Healthy minds,
healthy communities

Mental Health Project
for south-eastern Europe
The regional project office of the Mental Health Project for south-eastern Europe acknowledges with gratitude the political support and generous financial and technical contributions of the WHO Regional Office for Europe and of the Governments of Belgium, Greece, Hungary, Italy, Slovenia and Sweden.

The reform of psychiatric services in Greece, as in all other countries where similar reforms have taken place, has been a long-term process with varying rates of progress, requiring continuous efforts and persistence over a very long period of time in order to be successful. Yet it is only the beginning of the real process of reform, which to a very large extent is restricted to the transformation of the psychiatric services rather than to the creation of mental health services. In this respect, the word reform could even be a misnomer. The real reform is still to come, and has not yet been achieved by any country. The real reform is concerned with change in the mentality of people (a task of the highest possible order in every society) and the abolition of prejudices and discrimination towards fellow human beings who have the misfortune at some point in their lives to suffer mental ill health, something that awaits every one-in-four of us during our life span.

Dr Athanassios Constantopoulos
Member of the Executive Committee of the Mental Health Project for south-eastern Europe
Director, Mental Health Centre, Regional General Hospital of Athens

Servicing countries, responding to people's needs

The Mental Health Project for south-eastern Europe has managed to mobilize the international community for a good cause; it has helped the SEE countries themselves to coordinate the interventions by different organizations; and it has ensured that these interventions result in progress for their health systems and, ultimately, in better health for their people. This is a good example of an initiative that was facilitated by the WHO Regional Office for Europe and built up on the true partnership of 15 stakeholders and on the ownership and leadership of the Member States themselves. The project fully reflects the vision, principles, and directions of our country strategy Matching services to needs.

Dr Nata Menabde
Director, Division for Country Support
WHO Regional Office for Europe

The regional project office of the Mental Health Project for south-eastern Europe acknowledges with gratitude the political support and generous financial and technical contributions of the WHO Regional Office for Europe and of the Governments of Belgium, Greece, Hungary, Italy, Slovenia and Sweden.
In 1999, the international community established the Stability Pact for South Eastern Europe to strengthen social stability in the region by fostering peace, democracy, human rights and economic prosperity. The founding document was signed by 40 partner countries and organizations. In 2001, the Pact added health to its agenda as one of the five subject areas of its Social Cohesion Initiative.

Social cohesion is a flagship concept which constantly reminds us of the need to be collectively attentive to, and aware of, any kind of discrimination, inequality, marginality or exclusion.

Trends in Social Cohesion No.1
Council of Europe Publishing
December 2001

In September 2001, the WHO Regional Office for Europe and the Council of Europe established the South-eastern European (SEE) Health Network to improve the health of people living in the region. Initially the network comprised seven countries: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Romania, Serbia and Montenegro, and the former Yugoslav Republic of Macedonia. Subsequently they were joined by an eighth, the Republic of Moldova. Seven donor countries supported the initiative: Belgium, Greece, Hungary, Norway, Slovenia, Sweden and Switzerland.

The first political document to make a specific commitment to develop health in the region was the Dubrovnik Pledge: Meeting the health needs of vulnerable populations in South East Europe. The pledge was signed by the first seven countries and the WHO Regional Office for Europe in September 2001 at the Health Ministers’ Forum for South-eastern Europe, held in Dubrovnik, Croatia.

In May 2002, the Mental Health Project for South-eastern Europe (SEE) was established by the first seven countries, along with the Council of Europe, the WHO Regional Office for Europe, and Greece at a meeting held in Hilleroed, Denmark.

The health sector within the framework of the Stability Pact for South Eastern Europe Initiative for Social Cohesion has been the pioneer in strengthening regional cooperation on the basis of an agreed political process: the Dubrovnik Pledge of September 2001. In particular, the regional project on mental health has been able to put high on the agenda an issue of extreme importance and thereby achieve vital cooperation in the region at both the political and the technical levels. The Mental Health Project has been able to fully engage the donor community, to upgrade and harmonize relevant legislations, to boost capacity and institution building, and to induce an important change in disbursement procedures with each country being fully responsible for managing the funds allocated to its part of the regional project.

Ms Patrizia Mauro
Executive Secretary, Office of the Special Coordinator of the Stability Pact Initiative for Social Cohesion
The purpose of the Mental Health Project for south-eastern Europe is to improve the mental health of populations by setting up community mental health services in the region.

**Aim**

The commitment of the countries in the south-eastern European region to work in partnership to develop their mental health care is impressive. It reflects the recognition that mental well-being is at the heart of an inclusive and productive society. It also reflects the fact that care for persons with severe and enduring mental health problems should be a priority — they are the most vulnerable people in society who so often suffer discrimination and neglect in institutions.

Progress has been extraordinary, and the issues addressed wide-ranging as shown by this brochure. What is more difficult to illustrate is the enthusiasm and openness this programme has achieved. All countries have been honest about the massive challenges faced, but all have made remarkable progress in complex subjects such as human rights and legislation, service development and workforce planning. The mutual support and exchanges of good-practice experience have been stimulating to everyone involved. I am very confident that this mental health programme will make a lasting impact on the quality of life of the people we are concerned about, and will be remembered by everyone involved with pleasure and gratitude. This is reform in the making at its very best.

Dr Matthijs Muijen
Acting Regional Adviser for Mental Health
WHO Regional Office for Europe
The post-1989 period of political, social and economic transition has brought tremendous changes to all spheres of life in the region. One result is a massive deterioration in mental health. War and violent conflict in some SEE countries have left the population with an overwhelming burden of psychological after-effects.

Several concerns have been identified as common to all SEE countries:

- lack of interest in and political commitment to mental health issues
- inadequate mental health policies and legislation
- over-reliance on custodial institutions
- insufficient support for reforming the process of mental health treatment
- absence of community-based mental health services
- absence of effective intersectoral linkages
- detachment of mental health services from primary health care
- low budgets for both health and mental health services
- inadequate managerial and leadership skills
- absence of standardized systems for reporting, monitoring and evaluation
- insufficient participation of nongovernmental organizations (NGOs)
- stigmatization of and discrimination against the mentally ill.

The eight SEE countries show considerable differences in levels of mental health care development. However, all countries are strongly committed to transforming the traditional institutional care into community-based care. This transformation process will require continuing international support if it is to succeed. The Mental Health Project for south-eastern Europe is in the process of developing a model that can accommodate the many and complex differences between the eight countries, and at the same time provide a common framework for constructive and lasting regional cooperation.

To be the lead country of such a significant and ground-breaking project is at the same time an honour and a responsibility for Bosnia and Herzegovina. The opportunity we have of developing and promoting community mental health services through the implementation of the Mental Health Project for south-eastern Europe must not be wasted. We are aware, however, that supreme efforts will be required from the professional community to ensure sustainability of the project’s outcomes when the financial and technical assistance of the international community is no longer available. And that is likely to happen before long.

Dr Goran Cerkez
Member of the Executive Committee of the Mental Health Project for south-eastern Europe
Assistant to the Minister of Health of the Federation of Bosnia and Herzegovina
Components

The overall goal of the Mental Health Project for south-eastern Europe is to firmly establish the community mental health service as the cornerstone of mental health reform in south-eastern Europe. To do this, the project has been divided into three components, each requiring specific expertise and professional commitment to bring them to a successful conclusion.

**Component One** focused on developing mental health policies and legislation that comply with international standards.

*Implementation period: September 2002 — March 2004*

**Component Two** focuses on establishing a common SEE model for the community mental health service, including a pilot community mental health centre in each country.

*Implementation period: March 2004 — March 2005*

**Component Three** will focus on training mental health professionals and primary health care practitioners in community mental health care — which involves designing and delivering courses.

*Implementation period: March 2005 — March 2006*

By implementing the Mental Health Project for south-eastern Europe, Bosnia and Herzegovina seeks to contribute to the strengthening of regional cooperation in general, while focusing in particular on the improvement of the mental health of populations and the protection of human and civil rights. One of our objectives is to demonstrate that regional collaboration is more than just an effective vehicle for solving problems in the region. We believe that regional collaboration is a necessity if we are to become strong and progressive members of EU.

Mr Tomo Lucic
Minister of Health
Federation of Bosnia and Herzegovina

The pioneering of a project such as the Mental Health Project for south-eastern Europe involves many challenges, the greatest of which is to ensure that the full ownership of and responsibility for the project rests with the countries themselves. In our work, therefore, we dedicate special attention to capacity building in the domain of leadership and management of change.

Ms Vesna Puratic
Regional Project Manager
Mental Health Project for south-eastern Europe
Among its most significant results to date, the project has produced the following documents and associated actions.

- Assessments of the existing mental health policy and legislation in each SEE country (country level)
- An overview of the country assessments of mental health policies and legislation in SEE (regional report)
- The country documents: Mental Health Policy and Action Plan (country level)
- A framework for mental health legislation (country level)
- A joint statement (regional level)
- Recommendations to governments (regional level)
- A questionnaire to be used to map current mental health services and plan future community mental health services in the designated pilot area (country level)
- An operational plan for the establishment of the pilot community mental health centre (country level)
- Regional recommendations for community mental health centres (regional level)

Project members have also organized nine technical workshops at regional level. Each workshop has taken us one step forward towards our goals.
At regional level there is general recognition of the need to integrate mental health services in the community. The project's Component One has now been implemented with the result that all eight SEE countries have specific mental health policies and action plans. These outline long-term goals, objectives and frameworks for mental health reform across the spectrum of health care, and include system restructuring, de-institutionalization, and the development of community mental health services.

This workshop found that all countries currently have some form of mental health legislation. However, there is no consistency across the region and some laws require significant changes to enable them to conform to international standards on patient rights.

Governments need to invest both commitment and resources if these new reforms in mental health policy and legislation are to be put into effect successfully. Good governance is critical to the establishment of a comprehensive mental health policy and to the reform of service systems in SEE. Lack of good governance in the period following the fall of totalitarian regimes has left the region with failed institutions, a compromised rule of law, and confusion as to what constitutes good leadership. (Adapted from the report, Overview of country assessments of mental health policies and legislation in SEE).
The deterioration of mental health services over the past several years has become a matter of serious concern in the region. Reports of the appalling state of institutional care in some parts of the region have made decision-makers recognize that improving standards in mental health services is an urgent priority. The development of evidence-based policy is also considered crucial as it implies management of a type that engages providers and consumers alike in generating information on the state of affairs in the system of care. It promotes participatory involvement by providing for decision-making to be shared widely and at an early stage in system development.

Using both international and local (SEE) know-how and experience, this workshop drafted a list of standards for community mental health services. Issues covered were:

- interventions
- approaches
- staff composition
- training
- access to services
- availability of services, facilities and programmes
- management and safety
This workshop particularly emphasized the importance of writing down and disseminating policies in the field of mental health. Written policies provide a general blueprint to be followed; they facilitate the improvement of procedures, services and activities; they identify the principal stakeholders; they facilitate agreement on action by the different stakeholders; and above all they increase the visibility and status of mental health care.

The workshop was introduced to eight essential steps in developing a mental health policy:

- assess the needs of the population
- gather evidence on effective policy
- consult and negotiate with others
- exchange information and experiences with other countries
- set out the vision, values, principles and objectives
- determine areas for action
- identify the major roles and responsibilities of each sector
- conduct pilot projects.

The WHO guidance module, *Mental Health Policy, Plans and Programmes*, shows that a mental health policy can be implemented through the priority strategies identified in the action plan and the priority interventions identified by the programme. The implementation of these strategies and interventions requires associated action, mainly: disseminating the policy, securing political support and funding, finding supportive organizations, setting up demonstration areas, empowering providers, initiating intersectoral coordination, and establishing interaction between the ministry of health and the various stakeholders.

Mental health policy is an organized set of values, principles and objectives for improving mental health and reducing the burden of mental disorders in a population. It defines a vision for the future and helps to establish a model for action.

*Mental Health Policy, Plans and Programmes*
*Mental Health Policy and Service Guidance Package*
The country presentations at this workshop reflected a high level of understanding of the issues involved in developing modern mental health policies and legislation. The participant countries shared a number of common concerns on how to:

- set up financial regimes for service delivery
- ensure the availability of money to pump into prime reforms
- educate professionals in the new ways of working
- help people understand the importance of developing consensus on the reform programme and of strengthening a partnership model
- develop leadership skills
- deal with the lack of mental health nursing programmes.

Dr Martin Brown, WHO Temporary Adviser, said that the support of people in key positions could be extremely important in the early stages of policy development. Ultimately, however, successful implementation of the policy depended on leaders at all levels and in all professions. It was the willingness of senior managers and professionals to adopt new ways of working that would turn policy aspirations into practice. The core group responsible for developing the policy would need to engage, educate and encourage staff at all levels. Some people would embrace the new vision enthusiastically, some would reject it, and the majority would follow the general trend. Key components in any development programme for budding leaders would include:

- taking account of user movements or action groups
- understanding organizational cultures and how to change them
- creating alliances with like-minded people
- understanding the need for support mechanisms
- working to change cultures from within
- understanding what motivates people
- accessing the latest information on mental health services
- utilizing models of change.
This workshop focused on three main issues: (a) training participants to use the WHO framework for developing, reviewing, adopting and implementing mental health legislation; (b) identifying the international and regional conventions and standards related to mental health, human rights and legislation; and (c) promoting discussion and debate among participants on the development of mental health legislation in their respective countries.

Mental health legislation is essential because of the unique vulnerabilities of people with mental disorders.


Different countries have different processes for drafting new legislation, depending on their particular legislative, administrative and political structures. In some countries, a specially constituted drafting committee appointed by the legislature or the relevant ministry is given the task. Some countries have a law reform commission or a similar body to conduct this function. In other countries, the mental health section in the Ministry can play an important facilitative role. It is crucial that there is significant and sufficient expertise (e.g. lawyers, psychiatrists, user and family representatives) within the drafting bodies to ensure that the Bill produced is thorough, comprehensive and reflects a balance of competing (though reasonable) ideologies. Which model is chosen will depend on factors such as the cost of different approaches relative to funds available, the availability of expertise, assessment of which approach will be most effective in a country, and the scope and purpose of the legislation. (Excerpt from the presentation of Professor Melvyn Freeman, WHO Temporary Adviser.)
The purpose of this workshop was to ensure a thorough review of the project deliverables related to mental health policy and legislation before their submission to donors as part of the final report on the project’s Component One. At country level, the deliverables included the draft mental health policy and action plan, and the framework for mental health legislation. An Overview of country assessments of mental health policies and legislation was the main product at regional level.

In addition, a joint statement was drafted and agreed on by all country representatives. The workshop proposed that each country should include some elements of the joint statement into the national mental health policy.

Considering that:

- mental health is still frequently regarded as low priority by governments and the community in general;
- mental health is strongly related to social cohesion and the establishment of a stable and democratic civil society;
- in many areas mental health leadership is limited and resources are inadequate;
- a dominant culture of neglect and exclusion of people with mental illness still widely exists, most clearly expressed in the continued existence of large mental institutions that not only fail to meet the needs of people with mental illness but that also infringe their rights;
- a movement towards mental health reform in the SEE region is developing in response to a growing awareness of the severe and complex mental health issues experienced by post-conflict countries and countries in transition;
- the Mental Health Project for south-eastern Europe is one of seven public health strategies agreed to at a historic political meeting of regional health ministers in
Dubrovnik, Croatia, in September 2001;

over the past two years the project has developed into a crucial regional initiative that promotes and contributes to increased understanding, cooperation and reconciliation at country, regional and international levels;

this joint statement:

was developed by representatives of the eight countries taking part in the Mental Health Project for south-eastern Europe *Enhancing social cohesion through strengthening community mental health services in south-eastern Europe*: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Republic of Moldova, Romania, Serbia and Montenegro, and The former Yugoslav Republic of Macedonia;

sets out a common vision for reforming mental health policy and services within the SEE region that reflects the regional context in which the reforms are to occur; and

calls for sustained action in order to secure the following improvements.

♦ Mentally ill, disabled or vulnerable persons must be guaranteed the same human and civil rights as all other citizens in society.

♦ Mental health care systems in the region have a duty to protect human rights and respond effectively to the impact of catastrophic events and social disruption on both individual and society, and particularly on vulnerable groups such as children, young people, women and the elderly.

♦ Mental health is an integral part of individual and community health and well-being, development and restoration. People have a legitimate right to expect good mental health care.

♦ Comprehensive mental health systems that are evidence-based, effective, acceptable and sustainable must be developed and implemented. They must span the spectrum of mental health needs from initiatives that promote mental health and prevent mental illness, to those that ensure recovery and prevent relapse.

♦ Old-fashioned institutions must be downsized and abolished.

♦ Action must be taken to ensure the development of strong leadership and cooperative action by governments, professional associations, non-governmental organizations and organizations for consumers, carers and civil society.

♦ Governments must ensure that mental health systems are adequately supported in terms of both financial and human resources.

The work of the Stability Pact in the area of mental health is being carried out within an agreed framework for cooperative action across the region. Comprehensive assessments undertaken as part of the Mental Health Project for south-eastern Europe both highlight the need for change and serve as catalysts for reform. The project provides best-practice examples of mental health reforms — these include policies, legislation, community initiatives, and training.

Mental health is everybody’s business — and the time for mental health reform is now. Investment in mental health is essential for social and economic development. Both existing and new resources are required to support the reform process, particularly the establishment and further development of community-based treatment and care.
The central process of Component Two is the establishment and operation of a pilot community mental health centre (CMHC) in each of the eight SEE countries. This workshop therefore focused primarily on reviewing country reports that described current mental health services and outlined planned community services in the area in which the pilot CMHC will be located.

A general conclusion to be drawn from country descriptions of their existing mental health services is that improvements are needed in all segments of service provision—promotional, preventative, diagnostic, therapeutic and rehabilitative.

One of the weakest segments in existing systems across the region is the link between the mental health service and community organizations.

Information systems in the existing mental health services are also generally inadequate. The major deficiencies are related not so much to type of data as to the evident lack of linkages and coordination between the different components and levels in an information system.

The workshop participants felt assistance was essential in the following areas:

- training in establishing and running community mental health services
- technical assistance in developing information systems
- development of managerial and clinical guidelines
- multidisciplinary team building
- support for local psychiatric wards in general hospitals to enable them to achieve higher standards of care, such as setting up mobile crisis teams or programmes for the release of long-term patients
- training mental health personnel to be involved in the social welfare system
- establishing programmes for supported employment.
This workshop identified, explored and adopted structural and managerial frameworks for establishing the pilot CMHCs, taking into consideration the differences to be expected among the countries in pursuing the best fit between project goals and local reality. A most important outcome of the workshop was agreement by all participants as to what constitutes the essential elements of a CMHC. These are listed below.

1. The CMHC should give priority to people with serious mental illness and should offer an alternative to hospitalization.
2. The CMHC should be staffed by a multidisciplinary team, comprising at the very least psychiatrists, mental health nurses, social workers and psychologists. There should be a minimum of eight full-time staff. Ideally the team should also include occupational therapists and specialists in rehabilitation and employment.
3. Each staff member should have a job description specifying role, responsibilities, and lines of accountability. Tasks common to all staff should also be described.
4. The CMHC team should be able to offer continuing treatment and care that is appropriate to the needs of their patients.
5. CMHC services should be available at least during working hours, with cover available during nights and weekends.
6. The CMHC should serve a defined catchment area with a population of between 50 000 and 120 000.
7. The CMHC should be located in the community it serves and not in a hospital building.
8. The CMHC must be provided with guaranteed funding to ensure sustainable service beyond the pilot period.
9. The CMHC should be accorded formal recognition as an official mental health unit within the mental health service. The CMHC should have clearly specified responsibilities in relation to and linkages with primary care, hospital and other secondary and tertiary sector services, and agencies responsible for welfare, promotion and prevention.
10. The role of the CMHC must be underpinned by supportive mental health policy and legislation.
Standards can be defined as normative qualitative statements about what constitutes acceptable and adequate mental health care (Lund et al., 1998). In other words, they describe how a mental health service should be delivered. A standards document should therefore attempt to provide guidelines on all aspects of mental health care. How this information is arranged varies significantly between countries, depending on local needs, service utilization and history.

Collaboration within the health sector (intrasectoral) and between sectors (intersectoral) is essential for meeting the complex needs of persons with mental disorders or problems. Most successful collaboration is a dynamic and flexible process, perceived as a win-win situation, and includes vertical as well as horizontal linkages and collaboration. (Excerpt from the presentation of Dr Carlos Artundo, WHO Temporary Adviser.)

Many mental disorders, especially those with a chronic course or with a relapsing-remitting pattern, are better managed by services that adopt a continuing care model. This emphasizes the long-term nature of the disorders and the need for a continuing therapeutic input. A continuing care approach also emphasizes the need to address the totality of patients’ needs, including their social, occupational and psychological needs. Such approaches therefore require a significant degree of collaboration between different care agencies.


Standards can be defined as normative qualitative statements about what constitutes acceptable and adequate mental health care (Lund et al., 1998). In other words, they describe how a mental health service should be delivered. A standards document should therefore attempt to provide guidelines on all aspects of mental health care. How this information is arranged varies significantly between countries, depending on local needs, service utilization and history.


Ninth technical workshop

This workshop addressed some of the major issues concerning the effective ongoing management of community mental health services, including continuity of care, intersectoral collaboration and standards.

Ninth technical workshop: Community mental health service management – international experience and recommendations 28–30 October 2004, Belgrade, Serbia and Montenegro
To be continued in March 2005 in Moldova

Tenth technical workshop: Mental health information systems
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<tr>
<td>Serbia and Montenegro</td>
<td>Professor Veronika Ispanovic</td>
<td>Head, Department of Research in Child Psychiatry, The Institute of Mental Health, Palmoticeva 37, Belgrade</td>
</tr>
<tr>
<td>Council of Europe</td>
<td>Mr Alexander Vladychenko</td>
<td>Director General ad interim of Social Cohesion (DG III), Rue Boecklin, F-67075 Strasbourg Cedex, France</td>
</tr>
<tr>
<td>Dr Piotr Mierzewski</td>
<td></td>
<td>Directorate of Social &amp; Economic Affairs, Health Policy Division, Rue Boecklin, F-67075 Strasbourg Cedex, France</td>
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<tr>
<td>Greece</td>
<td>Dr Nata Menabde</td>
<td>Director, Division of Country Support, Regional Office for Europe, World Health Organization, Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark</td>
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<td>Bosnia and Herzegovina</td>
<td>Dr Goran Cerkez</td>
<td>Assistant to the Minister of Health, Ministry of Health, Federation of Bosnia and Herzegovina, Marsala Tit 9, 71000 Sarajevo</td>
</tr>
<tr>
<td>Greece</td>
<td>Professor Athanassios Constantopoulos</td>
<td>Consultant Psychiatrist and Director, Mental Health Centre, Regional General Hospital of Athens (G. Gennimata), Zalogou 6, Agia Paraskevi, TK 153.43 Attica</td>
</tr>
<tr>
<td>World Health Organization</td>
<td>Dr Maria Haralanova</td>
<td>Division of Country Support, World Health Organization, Regional Office for Europe, Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark</td>
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