Sida Evaluation 99/25

Psychiatry Reform in Eastern Europe

Nils Öström

Department for Central and Eastern Europe

Psychiatry Reform in Eastern Europe

Nils Öström

Sida Evaluation 99/25

Department for Central and Eastern Europe

Evaluation Reports may be ordered from:

Infocenter, Sida
S-105 25 Stockholm
Telephone: (+46) (0)8 795 23 44
Telefax: (+46) (0)8 760 58 95
E-mail: info@sida.se, Homepage http://www.sida.se

Author: Nils Öström.
Stockholm Group for Development Studies

Sida Evaluation 99/25
Commissioned by Sida, Department for Central and Eastern Europe

Registration No.: Öst 1999-004825/50
Date of Final Report: May 1999
Printed in Stockholm, Sweden 1999
ISBN 91 586 783 3 6
ISSN 1401–0402

SWEDISH INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
Address: S-105 25 Stockholm, Sweden. Office: Sveavägen 20, Stockholm
Telephone: +46 (0)8-698 50 00. Telefax: +46 (0)8-20 88 64
Telegram: sida stockholm. Postgiro: 1 56 34–9
E-mail: info@sida.se. Homepage: http://www.sida.se

Table of Contents

Evaluation of the Psychiatry Project of the East Europe Committee of the Swedish Health Care Community (SEEC)

1. Executive Summary

Psychiatry has been a key area of cooperation and support through the East Europe Committee of the Swedish Health Care Community (SEEC) since its establishment in 1992. The Swedish Parliament decided in 1994 on a special appropriation for the period 1995–1997 of 15 MSEK for the implementation of cooperation in the area of psychiatry.

In its request to Sida for funding for 1999, SEEC proposed an allocation of 5 MSEK for cooperation in the area of psychiatry. As basis for the decision on this allocation, Sida has decided to perform an independent evaluation of the cooperation in the area of psychiatry since 1995. The evaluation has been performed by Nils Öström, Stockholm Group for Development Studies AB (SGDS), in accordance with a contract with Sida-Öst/EVA and Terms of Reference dated 1999-03-25. The purpose of the evaluation has been to assess the results of the psychiatry cooperation in relation to stated objectives and to provide recommendations on the formulation of operational aims for possible future cooperation.

The support has mainly concerned the three Baltic countries, and recently also the North Western part of Russia. The objectives of the support have been transfer of knowledge and development of organisational structure and legislation. The projects supported should promote long term capacity development and changes in attitudes and approaches. Out of a total of 230 contributions, about 60% refer to 30 longer term cooperation projects between the same partners regarding clinic-to-clinic cooperation, continuous training and series of seminars. Other projects supported refers to translation and publication of literature and journals, and to participation in Nordic or international conferences. The funds have been distributed with 40% on joint projects, including a full time coordinator for the cooperation, and from 19% to 7% for each of the four cooperating countries.

A conclusion of the present evaluation is that the support has clearly promoted development of knowledge and changes in attitudes and approaches. At the same time, there has been less results concerning organisational structures and legislation. Reasons for the difficulties to achieve results regarding structural change are external factors, such as general budget restrictions and financing policies. Another reason is that the present cooperation has been focused on financing of voluntary requests from cooperating partners, and has not included initiatives related to central or regional administrative authorities. It is further noted that a specific area, which possibly could have been more strongly supported in relation to its importance as a public health problem, is the prevention and treatment of drug abuse.

The general conclusion of the evaluation is that the SEEC cooperation in psychiatry has been an important contribution to the process of change in the cooperating countries. There are clear results and effects of the cooperation, which should be considered reasonable in relation to stated objectives, the form in which the cooperation has been initiated and implemented, the time period of the support and the costs. The influence of the cooperation is strengthened by the fact that Sweden has been a major donor country in psychiatry in the Baltic countries.

A further conclusion is that there seems to be a need for some further support in order to sustain the capacity created and changes initiated on a longer term perspective. This future support should be directed towards activities supporting the internal capacity for change and development in the form of teachers training, leadership training and training in basic research methods.

Finally, recommendations are made on how to strengthen the formulation of operational aims and the follow up of results of future cooperation. The support is proposed to be based on a medium term plan for each project on activities over 2–3 years, stating objective, expected results and activities planned. The reporting and evaluation of the support should assess if staff had confirmed increased competence and capacity, if the capacity is regularly utilised, if new activities had been introduced and if organisation and procedures had changed.

2. Evaluation Methodology

With regard to documentation, this evaluation is based on a review of basic documents and reports made available by SEEC, a selection of around 50 files (each referring to a decision on a contribution) in the SEEC archives and 23 answers to a questionnaire from the SEEC coordinator to main actors in the Baltic countries (1998).

In accordance with the Terms of Reference, the assignment should include a visit to one of the Baltic countries, Latvia, which was visited during 5 days (12–16 April). In Latvia visits were made to the Mental Health Care Centre in Riga, the Psychiatric Hospitals in Jelgava and Strenci and the newly inaugurated Forensic Psychiatry Department in Riga.

In Sweden interviews have been conducted with the Chief Administrator of SEEC, the coordinator of psychiatric cooperation and members of the SEEC expert group on psychiatry present in Stockholm. Telephone interviews have been conducted with a selection of representatives of clinics in Sweden involved in long term psychiatry cooperation projects.

A list of persons met and contacted is attached in Annex 1.

3. Context of SEEC Psychiatry Cooperation

3.1 SEEC in general and Psychiatry Cooperation

SEEC was established in 1992 as an association of actors within the Swedish health care community (central and local government authorities, professional associations and others). The aim of SEEC is to contribute to socially sustainable economic transition in East Europe, through the development of good health care services. The support from SEEC shall promote development of capacity and competence. The projects supported by SEEC are either voluntary cooperation between partners in Sweden and in the respective countries or longer term projects initiated by, and related to, central or regional authorities. The Swedish funding shall be used for auscultation in Sweden, training activities, development of model institutions and strategical support for reforms.[1]

[1] Agreement of cooperation between Sida and SEEC 1997–1999

Psychiatry has been a key area of cooperation for SEEC since its establishment. For the fiscal year 1993/94, the support for cooperation regarding psychiatry amounted to 1 MSEK or 15% of total SEEC funding. In the same year the parliament bill regarding a mental health reform in Sweden also proposed a special appropriation for psychiatric development cooperation with Eastern Europe of 5 MSEK annually for three years (1995–1997). The reason for this appropriation, as stated in the parliament bill, was the need for support for knowledge development and changes in attitudes towards the patients as well as in the cooperation among different categories of staff in the psychiatric services. The development of ethical norms and legislation in relation to human rights of the patients and the use of force are also mentioned. Sweden should support auscultation, training courses and model institutions aiming at the development of a modern psychiatry with activation and rehabilitation of patients, outpatient care and cooperation between psychiatry, social services and the labour market.[2]

3.2 Objectives and Guidelines for Psychiatry Cooperation 1995

Based on the approval by parliament of the special appropriation mentioned above, the Swedish government requested SEEC to perform a review of psychiatry in the Baltic countries, Poland and Russia and to give proposal on the direction and channels for the support. The support should be aimed at transfer of knowledge and development of organisational structure and legislation. The projects to be supported should promote long term capacity development and changes in attitudes and approaches. It should also be possible to evaluate the results of the projects.[3]

SEEC appointed a working group to perform the review. Based on information on the general health situation and the conditions of the psychiatric services in the respective countries, the working group presented a proposal for guidelines for the SEEC funding of psychiatric cooperation.[4] Geographically the support was proposed to be focused on the Baltic countries and the North Western part of Russia (St Petersburg, Archangelsk and Murmansk). The guidelines includes the following areas of support:

- Organisation of a conference on psychiatric *legislation* with the health ministers and other high level ministerial staff from the Baltic countries, Russia, the Nordic countries and WHO. Support for follow up contacts between experts from the different countries.
- *Continuous training* activities for doctors, psychologists, nurses, etc with high priority for rehabilitation of patients, family therapy, crisis therapy, suicidal prevention and leadership issues in general.
- *Basic training* for assistant staff, occupational therapists and social workers.
- Promotion of *human and psychosocial* aspects of care and *teamwork* among staff of different categories, including structural changes from large hospitals to smaller clinics and more outpatient care.
- Development of *child psychiatry* towards more outpatient and less institutional care and including family therapy.
- Training and information activities for prevention and treatment of *alcohol and drug abuse*.
- Training and information activities to promote new attitudes towards psychiatry among the *general public.*
- Support for the creation of associations and *organisations of patients and parents*.

[2] Parliament Bill 93/94: 218
[3] Government request to SEEC 1995-05-04
[4] SEEC report to the Swedish government 1995-06-15

The proposal from SEEC also included the establishment of an expert group for the appraisal of requests for funding, including competence on child psychiatry and drug abuse. SEEC should also employ one full time coordinator for the psychiatry cooperation with the following task:

- Review ongoing Swedish cooperation.
- Collect information on support from other Nordic countries.
- Establish contacts and cooperation with WHO European office in Copenhagen.
- Appraise the need for future Swedish support.
- In cooperation with psychiatry representatives in Baltic countries and Russia, initiate, plan and implement development projects regarding legislation, organisational change and stafftraining.

The review[5], performed by the coordinator, showed that 20 Swedish psychiatric institutions had active ongoing cooperation in adult psychiatry and 4 institutions in child psychiatry. Among the other Nordic countries, Finland had an active cooperation with Estonia and both Finland and Norway participated in the cooperation with Northern Russia in the Barents region. Norway was also giving limited support to some of the Baltic countries. The review further proposed that the future cooperation should include the following:

- The establishment of more cooperation clinic-to-clinic, through direct contacts and a conference in Sweden.
- Seminars for younger Baltic psychiatrists twice a year.
- Annual meetings of Chief Psychiatrists from the Baltic countries.
- Translation and publishing of psychiatric literature in the Baltic languages.

3.3 SEEC Internal Evaluation 1998

In 1998, SEEC presented an internal review and evaluation of the cooperation in psychiatry[6]. This review describes the main type of projects (exchange of experience clinic-to-clinic, training programmes, support for literature, forensic psychiatry and child psychiatry), distribution of funding by country and by main type of activity supported (training, auscultation, development of model institutions). The review includes a summary of answers to a questionnaire sent to the main actors in the Baltic countries.

The general conclusion of the SEEC review is that the projects supported have been in line with objectives of the cooperation and that they gradually have acquired a long term character as parts of an ongoing reform process towards more outpatient care, changes of attitudes and staffing structures. It is pointed out that inpatient care is decreasing and that several initiatives are taken to increase outpatient care as well as activation and rehabilitation of patients. The attitude from staff and relation to the patients is changing towards more respect and involvement of the patients in the planning of their treatment. Clear efforts to involve the patient's family in treatment and rehabilitation are also mentioned.

With regard to training, it is stated that the cooperation has supported and enabled nurses and to some extent also social workers and occupational therapists to assume a more active role. Teamwork between different categories of staff has increased in many clinics and new forms of treatment, such as psychotherapy and active rehabilitation, has been introduced. As an additional result

[5] Summary Report on SEEC psychiatric cooperation February–July 1996
[6] Report and internal evaluation of the appropriation for development of psychiatry in Eastern Europe 1995–97, 1998-06-30

of a joint training of nurses from the Baltic countries, professional associations of psychiatric nurses have been formed in these countries.

Other clear results of the cooperation, which are mentioned, are translation and distribution of some basic textbooks, subscription of professional journals and publishing of national newsletter on psychiatry. Furthermore contacts and exchange of experiences among the Baltic countries (and to some extent Russia), such as the annual meetings of the Baltic Chief Psychiatrists, were made possible by the support from Sweden. Areas with little activity and result have been legislation and basic training for assistant staff (orderlies). It is also noted that it has not been possible to mobilise interest for the organisation of a ministerial conference on legislation and that the only direct support in this area has been comments from Swedish specialists on a draft psychiatric law in Estonia. The contacts and cooperation with WHO regional office in Copenhagen has been limited due to a staff vacancy in the WHO office. As from late 1998 this vacancy is filled by a Swede with extensive experience from the Baltic psychiatry cooperation (nurse training and network meetings in Visby).

3.4 SEEC Documentation and Decision Procedures

SEEC is taking decisions on individual contributions to the cooperation covering activities up to one year. In many cases, especially during 1996 and 1997, the same requesting institution/person have received several contributions during the year for continued exchange visits and other activities related to the same cooperating partner/clinic in the respective countries. As from 1998 the requests for contributions have to be presented twice a year (before 1/5 and 1/12) following a standard format. After the decision on support, SEEC signs a contract with the requesting institution. The contract stipulates that the receiver of the contribution shall present a report on the implementation of activities and economic accounts on the use the funds.

The SEEC expert group on psychiatry consists of 6 persons, including the coordinator, who is acting as secretary. The group meets 6–8 times a year, primarily for appraisal of the requests and proposal for the decisions on funding by SEEC. The members of the group are at the same time some of the most active Swedish partners in the cooperation. This situation could be questioned from a point of view of dual interests and of threatening the objectivity in the appraisal of requests. On the other hand, it would not be possible to select a group of experts for this functions with relevant knowledge and experiences without choosing persons that are already actively involved in the cooperation.

The evaluation of results of individual project contributions is restricted by the fact that the requests for funding to SEEC in several cases are short, with presentation of the aim of the activities in general terms, without specifying the results expected to be achieved after the implementation of the activities. This situation could possibly be improved by introducing separate headings for Objectives and Expected Results in the standard format for requests, that was introduced in 1998. (See further under section 7 below.)

Another factor limiting the possibilities for follow up and evaluation is the fact that reports of performed activities, as well as economic accounts of the use funds were lacking in about half of the 50 files/contributions reviewed in SEEC archives. This could be explained by the normal time lag of reporting and rendering of accounts in the case of the latest contributions in 1998, but should generally not be accepted in the case of earlier contributions. SEEC seems not to demand reporting and accounting of earlier contributions as a prerequisite for decisions on new contributions to the same requesting partner in Sweden. Some of the existing reports were also very brief

and general, often reflecting the lack of formulation of expected results in the requests. Detailed and clearly specified requests and reports were, however, noted for several contributions regarding training of nurses, occupational therapist, abuse prevention and other areas.

3.5 Distribution of SEEC Funding for Psychiatry Cooperation 1995–1998

The following overview of distribution of project contributions (decisions on funding) for the psychiatric cooperation 1995–1998 is based on information from the internal evaluation report and the SEEC annual report for 1998 (March 1999).

Country	Number of contributions	Amount (TSEK)	% (of amount)
Estonia	60	2318	15
Latvia	64	3032	19
Lithuania	33	1516	10
Russia	19	1127	7
Other	10	1187	8
Joint	45	6460[7]	41
TOTAL	231	15 640	100
Year			
1995/96	84	5429	
1997	76	4622	
1998	71	5559	
TOTAL	231	15 640	

The avarage amount per contribution is 78 300 SEK and the range of contributions is from 2 500 SEK to 510 000 SEK. Nearly 60% of the contributions (135) refer to some 30 longer term projects (over 2–3 years or more) regarding clinic-to-clinic cooperation, continuous training and series of seminars. Another 8% of contributions relate to translation and publication of literature and journals and 5% to participation in Nordic or international conferences. The costs for the coordinator covers about 20% of the total amount.

The psychiatry cooperation has been the biggest part of cooperation for SEEC during the period 1995–1998, basically due to the special appropriation mentioned above. For 1998 the distribution among areas of SEEC cooperation is shown below.

Country	Number of contributions	Amount (TSEK)	%
Psychiatry	71	5559	27
Maternal and child care	59	3933	20
Primary health care	24	2834	16
Nursing	21	1572	8
Care for disabled	34	1298	6
Infectious care	16	1222	6
Dental care	9	704	3
Other	63	3298	16
TOTAL	298	20 420	100

The average amount per contribution for all SEEC cooperation is 68 500 SEK (ranging from 38 200 for care for disabled to 118 000 for primary health care). The geographical distribution of SEEC funding (1998) to other areas of cooperation then psychiatry, was dominated by Russia

[7] Including 3 000 TSEK for full time coordinator.

(35%) and joint projects (29%). The Baltic countries received 10–15% each. It could be noted that the cooperation in the areas of maternal and child care, care for disabled and nursing are similar to the psychiatric cooperation in the mix of clinic-to-clinic contacts and training activities, whereas the cooperation regarding infectious care and primary health care is relatively more concentrated to bigger projects between institutions at a higher administrative level (national centres and county administrations).

It could also be noted that SEEC is financing special coordinators for three other areas of cooperation. These areas are infectious care, primary health care support to Russia and support to Bosnia-Hercegovina. However, the coordinators in these areas are financed with 50% of full time work, whereas the coordinator for psychiatry is has been financed up to 100%.

4. Findings

4.1 Results in Relation to Objectives and Guidelines.

As a basis for the assessment of the results of the cooperation, the stated objectives, guidelines and activities could be slightly reformulated and related to the Logical Framework terminology in the following way.

SEEC General Objective (page 1 above) Contribute to socially sustainable economic transition through development of good health care services.	*Development Objective* Benefit for society to which the project (psychiatry cooperation) is contributing.
SEEC Objectives for psychiatry cooperation (page 2) Promote development of knowledge, capacity, organisational structures and legislation, and changes in attitudes and approaches.	*Project Purpose* Benefit for those receiving psychiatric care and services (patients and their families).
Guidelines for psychiatry cooperation (page 3) 1. Legislation reformed. 2. Doctors, psychologists, nurses, etc, trained in rehabilitation, family therapy, crisis therapy, suicidal prevention and leadership. 3. Assistant staff, occupational therapists and social workers have basic training. 4. Psychiatric care is given with human and psychosocial considerations and through teamwork among staff of different categories 5. The structure for psychiatric care has changed from large hospitals to smaller clinics and more outpatient care. 6. Child psychiatry has changed towards more outpatient and less institutional care and includes family therapy. 7. Training and information activities for prevention and treatment of alcohol and drug abuse has increased. 8. Attitudes towards psychiatry among the general public is changing. 9. Associations and organisations of patients and parents have been created.	*Results – outputs* Capacity created and services offered.
Activities supported in psychiatry cooperation 1. Clinic-to-clinic exchange, including training of different staff groups and changes in approach, working methods and organisation. 2. National training programmes for different categories of staff in collaboration with Swedish institutions. 3. Participation in international and regional conferences. 4. Translation and printing of literature, publishing of newsletters. 5. Conferences and consultancies on legislation and national reforms.	*Activities* Which will possibly produce the results expected.

The following sections assess the results of the cooperation in relation to the objectives and guidelines established. The number of projects noted for each item of guideline refers to a group of contributions for cooperation between the same partners in Sweden and the respective countries over more than one year (the 30 projects mentioned on page 6 above).

1. Legislation

Although a stated priority in the objectives and guidelines for the psychiatry cooperation, there have not been specific projects supported regarding legislation. The ministerial conference, mentioned above, was planned as a start of activities in the area, but it has so far not been possible to stimulate an interest for such a conference in the first hand in the cooperating countries. Comments on the draft psychiatry law in Estonia, has been given as part of the cooperation in forensic psychiatry. Other direct initiatives seem not to have been taken in this area.

2. Continuous training of staff in new approaches and teamwork

(8 projects – 28 contributions)

A very clear and noticeable result with regard to complementary training is the six weeks training for psychiatric nurses held in Visby. A total of 63 nurses (21 from each of the Baltic countries) have been trained in modern psychiatric nursing and teamwork, in three courses 1994–1996. These courses have been systematically followed up both through joint meetings with the nurses six month after the course and through visits by the teachers to the hospital and clinics where the nurses are working. Finnally, most of the nurses trained took part in a one week's seminar together with doctors from their clinics to discuss teamwork and treatment in psychiatric care.

Nurses met during the evaluator's visit to Latvia confirmed that changes in the role of nurses were taking place and that a broader and more active role for nurses was met with acceptance from most doctors. Other effects of this training in Latvia are the appointment of nurses responsible for staff training in hospitals, regular monthly meetings among head nurses and training nurses, and annual meetings of all psychiatric nurses in the country. The professional association of nurses has formulated national curricula for complementary training of psychiatric nurses as well as for basic training of assistant staff. The nurses met in Latvia seemed to be very active and dynamic in their work and had generally a better command of English than the doctors met.

Another important complementary training is an ongoing three year university course (30 p) in psychotherapy for psychiatrists in Latvia, which will finish this year. A training programme in cognitive psychotherapy is being initiated in Latvia. Other ongoing short term training activities and series of seminars (1 day – 1 week each) regard forensic psychiatry (Estonia and to some extent Latvia), suicidal prevention (Estonia and Russia) and seminars for outpatient psychiatrits (Latvia). A special effort for complementary training and promotion of new knowledge and ideas, as well as for exchange of experiences, is the joint seminars for young Baltic psychiatrists that has taken place twice a year since 1996.

The persons interviewed do all confirm a great interest and a wish to acquire new knowledge and approaches from the participants in the training activities. They refer then to formal course evaluations, as well as to the active attitude of most participants. It is, however, not possible to assess the result and effect of each of these short term training activities, as several of the activities are ongoing or recently started. In some cases the reason also is that the expected results of the activities have not been clearly formulated in advance.

3. Basic training for assistant staff, social workers and occupational therapists.

(No separate projects; acitivities included in 1 nurse training project and 3 clinic-to-clinic projects.)

In this area there has been less result than in complementary training for doctors and nurses. With regard to training of assistant staff, nurses from some hospitals in Latvia have been trained in Visby during 1998 to be able act as teachers of assistant staff in their hospitals. A problem mentioned in relation to assistant staff is the extremely low salaries for this group, which makes it necessary for them to have other jobs besides working in psychiatric care.

In the case of occupational therapists, there is an ongoing training at university level (general occupational therapy) in Latvia, with practical work training for those specialising in psychiatry planned to start in 1999 at one of the psychiatric hospitals (Strenci). This practical training is supported within the clinic-to-clinic cooperation between Strenci and Östersund. In Lithuania, short term practical training of occupational therapists and assistant staff has also taken place in connection with clinic-to-clinic cooperation with the hospital in Siauliai (cooperation with Sandviken and Umeå), and training of social workers has taken place in Kaunas (cooperation with Växjö).

All the training activities mentioned above are either ongoing or planned, which does not allow any evaluation of their effects yet.

4. Attitude to patients and approach to treatment.

(15 clinic-to-clinic projects – 58 contributions; including forensic psychiatry in Estonia and suicide prevention in Estonia and Russia.)

It is clearly indicated by all persons interviewed and in available reports that there is a general understanding and a wish, among the majority of psychiatric staff in the cooperating countries[8] to change attitudes and approaches towards the patients and their treatment, including realising the advantage of a broad psychosocial approach to treatment and rehabilitation of patients. The change in attitudes and approaches also include a closer cooperation and teamwork between the different staff categories in the psychiatric services, especially with regard to the role of nurses. The degree of implementation of this understanding and changes does, however, vary among different institutions and staff in these countries.

A joint project on rehabilitation between one hospital in each of the Baltic countries and Malmö in Sweden could be mentioned as an important example of clinic-to-clinic cooperation. In relation to this project, a textbook on psychiatry rehablitation has been translated and utilised for training, and peer reviews have taken place between the cooperating clinics.

Both actors from Sweden and from the cooperating countries point out the importance of visits and auscultations in Sweden in the initial stage of the cooperation. When several persons in different positions have seen and have practical experience from psychiatric services in Sweden, it has been easier to change attitudes and approaches. It is further pointed out by several actors in the cooperating countries that proposals for new or changed methods and approaches initially has had a stronger weight when coming from the outside, than if proposed by national staff.

[8] This refers mainly to the Baltic countries as the cooperation with Russia is still in an initial stage of the first round of exchange visits and planning.

5. Structural change

(1 project – 3 contributions)

As in the case of attitudes and approaches to treatment, there seems to be a general understanding of the need to change the structure of psychiatric care towards more outpatient care and integration of patients in normal life of the society. This also includes the need to change towards smaller and decentralised units for inpatient care instead of the large hospitals still dominating the psychiatry services in the Baltic countries and Russia. The number of patients in the hospitals has decreased during the last decade, but outpatient services and establishment of smaller clinics have increased very slowly.

The reason for this situation is said to be lack of resources for investment in outpatient infrastructure and salaries. The most important factors behind this lack of resources seems to be limited budgets in general and the fact the health services are financed through an insurance system that promotes inpatient and not outpatient care. Another factor is a generally weak central management of health services, which does not seem to actively promote changes and reallocations of existing resources. Furthermore, the integration of former hospital patients in society is limited by the possibilities of their families to support them, the high level of unemployment and the lack of social welfare support.

The clinic-to-clinic projects and other parts of the cooperation have contributed indirectly to the increased general understanding of the need for structural change. However, the only project with a possible more direct influence on this understanding is the annual conference of Chief Psychiatrist and Chairpersons from the Psychiatric Associations in the Baltic countries, which is financed by the cooperation.

6. Child psychiatry

(3 projects – 26 contributions)

Child psychiatry is said to have gradually become more accepted as a separate speciality within psychiatry and the contacts with the parents has developed, including the use of family therapy. This area has been actively supported in Estonia (from Stockholm and Uppsala) and in Latvia (from Malmö). The cooperating institutions point stress that the direction of their development work has been confirmed and strengthened by the cooperation with Sweden.

However, the change from large institutions to more outpatient care is slow for the same reasons as mentioned above.

7. Prevention and treatment of alcohol and drug abuse

(3 projects – 5 contributions)

Although alcohol and drug abuse are presented as major public health and societal problem in all cooperating countries, there are only one longer term project in Latvia and two recently started in Russia. The project in Latvia regards training in group therapy for different categories of staff, including those in supervisory positions. The first training course started in 1991 and there have been two more courses in 1995 and 1998. An advanced course over 3 years is planned in order to train trainers for future courses. These courses have had a clear influence on changes in attitudes and approaches towards abusers. The participants has showed great demand for, and wish to learn, new methods.

The other projects in this area are clinic-to-clinic cooperation on prevention of abuse among pregnant women in St Petersburg (Göteborg) and on alcohol abuse in Archangelsk (Örnsköldsvik), which have recently started in the form of exchange of visits from and to Sweden.

8. Attitudes towards psychiatry among the general public.

No specific projects have been supported in this area. However, cooperation in other areas could have an indirect influence on the public attitudes, if information about changing attitudes and approaches to patients is spreading from relatives and families of patients into the society in general. In Tallinn, Estonia, the establishment of a crisis centre for families to victims of the Estonia ferry disaster, is said to have helped to overcome suspicion and the historically negative conception of psychiatry among the public.

9. Establishment of patient and parents associations

This is also an area with no specific projects supported, but where the cooperation also could have had an indirect influence. In the answers to the SEEC questionnaire the existence of patient and parents organisations is mentioned in all of the three Baltic countries.

In the sections below, the findings are summarised in relation to ethical, legal, structural and quality issues and other aspects in accordance with the Terms of Reference for the evaluation.

4.2 Ethical Issues

The ethical aspects of psychiatry care relates basically to the contacts with and treatment of the patient. With the increased understanding and change of attitudes and approaches towards the patient, as noted above, the cooperation has clearly promoted consciousness about the ethical dimensions in the psychiatric services. This has been a direct or indirect component in both clinic-to-clinic contacts and in different training activities. However, the implementation in practice of these aspects regarding the respect for the patients and their rights, still seems to vary with the local situation and the progress of change within different institutions. In Latvia, a specific project has been supported, where a local non governmental organisation has conducted seminars on human rights of patients for staff in psychiatry hospitals. Two important factors for the promotion of human rights and ethics have been the signing by the cooperating countries of international declarations regarding psychiatry and the wish from the Baltic countries to join the European Union.

4.3 Legal Issues

The legal issues are also closely related to the rights of the patient, especially with regard to regulating the conditions for the use of coercion in order to prevent the patient from hurting himself or others. As noted above, the direct influence of the cooperation on the change of legislation has been limited. However, it has most probably had an important indirect influence, especially in relation to cooperation regarding forensic psychiatry in Estonia. Both Estonia and Lithuania have recently adopted new psychiatry laws, even if the implementation of the laws is lagging behind. In Latvia a draft law is presently waiting approval by government and parliament.

4.4 Structural Issues

As noted above, the structural change from institutional to community based outpatient care is still slow due to financial, administrative and other obstacles. It could not be expected that the SEEC cooperation in its present form should be able to influence this situation other than marginally. Effective support for structural change has to be directed towards the political and decision making level and involve Swedish expertise from central health care administration. It would possibly also require an increase in financial contributions. A cooperation with, or involvement in, planned World Bank financed projects for health sector reform in Lithuania and Latvia could be a possibility for Sweden and SEEC of giving an important and direct contribution to the structural change of psychiatry care in these countries.

4.5 Quality Issues

From the assessment above, it is obvious that the cooperation has had a clear and important influence for the quality of psychiatric care, by introducing a broad psychosocial perspective on treatment of patients and of promoting increased knowledge and capacity in specific methods and areas, such as psychotherapy, family therapy, treatment of drug abuse and suicidology. The cooperation has also had great influence on the strengthened roles for nurses, occupational therapists and social workers, as well as for promoting teamwork between the different categories of staff. However, the financing of salaries, especially for new categories such social workers, is a structural problem affecting this process. The effect of the cooperation on leadership and management is more difficult to assess based on available information. Possibly, there is a gradual shift from a strict hierarchical organisation of work towards more democratic leadership in connection with increased teamwork and strengthened role for other categories of staff than doctors.

4.6 Sustainability

Sustainability could be viewed from a financial and competence point of view. Furthermore these two dimensions of sustainability could be related to daily activities (service delivery) and to development activities (change of approaches and organisation). The psychiatric services in the cooperating countries could be said to be financially sustainable, or independent of financial support, with regard to daily activities, although at a low level of salaries and infrastructure investment. There is, however, so far limited national resources available for development activities, which means there is at present little financial sustainability in these activities. Therefore there is a need for financial support from Sweden and other donors.

From a competence point of view there is sustainability, or no major dependence on external technical assistance for the daily activities of services delivery. However, there has been and still is some dependence on external technical assistance for the change and development process. The results of the cooperation in the form of increased knowledge and capacity, and changed attitudes and approaches, could be said to have increased the sustainability of development activities in a medium term perspective. For the long term sustainability of knowledge and capacity, however, it would be necessary to further strengthen the capacity for internal development and change. The most important measure to be supported by future cooperation in this respect would therefore be:

- training of trainers, to be able to conduct future training without teachers from abroad;
- training in leadership, so that development work is understood and actively promoted by the mananagement;

- training in methods for studies and applied research, to supply basis for new initiatives and to follow the results of changes made..

4.7 Vulnerable Groups

With regard to the effect of the cooperation on the situation of vulnerable groups, the major effect seems to have been the gradual improvement and strengthened role for child psychiatry in Estonia and to some extent in Latvia. Another potentially vulnerable group in Estonia and Latvia is the Russian population, which is over represented among unemployed and drug abusers. There are also indications of discriminatory attitudes towards this group in general and sometimes also in the psychiatric care. The effects of the cooperation with respect to this situation, if any, could possibly have been the promotion of the equal right of all patients as part of the support for changed attitudes and consciousness of ethical issues.

4.8 Results in Relation to Costs

The dominant type of cost financed by SEEC in the cooperation is cost for travel between Sweden and the cooperating countries and cost for accommodation during visits and conferences (60–70%). In many cases, these costs have been kept low through cheap air tickets and different arrangements for accommodation and boarding both in Sweden and in the cooperating countries.

The second major item is the costs for the full time coordinator (20%). The coordinator seems to have played an important role for the development of the psychiatric cooperation during the last three years. This role refers to active promotion of new contacts between institutions in Sweden and in the cooperating countries, as well as between representatives from these countries. It refers also to direct initiatives for projects in, or among, the cooperating countries. However, in view of the fact that these contacts and initiatives now are established, the relatively high costs required for financing a fulltime coordinator and the comparison with the financing of other SEEC coordinators (half time), it seems reasonable to reduce the financing of the psychiatry coordinator to half time, later followed by a gradually phase out this function.

A third major cost item refers to translation and printing of literature (8%). In a few cases the cooperation has financed essential equipment, such overhead projectors for training programmes. Salaries and fees have generally not been paid as part of the contributions. These type of costs have been born either by the Swedish institutions participating in the cooperation or by the involved persons themselves in the form of vacation or free time.

5 Conclusions

The general conclusion from the findings presented above is that the SEEC cooperation in the field of psychiatry has been an important contribution to the process of change in the cooperating countries. There are clear results and effects of the cooperation, which should be considered satisfactory in relation to stated objectives, the form in which the cooperation has been initiated and implemented, the time period of the support and the costs.

With regard to the objective it could be concluded that the support has promoted development of knowledge and changes in attitudes and approaches. There has been less result concerning overall organisational structures and legislation. One important reason for the difficulties to achieve results regarding structural change is external factors, such as general budget restrictions and financing policies. But another reason is also that the present cooperation has been almost entirely focused on financing of voluntary requests from cooperating partners. It has not included initiatives from, or related to, central or regional administrative authorities, although this is the other main type of projects supported by SEEC.

The different cooperation projects have mainly been initiated by individual professionals in Sweden with strong personal commitments, often including personal relations to the respective countries. The results of the cooperation have been achieved through a number of visits in both directions for lectures, training activities and auscultations, complemented by participation in international and Nordic conferences and translation and distribution of literature and newsletters. The influence of the cooperation is also due to the fact that Sweden has been a major donor country in the field of psychiatry in the Baltic countries.

In a time perspective, it seems important to note that the psychiatry cooperation, although started on very small scale of first individual contacts in the early 1990s, has been going on for only a few years. In this perspective, it seems realistic to expect that changes in attitudes and approaches are started, but less realistic to expect structural change as an effect of this kind of cooperation. It could at the same time be noted that several Swedish actors assess the change of attitudes and approaches in the Baltic countries since 1990 to be much quicker than the same process in Sweden, which took about 40 years (1950–1990).

With regard to the areas of the cooperation, as mentioned in the guidelines, it could be noted that some of these, such as attitudes towards psychiatry from the public and organisation of patients and parent associations, were not supported with specific projects, but were probably indirectly influenced by the support in general. However, an area which could have been more strongly supported in relation to its importance as a public health problem, is the prevention and treatment of drug abuse.

From a cost effectiveness point of view, it could be concluded that the costs in general are low in relation to the results achieved and also in comparison with other forms of development cooperation. However, the cost for the full time coordinator is high in relation to the total amount of support.

A final conclusion is that there seems to be a need for some further support in order to sustain the capacity created and changes initiated in a longer term perspective. This future support should be directed towards activities supporting the internal capacity for change and development in the form of teachers training, leadership training and training in basic research methods. The support should also seek to support the ongoing transition of the health care in general by promoting strategic policy formulation, national targets and organisational structures in the field of psychiatry.

6. Recommendations

In this section recommendations are made on how to strengthen the formulation of operational aims and the follow up of results of future cooperation. These recommendations are given for each major type of activity supported (see page 8 above).

6.1 Clinic-to-clinic Cooperation

This type of cooperation is presently established in about 15 projects. It is recommended that further support to these projects are based on a medium term plan for each project on activities over 2–3 years. This plan should state:

- objective,
- expected results,
- activities planned.

The plans should be agreed upon between the partner institutions. The expected results could be presented in the form of:

- specific knowledge and capacity to be acquired by different categories of staff,
- new activities and treatments to be introduced,
- changes in organisation and procedures.

The reporting and evaluation of the support should assess if staff had confirmed increased capacity, if this capacity is regularly utilised, if new activities had been introduced and if organisation and procedures had changed.

The agreed plan, mentioned above, should be part of the requests for support to SEEC as annex to the standard format. SEEC could, after receiving permission from Sida, decide to support the plan for 2–3 years in one decision, but condition annual or semi-annual disbursements to the rendering of economic accounts for the use of funds already received together with an activity report. A final report should be presented on results achieved in relation to the objectives and expected results.

The reduction in the number of decisions resulting from this recommendation could possibly ease the work of the SEEC administration and make it possible to be more strict on activity and financial reporting as a condition for disbursement of funds.

6.2 Training Programmes

These programmes should preferably also be planned for 2–3 years. There should be a formal agreement between the Swedish institution and an institution responsible for the training in the cooperating country stating:

- the role of the proposed training in the national education system and in the development of psychiatry,
- basic competence and experience required to be able to participate in the training,
- level of knowledge and competence to be reached and proved after completing the training,
- positions and functions were the acquired competence should be used,
- how national teaching capacity for continued training should be formed.

The final reporting and evaluation of the contribution should assess how the training has been performed, the participants opinion of the training, if knowledge and competence have been proved in tests by the participants, if (later) the participants have positions and functions where they can and do utilise their competence.

6.3 Participation in Separate International and Regional Seminars and Conferences

Criteria for the financing of such participation should be that the conference could provide:

- new knowledge and information, which is of crucial importance in specific area of competence of the participant,
- mutual exchange of experiences where the participants also are required to present their own work and experience,
- network for regular contacts and exchange of information.

The participants should be obliged to present a report of knowledge, information and contacts acquired in their local environment (national newsletter, institution colleagues, etc). The reporting of the contribution should verify the presentation of these conference reports

6.4 Literature and Periodicals

In the case of continued substantial support for literature and periodicals, there should be an agreement between the Swedish institution and an institution responsible for the distribution or publishing of the material, including by whom and how the material is planned to be used, e.g. in relation to training programmes or treatment of patients.

The reporting and evaluation should assess the distribution, availability and utilisation of the material in training, in hospital and clinical work.

6.5 National Reform, Organisation and Legislation

Possible SEEC contributions could be made directly to each country or in cooperation with major programmes supported by the World Bank, WHO and other donors. Such support should relate closely to nationally defined plans and programmes. SEEC should in this case contribute with expertise with high levels of competence in specific areas of importance for the reforms and financed on international consultancy terms. This could be a priority area for the future work of the coordinator for the cooperation in the field of psychiatry.

The annual meetings of Baltic Chief Psychiatrist could possibly also be further utilised for systematic exchange of information on ongoing reform and cooperation.

A general recommendation would be that the improvement of requests and reporting is complemented by periodical independent evaluations initiated by SEEC. It could be noted that the SEEC budget proposal for 1999, the area of nursing includes funds for such an evaluation.

7. Lessons Learned

An important lesson learned from this cooperation is that it requires special efforts and initiatives from sufficiently high level of authority (regional or national health administration) to directly promote structural change and legislation. These types of changes do not follow automatically from clinic-to-clinic cooperation and different training activities. However, the latter kind of projects could serve as examples and basis for the structural changes.

Another lesson learned is the importance of strategic considerations about sustainability in the development of capacity and competence. This means that it is important to gradually change the support from direct training activities towards training of trainers, leaders and researchers.

Annex 1

List of Persons Met and Contacted

In Sweden

Gunnar Wennström	SEEC, Administrator
Roy Persson	SEEC, Psychiatry Coordinator
Aina Siksna	Chairperson, SEEC Expert Group on Psychiatry
Jüri Männik	Member, ”
Inara Erdmanis	Member, ”
Kari Schleimer	Member, ”
Ants Andersson	Former chairperson, ”
Eve Suurve	Training programme in psychotherarpy, Riga, Latvia
Lennart Tysk	Sandviken – Siauliai, Lithuania
Eva Kjellberg	Gällivare – Archangelsk, Russia
Glenn Nordlund	Alcohol abuse, Örnsköldsvik – Archangelsk, Russia
Kristina Vikman	Växsjö – Kaunas, Lithuania
Eva Bona	Drug abuse and pregnancy, Göteborg – St Petersburg

In Latvia

Solita Udrasa	Head of Mental Health Care Centre, Riga
Sandra Kregere	Head nurse, ”
Aigris Kisuro	Child psychiatrist, ”
Gunta Ancane	Head of Dept, Medical Academy, Riga
Georg Sturms and staff	Psychiatry Hospital, Jelgava
Victor Rodhins and staff	Psychiatry Hospital, Strenci
Inga Weinberga	Regional psychiatrist, Sigulda
Staff at	Forensic Psychiatry Department, Riga

Terms of Reference for the Evaluation of The Psychiatry Project of the East Europe Committee of the Swedish Health Care Community (SEEC)

1 Background

The Swedish parliament decided in 1995 of an annual appropriation of 5 MSEK during the three years of 1995 to 1997 to be allocated for psychiatric development activities in Eastern Europe. In total 14,9 MSEK have been channelled by Sida to SEEC for the implementation of the activities. In mid 1998 SEEC presented to Sida a final utilisation report.

Psychiatry has been one of the key priorities in the activities of the SEEC. A special advisory committee on psychiatry was set up, with a full-time psychiatrist, Dr. Roy Persson, as secretary. The activities have, geographically, focussed on the Baltic countries. The objectives of the activities have been related to;

- *ethical issues*; improving the human rights of the patients in the mental health system,
- *legal issues*; giving comments and advice aiming to reform of the laws governing mental health care,
- *structural issues*; aiming to reform the system in the direction of more community based care and less institutionalised care and
- *quality issues*; with strengthening of psychotherapy, child psychiatric care, drug abuse control, suicidology, team work and leadership training.

SEEC has requested an appropriation of 5 MSEK for 1999, for the continuation of the Psychiatry project. Sida decided to have this independent evaluation as a basis for a decision on continuation of the activities.

2 Purpose and Scope of the Evaluation

The purpose of the evaluation is twofold. The first purpose is to assess the results in relation to the costs of the project for the period 1995-1997 The assessment of the results should be related to the objectives listed above.

The second purpose, contingent on a positive evaluation of the results, is to provide recommendations on the formulation of operational aims and indicators for the requested second phase of the project. A second phase of the project should be guided by a clear operational definitions of the objectives, with indicators reflecting the objectives in order to facilitate future evaluations.

3 The Assignment (issues to be covered in the evaluation)

The evaluation should analyse the results separately for the four areas of activities; ethical, legal, structural and quality aspects. The results should be assessed both from the perspective of cost-effectiveness, sustainability, long-term effects as well as for the effects on vulnerable groups, notably women, children and ethnic minorities.

4 Methodology, Evaluation Team and Time Schedule

The evaluation should be based on interviews with key persons, review of relevant documents, reports and evaluations. ÖEK presented its own evaluation of the Psychiatry project 30-06-98. ÖEK carried out a survey by mail of the collaborating partners in the countries. The results of the survey and the ÖEK evaluation may be used for this assignment.

The consultant should have a strong background in public health or international health, be well experienced in project preparation, monitoring and evaluation. The assignment may be carried out by one person, if necessary assisted for some of the tasks.

The assignment should include a visit to one of the Baltic countries, preferrably Latvia, to gather data on the collaboration and its results.

The assignment will start from 30-03-99 and should not exceed 15 working days in total.

5 Reporting

The draft results and recommendations shall be shared with ÖEK and discussed in a meeting with the consultant, ÖEK and Sida, prior to finalising the report.

The evaluation report shall be written in English and should not exceed 30 pages, excluding annexes. Format and outline of the report shall follow the guidelines in *Sida Evaluation Report – a Standardized Format* (see Annex 1). 3 copies of the draft report shall be submitted to Sida no later than 03-05-99. Within 2 weeks after receiving Sida's comments on the draft report, a final version in 5 copies and on diskette shall be submitted to Sida. Subject to decision by Sida, the report will be published and distributed as a publication within the Sida Evaluations series. The evaluation report shall be written in Word 6.0 for Windows (or in a compatible format) and should be presented in a way that enables publication without further editing.

The evaluation assignment includes the production of a Newsletter summary following the guidelines in *Sida Evaluations Newsletter – Guidelines for Evaluation Managers and Consultants* (Annex 2) and also the completion of *Sida Evaluations Data Work Sheet* (Annex 3). The separate summary and a completed Data Work Sheet shall be submitted to Sida along with the (final) draft report.

Annexes 1, 2 and 3 are retrievable from 'Sida-mallar'/Sida Evaluations.

Recent Sida Evaluations

99/12 Nordic Support to SATCC-TU, Southern Africa Transport Communications Commission, Technical Unit. Björn Tore Carlsson, Leif Danielsson.
Department for Infrastructure and Economic Cooperation

99/13 Cooperation Between Sweden and Ukraine in the Field of Local Self-Government.
Lars Rylander, Martin Schmidt
Department for Central and Eastern Europe

99/14 Research Cooperation between Sweden and Uruguay 1986-1995. An evaluation and some general considerations. Osvaldo Goscinski, Mikael Jondal, Claes Sandgren, Per Johan Svenningsson
Department for Evaluation and Internal Audit

99/15 Sida Supported Advantage Projects in the Baltic States. Claes Lindahl, Petra Stark
Department for Central and Eastern Europe

99/16 Diakonia Program for Democracy and Human Rights, the El Salvador Case. A qualified monitoring. Vegard Bye, Martha Doggett, Peter Hellmers
Department for Latin America

99/17 Dollars, Dialogue and Development. An evaluation of Swedish programme aid. Howard White, Geske Dijkstra, Jan Kees van Donge, Anders Danielsson, Maria Nilsson
Department for Evaluation and Internal Audit

99/18 Atmospheric Environment Issues in Developing Countries. Gun Lövblad, Per Inge Iverfeldt, Åke Iverfeldt, Stefan Uppenberg, Lars Zetterberg
Department for Infrastructure and Economic Cooperation

99/19 Technical Assistance to Central and Eastern Europe. A cooperation between Chambers of Commerce in Sweden and in Central and Eastern Europe. Claes Lindahl, Monica Brodén, Peter Westermark
Department for Central and Eastern Europe

99/20 Sida Support to the Energy Sector in Egypt. Rolf Eriksson, Edward Hoyt
Department for Infrastructure and Economic Cooperation

99/21 Sida Support to the Energy Sector in Jordan. Rolf Eriksson, Edward Hoyt
Department for Infrastructure and Economic Cooperation

99/22 Environmental Aspects in Credit Financed Projects. Gunhild Granath, Stefan Andersson, Karin Seleborg, Göran Stegrin, Hans Norrström
Department for Evaluation and Internal Audit

99/23 Sida SAREC Marin Science Programs in East Africa. Stephen B. Olsen, James Tobey, Per Brinck
Department for Research Cooperation, SAREC

99/24 Sweden's Assistance to Bosnia Herzegovina. A study of aid management and related policy issues. Claes Sandgren
Department for Central and Eastern Europe

Sida Evaluations may be ordered from:

Infocenter, Sida
S-105 25 Stockholm
Phone: (+46) 8 795 23 44
Fax: (+46) 8 760 58 95
info@sida.se

A complete backlist of earlier evaluation reports may be ordered from:

Sida, UTV, S-105 25 Stockholm
Phone: (+46) 8 698 5099
Fax: (+46) 8 698 5610
Homepage:http://www.sida.se

SWEDISH INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
S-105 25 Stockholm, Sweden
Tel: +46 (0)8-698 50 00. Fax: +46 (0)8-20 88 64
Telegram: sida stockholm. Postgiro: 1 56 34–9
E-mail: info@sida.se. Homepage: http://www.sida.se