education and links with other sectors, and monitoring and research. The goal of collecting this information is to enable policy makers to develop information-based mental health plans with clear baseline information and targets. Data for this report was collected in 2007 and based on the year 2006.

Azerbaijan is a country with an area of 86,600 square kilometers. Its population is 8,436,400 and more than 10% of the population is refugees and IDPs

There is no mental health policy or plan present in the country. The first piece of mental health legislation was enacted in 2001. However, standardized procedures for implementing mental health legislation do not exist for many of the legislation components.

Three percent of the government's health care expenditures are devoted to mental health; 85% of which are allocated to mental hospitals. Mental health services are not covered in social insurance schemes.

The mental health care system is still predominantly institutionally-based. There are 11 outpatient mental health facilities, 9 mental hospitals and 5 day-treatment facilities in the country. There are only 2 community-based psychiatric inpatient units; none of which are reserved for children and adolescents.

There is no effective cooperation between mental health care system and the primary health care system. In terms of human resources, the mental health system lacks psychologists, social workers, and occupational therapists. Education of psychiatrists and psychiatric nurses in mental health is limited.

The data collection system covers all governmental mental health facilities. The limited number of researches on mental health that is conducted in the country does not completely meet criteria as evidence-based investigation.

The report outlines the main steps that need to be taken to strengthen the mental health system in Azerbaijan.