



LINKING DOTS:

## Assessment of opportunities for optimal access to MENTAL HEALTH CARE services for people who use drugs in the CEECA region

Regional overview based on country cases of  
Czechia, Estonia, Moldova, Poland

This document is a publication of the Eurasian Harm Reduction Association (EHRA). EHRA is a non-profit, membership-based public organisation that unites and supports 279 harm reduction activists and organisations from Central and Eastern Europe and Central Asia (CEECA) to ensure the rights and freedoms, health and well-being of people who use psychoactive substances. For more information, visit the website:

<https://harmreductioneurasia.org/>

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# Executive Summary

Mental health is an integral part of the overall health of an individual and is a basic human right. A healthy and positive life is impossible without good mental health. Problems with mental health can have a significant impact upon the daily life and the quality of life of each individual if not treated effectively using evidence-based international good practices.

People who use drugs, like all people, should have access to, and utilisation of, quality mental health support. People who are exposed to unfavourable circumstances – including inequality and discrimination – are at higher risk of experiencing challenges to their mental health. Mental health issues and drug dependence can be categorised under the same umbrella as poverty, lack of access to healthcare, homelessness, and stigma and discrimination; people may also start – or continue using – drugs to deal with mental health issues.

Providing adequate access to mental health services for people who use drugs “without framing drug use and/or dependence as mental health issues in absolute terms”<sup>1</sup> should be a priority. People who use drugs, including more specific subgroups such as opioid agonist therapy (OAT) clients

and NPS users, should be able to exercise their right to have a choice regarding their physical/mental health and relevant ways to encourage better access to mental health and to overcome barriers hampering such access.

This exploratory study inquired as to how mental health care services are rendered to people who use psychoactive substances in the region of Central and Eastern Europe and Central Asia (CEECA) region.

Data for this study were collected during in-depth research of the situation in four selected countries of the region: Czechia, Estonia, Moldova and Poland. This was followed by an analysis of research publications/literature on mental health services and services available for selected target groups. In addition, semi-structured interviews were conducted with health service providers, harm reduction service staff and patients/clients. Reflections on the situation in the region were also utilised from a multidisciplinary expert group meeting, ‘On barriers, challenges and needs on accessing mental health care and support services for people who use drugs during COVID-19, people who use new psychoactive substances (NPS), as well as migrants and refugees’<sup>2</sup>.

People who use drugs, like all people, should have access to, and utilisation of, quality mental health support.

- 1 Harm Reduction International (HRI), International Network of People Who Use Drugs (INPUD). (2022). People Who Use Drugs and Mental Health. Joint statement. London; HRI/INPUD. [https://inpud.net/wp-content/uploads/2022/01/Mental\\_Health\\_Statement\\_HRI\\_INPUD\\_1.pdf](https://inpud.net/wp-content/uploads/2022/01/Mental_Health_Statement_HRI_INPUD_1.pdf) (accessed 19 May 2023).
- 2 Eurasian Harm Reduction Association. Multidisciplinary expert meeting in Istanbul. 5 September 2022. <https://harmreductioneurasia.org/news/multidisciplinary-expert-meeting-in-istanbul> (accessed 8 June 2023).



**This research found that in most cases, the mental health systems existing in countries of the CEECA region are incapable of addressing the needs of people who use drugs due to the following systemic issues:**

- 1. Functioning through specialised sizeable mental health institutions (hospitals) with a high number of beds, prioritising in-patient facilities;**
- 2. Hospitalisation as the principal form of psychiatric care when mental health care remains largely institutionalised with limited alternative care options in the community;**
- 3. Medical treatment methods predominate in comparison to psychotherapy options;**
- 4. Funding for mental health services is insufficient to respond to the needs and emerging changes and inside the system it is distributed improperly, such as the focus being more money for biological treatment; and,**
- 5. The lack of client-centered approaches and stigmatising attitudes of service providers.**

The stigma attached to psychiatry is an important factor that complicates the application by a patient to mental health services in all involved countries.

Although all four participating countries of the study have relatively developed structures of both mental health and treatment facilities for people who use psychoactive substances, all of them find significant obstacles when mental health services are needed for people who use psychoactive substances, as integration of these services has not yet become a reality. Similarly, although mental health care is expected to start at the primary level of healthcare, only in some countries are general practitioners ready to provide an initial assessment of the mental health status of a patient.

The stigma attached to psychiatry is an important factor that complicates the application by a patient to mental health

services in all involved countries. An additional factor is that of psychiatric and drug use registries that deter people in need of help from applying to official health institutions.

Where mental health care services are available, their use normally anticipates the availability of health insurance, which might be a challenge for people who have substance use issues; it has also become a stumbling block for war refugees in some countries of the CEECA region.

Systems of mental health care are generally marked by major gaps and imbalances in service provision and, for the past few years, certain factors have influenced the optimal access to mental health services, such as

the COVID-19 pandemic<sup>3</sup> and the most recent invasion of Ukraine by Russia<sup>4</sup>. Such extremely stressful situations have revealed the vulnerabilities related to mental health and substance use. While people without comorbidities might reduce substance use when access to these substances is limited, people with diagnosed mental health issues react differently. Stressful situations are more likely to cause post-traumatic stress disorder (PTSD) which, in turn, leads to self-medication and substance use disorders. Thus, integration of mental health and substance use services becomes even more needed in times of mass disasters.

Such extremely stressful situations have revealed the vulnerabilities related to mental health and substance use.

Among its many impacts, the COVID-19 pandemic and related lockdowns created a global mental health crisis, fueling short-

and long-term stresses and giving rise to anxiety and depressive disorders. The pandemic also disrupted the established provision of mental health services and put extra strain on healthcare systems as well as contributing to an increase in home- and gender-based violence.

The most recent invasion of Ukraine by Russia has caused nearly one-third of the Ukrainian population (around 14 million individuals) to flee the violence and abandon their homes by moving abroad (over 6 million Ukrainians) or by relocating within Ukraine as internally displaced persons (over 8 million)<sup>5</sup>. Many of these people are, or will be in the near future, in dire need of essential mental health support, including more specialised services needed for key populations, such as people who use drugs.



3 International Network of People Who Use Drugs (INPUD) (2022). Pandemic Preparedness and Response: Voices of People who Use Drugs. London; INPUD. [https://inpud.net/wp-content/uploads/2023/03/000796\\_INP\\_Pandemic-preparedness\\_v8.pdf](https://inpud.net/wp-content/uploads/2023/03/000796_INP_Pandemic-preparedness_v8.pdf) (accessed 19 May 2023).

4 World Health Organization (2022a). Scaling-up mental health and psychosocial services in war-affected regions: best practices from Ukraine. Geneva; World Health Organization. <https://www.who.int/news-room/feature-stories/detail/scaling-up-mental-health-and-psychosocial-services-in-war-affected-regions--best-practices-from-ukraine> (accessed 19 May 2023).

5 United Nations High Commissioner for Refugees (UNHCR). Ukraine Refugee Situation. Geneva; UNHCR, 16 May 2023. <https://data.unhcr.org/en/situations/ukraine> (accessed 19 May 2023).

**As one of the key tasks of this assessment was to classify and analyse barriers preventing optimal access to mental health care, in addition to those listed above, the following were identified:**

- 01.** Stigmatisation/discrimination in health institutions and judgmental attitudes toward people who use drugs by the general public remains a barrier for those who may be in need of mental health services;
- 02.** Lack of mental health-substance use treatment service integration, service coordination and multidisciplinary referral;
- 03.** While OAT programmes have been shown to be universally effective, some inclusion and exclusion criteria may be extremely hard to meet, creating artificial barriers to retention in the programme for people with mental health and opioid use dual diagnosis; furthermore, there are considerable challenges for clients of OAT programmes to access treatment in a psychiatric ward, such as if their condition requires stabilisation in a mental health area other than for drug dependence, i.e. depression, psychosis, etc.; even facilities equipped to treat dual diagnoses have difficulty with opioid agonist administration;
- 04.** Services for NPS users are usually unavailable in existing harm reduction services and opportunities to receive help with mental health are limited. Only a few countries in the region – Kazakhstan, Kyrgyzstan, Belarus and Moldova – have established clinical protocols for the diagnosis and treatment of mental health and behavioural disorders related to use of NPS; even such protocols are not widely used due to the lack of knowledge among health professionals;
- 05.** Lack of mental health professionals, a high work overload for the existing limited cadre of specialists and, thus, the tendency by psychiatrists and/or psychologists to refer patients which they consider as “not our clients” to the addictologists (in the EECA region they are also known as ‘narcologists’);

06. Lack of comprehensive understanding about substance use and drug dependence among mental health professionals;
07. Lack of knowledge among people who use drugs on available mental health assistance;
08. Misconceptions regarding psychiatry and medications among people who use drugs;
09. The lack of access to mental health services: people who use drugs do not have money/cannot afford it; in some countries, psychological support is not free, or includes a limited number of visits per year;
10. High-threshold access to mental health services (absence of documents, fear even to approach services due to encountered prior stigma/discrimination, etc.). In harm reduction services (which are low-threshold) such services are usually not provided because of a lack of funding and the impossibility to hire a psychologist or psychiatrist;
11. Geographic access: while mental health services are usually established in big cities, there is a lack of them in rural areas; and,
12. The availability, or rather the lack of, medical insurance may hamper access to treatment; in many cases people who use drugs do not have insurance.

**Given such problems with applying to the healthcare system for support, many harm reduction programmes run by civil society organisations have had to develop at least some mental health related services provided by their staff, as well as referral to existing mental health facilities.**

**KEY RECOMMENDATIONS** address the most critical barriers and other significant factors influencing the provision of services and aim at further optimisation of mental health support with an emphasis on people who use drugs. It should be noted that mental health interventions for key populations are components of the essential package of HIV response services for key populations, i.e. mental health services should be available to people who use drugs not only in the context of treating drug dependence.

Most recommendations anticipate the implementation of changes at the public policy and institutional levels, while the consequences are to be felt also at the societal, intra- and interpersonal levels. However, before introducing these changes at the public policy and institutional levels, the related ideas need to be accepted and elaborated at the level of the professional community.

Changes within professional communities are crucial; it is likely that this community needs reshaping and possibly the inclusion of new players and new approaches, such as psychological and psychotherapeutic. Educational curricula for mental health specialists in addictology/dependence and the provision of mental health care to people who use drugs at all levels (undergraduate, postgraduate and professional development) should be revised and upgraded, with inclusion of the best practices developed by relevant professional communities at national and international levels.

Mental health and substance use services should be integrated and offered at the level of primary health care, also by qualified and trained nurses. Routine screening and management for mental health issues (particularly depression and psychosocial stress) should be provided for people from key populations. Multidisciplinary teams operating in the community context should be developed and launched.

Mental health services should be made more accessible to people who use drugs and people on OAT, such as the creation of services (both outpatient and in-patient) for clients with a dual diagnosis; integrate social and health services, including the involvement of addictologists/dependence specialists, in mental health centres; introduce and develop crisis outreach teams with a psychiatrist/psychiatric nurse, establishing a system of friendly clinics to provide mental health care along with other health services.

Drug policies need to be revised with the aim of allowing possession for personal use and enabling essential services which are not offered at present, such as drug checking and drug consumption rooms, etc., resulting in comprehensive health and social care which includes mental health services.

Information campaigns aimed at social inclusion, prevention of mental disorders and diminishing stigma, as well as raising awareness of the available health services, and developing mental health literacy, should be conducted as a long-term activity in partnership with the media.



Interventions to ensure integration of mental health services into the harm reduction continuum should be offered by NGO's and community-based organisations, such as individual psychological and crisis counselling, including an online/web-based format, group trainings and self-support groups.

Mental health medication for free, or with partial compensation of expenses for medications, should be considered if a need is exceptional and no other medical insurance is available to an individual.

Evidence-based treatment methods, without torture or humiliation, need to be introduced through professional education and changes to treatment protocols and practices as there are still cases whereby people with mental health issues are treated using an 'old school' approach which causes further harms to the individual.

Further research should also be conducted on measuring the quality of life and in assessing the efficiency of the services provided to key populations using the clinical-epidemiological evaluation methods for mental health services. Community-led monitoring of access to and quality of the mental health care services for people who use drugs should be organised.

The study team believes that the assessment findings and recommendations can be used as background for improving harm reduction programmes, specific health and social care programmes for people who use psychoactive substances (including Ukrainian refugees) to achieve optimal access to mental health care. It could be used to overcome systematic barriers created by mental healthcare authorities and for improving cooperation between agencies providing – or those who could potentially provide – mental health care support to people who use psychoactive substances.

# Abbreviations

**AOTMiT**

Agencja Oceny Technologii Medycznych i Taryfikacji [Agency for Health Technology Assessment and Tariffs] [Poland]

**ART**

Antiretroviral Therapy

**CBT**

Cognitive-Behavioural Therapy

**CEECA**

Central and Eastern Europe and Central Asia

**CIS**

Commonwealth of Independent States

**CMHC**

Community Mental Health Centre

**COVID**

Coronavirus

**DOT**

Directly Observed Treatment

**EECA**

Eastern Europe and Central Asia

**EHRA**

Eurasian Harm Reduction Association

**EU**

European Union

**EWS**

Early Warning System

**FDP**

Forcibly Displaced Person

**GP**

General Practitioner

**HCV**

Hepatitis C Virus

**HIV**

Human Immunodeficiency Virus

**HRI**

Harm Reduction International

**INPUD**

International Network of People who Use Drugs

**MMT**

Methadone Maintenance Therapy

**MSM**

Men who have Sex with Men

**NFZ**

National Health Fund [Poland]

**NGO**

Non-Governmental Organisation

**NPS**

New Psychoactive Substance

**NSP**

needle and syringe program  
(harm reduction program)

**OAT**

Opioid Agonist Therapy

**PTSD**

Post-Traumatic Stress Disorder

**RND**

Republican Dispensary of Narcology  
[Moldova]

**SEP**

Syringe Exchange Programme

**SSRI**

Selective Serotonin Reuptake Inhibitor

**TB**

Tuberculosis

**TIC**

Toxicology Information Centre [Czechia]

**UHC**

Universal Health Coverage

**UNAIDS**

Joint United Nations Programme on HIV/  
AIDS

**UNHCR**

United Nations High Commissioner for  
Refugees

**VOT**

Video Observed Treatment

**WHO**

World Health Organization





# Assessment objectives and methodology



The central goal of this exploratory study was to collect and analyse first-hand data on how mental health care is provided to people who use psychoactive substances in the region of Central and Eastern Europe and Central Asia (CEECA) based on more thorough research of the situation in the selected countries of Czechia, Estonia, Moldova and Poland, respectively.

This assessment is intended to be used as background for improving harm reduction programmes and specific health and social care programmes for people who use

**This assessment is intended to be used as background for improving harm reduction programmes and specific health and social care programmes for people who use psychoactive substances to achieve optimal access to mental health care.**

psychoactive substances to achieve optimal access to mental health care. It could be used to overcome systematic barriers created by mental health care authorities and for improving mutual cooperation between agencies providing, or who could potentially provide, mental health care support to people who use psychoactive substances.

The reality of existing mental health care services and access to them for the general population in the region was proposed to be studied to serve as background against which provision of relevant services for people who use psychoactive substances should be researched.

In addition, looking into current conditions affecting the region, additional circumstances were taken into account, namely the impact and aftereffects of the COVID-19 pandemic and the full-scale war

started by Russia against Ukraine which has caused a massive wave of refugees and migrants fleeing the atrocities of the war and temporarily settling in neighbouring countries in the CEECA region.

This current report also intends to address such objectives as exploring existing barriers identified by health professionals, service providers and service users in securing optimal access to mental health services, identifying innovations and best practices in this area as well as formulating prospective recommendations to overcome the existing barriers and addressing systemic challenges.

This study was aimed to assess the situation for several population groups affected by the above-mentioned factors. The general population was to serve as a benchmark for all other groups. What this population gets in terms of mental health services would be a maximum of what can be expected for other, narrower and more specific groups. However, there could be exceptions to this rule as services developed for specific groups can sometimes reach much higher standards than those for the general population.

People who use psychoactive substances are the second and more specific target group. This group includes two specific sub-groups: opioid agonist therapy (OAT) service users (studies have shown that about half of OAT clients can have serious mental health disorders<sup>6</sup> and other comorbidities which also makes retention on OAT programmes more problematic<sup>7</sup>)

6 Harm Reduction International (HRI), International Network of People Who Use Drugs (INPUD). (2022). People Who Use Drugs and Mental Health. Joint statement. London; HRI/INPUD. [https://inpud.net/wp-content/uploads/2022/01/Mental\\_Health\\_Statement\\_HRI\\_INPUD\\_1.pdf](https://inpud.net/wp-content/uploads/2022/01/Mental_Health_Statement_HRI_INPUD_1.pdf) (accessed 19 May 2023).

7 Eurasian Harm Reduction Association. Multidisciplinary expert meeting in Istanbul. 5 September 2022. <https://harmreductioneurasia.org/news/multidisciplinary-expert-meeting-in-istanbul> (accessed 8 June 2023).

and users of new psychoactive substances (NPS), representing different groups – synthetic stimulants, synthetic cannabinoids, synthetic hallucinogens and synthetic depressants (including synthetic opioids and benzodiazepines<sup>8</sup>.

Refugees constitute another specific target group that consists of representatives of the general population displaced to other countries, including above-described users of psychoactive substances. According to media reports and the opinions of mental health professionals in Poland, as of March 2022, about half a million refugees from Ukraine who have fled to Poland were estimated to need support for mental health disorders,

The Ukrainian refugee crisis has highlighted various issues associated with trauma, distress, mental and physical health, and a need for meaningful support and interventions.

and 30,000 were deemed to have severe mental health problems. The Ukrainian refugee crisis has highlighted various issues associated with trauma, distress, mental and physical health, and a need for meaningful support and interventions<sup>9</sup>.

**Methods of data collection** included analysis of research publications/literature on mental health service structure and specific services for selected target groups as well as semi-structured interviews with health service providers (including representatives of public health authorities, mental health care institutions, emergency/toxicology departments), harm reduction service staff and clients belonging to identified target groups and subgroups.



- 8 Shafi A, Berry AJ, Sumnall H, Wood DM, Tracy DK. (2020). New psychoactive substances: a review and updates. *Ther Adv Psychopharmacol*. Dec 17;10:2045125320967197. <https://doi.org/10.1177%2F2045125320967197>
- 9 Kaufman KR, Bhui K, Katona C. (2022). Mental health responses in countries hosting refugees from Ukraine. *BJPsych Open*. Apr 1;8(3):1-10. <https://doi.org/10.1192/bjo.2022.55>

**Semi-structured interviews were conducted according to developed guides and included, but were not limited, to the following research questions:**

- 01.** How are mental health services structured in particular countries?
- 02.** What services are available for OAT users?
- 03.** What services are available for NPS users?
- 04.** Which obstacles do target groups perceive when trying to access mental health facilities in selected countries?
- 05.** How comfortable do representatives of target groups feel with regards to the above-mentioned services?
- 06.** Which needs of the target groups are met and which are not?
- 07.** Which of the above services are accessible to refugees?
- 08.** How prepared and effective are mental health facilities with regards to the needs of refugees from Ukraine?
- 09.** Were there any changes in how services are organised in terms of the COVID-19 pandemic?

One of the **limitations of this study** was related to the discrepancy between the number of questions and the availability of respondents. The saturation of data expected in full qualitative studies could not be reached as certain questions were asked to just one or two respondents; some findings were based on single reports.

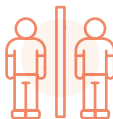
**Data were collected by qualified researchers in four target countries: Czechia, Estonia, Moldova and Poland. Accumulated data were organised into the pre-structured national reports that included the following main chapters:**



Mapping of patient (representing the selected target groups) pathways to receive mental health care services



Assessment of innovations and best practices implemented in particular countries



Assessment of barriers that clients encounter on these pathways



Recommendations to address the encountered challenges and systemic gaps in service provision

One of the significant tasks of this assessment was to identify, classify and analyse barriers preventing optimal access to mental health care for the selected target groups or sets of circumstances impacting the provision of relevant services.

**Several approaches to classify existing barriers were employed; some barriers have been collected from the studies published earlier and used in the data collection process:**



Structural or logistics-related barriers



Knowledge and information-related barriers



Barriers related to the influence of drugs and treatment



Stigma-related or attitudinal barriers



Legal barriers



Linguistic and cultural barriers



Social factors or social determinants of health-related barriers

Collected data and some ideas expressed during the interviews pointed to some barriers that had not been initially anticipated and another approach has been used to present such findings based on the ecological perspective model<sup>10</sup>, widely applied to research in various areas of public health, psychology, social work, etc., covering the following levels:



Individual or intrapersonal level factors/barriers



Community-level factors/barriers



Interpersonal level factors/barriers



Societal-level factors and barriers

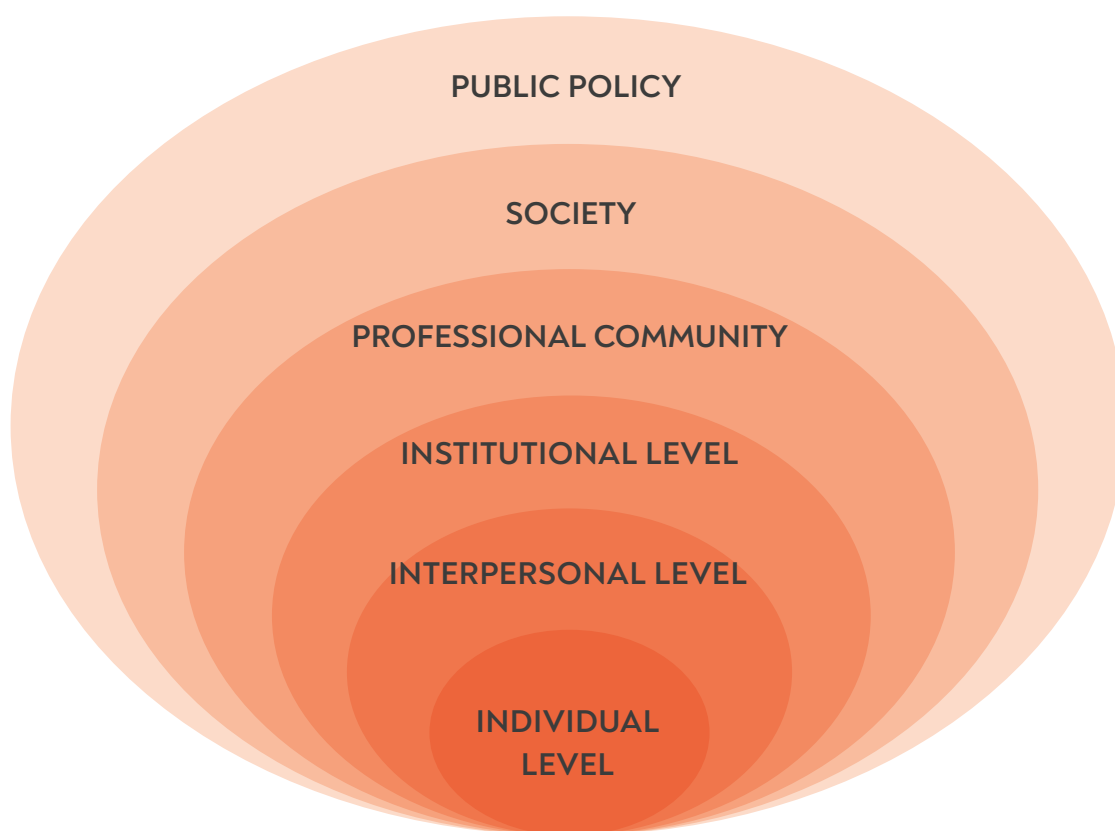


Institution and organisation level factors/barriers



Public policy at the national/supranational level

## The Social Ecological Model of Health



10 McLeroy KR, Bibeau D, Steckler A, Glanz K. (1988). An ecological perspective on health promotion programs. *Health Educ Q.* Winter;15(4):351-77. <https://doi.org/10.1177/109019818801500401>

It's important to remember that higher-level factors/barriers usually can influence lower-level phenomena. When advocating to implement changes at all levels of the system, actions should be started at the level of public policy.

Some of the barriers are explained below, listed from bottom-to-top levels:

**Individual or intrapersonal level factors/barriers** include individual user's genetics, individual history, knowledge, attitude, self-stigma, behaviour, resources, etc.

**Interpersonal level factors/barriers** incorporate things at the level of family history and relations, friends, and social networks. For example, whether networks of users are informative, supportive, etc., and can influence access to the needed mental health services. Interaction between the service provider and service user was also considered at this level, while existing institutional and regulatory mechanisms play their own role.

**Institution and organisation level factors/barriers** relate to multiple systemic, logistics and information-related factors.

**Community-level and societal-level factors/barriers** can be considered together; however, it is critical to emphasise the importance of the professional community which as one of the most powerful sources can both generate the problems and facilitate the solutions, setting an impulse to change the whole system. All issues of societal health awareness and attitudes toward people with mental problems and needs, stigmatisation and information campaigns belong at this level.

**Public policy at the national level** includes drug policies and regulations which can impact all the lower levels mentioned above.

**Public policy at the supranational level** serves as an essential level in the case of mental health services provided to people who use psychoactive substances. Numerous countries of the CEECA region, including selected countries of this Report, were previously part of the so-called ex-Soviet system, bearing similar deficiencies not seen in the West.

Best practices and recommendations are summarised for all the participating countries and all covered research questions. National reports are presented in a format of the individual country cases and attached as an annex to this Report. Summarised suggestions in the recommendations chapter are not evidence-based findings derived from the studies that considered cause-and-effect associations. Recommendations collected herein are hypotheses regarding what could be helpful for improving the mental health care situation expressed:

1. by the authors of the national reports;
2. by health professionals and service users that were interviewed;
3. by experts in the field; and,
4. by the authors of various documents, reports and research publications found online and offline.

**Therefore, every recommendation deserves critical consideration before being implemented.**

Summarised suggestions in the recommendations chapter are not evidence-based findings derived from the studies that considered cause-and-effect associations.

After analysing needs, experts identified barriers and challenges in accessing mental health care services and subsequently developed recommendations on optimisation of mental health service provision for key populations.

This Report summarises findings of the national reports, adding from the expert reflection during the EHRA Multidisciplinary Expert Group Meeting, 'On barriers, challenges and needs on accessing mental health care and support services for people who use drugs during COVID-19, people who use new psychoactive substances, and migrants and refugees', held on August 30-31, 2022, in Istanbul, Turkey<sup>11</sup>. During the meeting, 21 experts involved in organising comprehensive mental health services in different countries of the CEECA region had the possibility to discuss the definition of mental health and problematic issues in the region. Experts working with key

populations prepared presentations on the needs of people who use drugs in accessing mental health care and support services. Presentations focused on OAT clients, NPS users, people who use drugs during COVID-19, migrants, refugees, MSM, and the needs of women and young people in accessing mental health care services. After analysing needs, experts identified barriers and challenges in accessing mental health care services and subsequently developed recommendations on optimisation of mental health service provision for key populations. At the end of the meeting, experts had the possibility to discuss integration of mental health care and support services into harm reduction services and vice versa.





# Healthcare and mental health in CEECA region

According to the Constitution of the World Health Organization (WHO), an individual's health means their full physical, mental and social well-being, not just the absence of a disease or a disability. Also in the Constitution of many countries, mental health and well-being is granted as a right guaranteed to citizens without discrimination. However, despite global efforts, a share of people with mental health problems still face the infringement of their human rights, discrimination, stigma and/or limited access to affordable healthcare.

In the Mental Health Declaration for Europe, adopted in Helsinki in 2005<sup>12</sup>, the promotion of mental health and the prevention, treatment, care and recovery from mental health problems were acknowledged as priorities by WHO and its Member States, the European Union and the Council of Europe, all of which were urged to take action in order to alleviate the burden of mental health problems and to improve mental well-being. The Declaration specified the importance of community-based mental health services in the European region

and the start of a new process of reforming the mental health system and the deinstitutionalisation of people with mental disabilities.

The Comprehensive Mental Health Action Plan 2013-2020 of WHO, approved in 2013 and recently extended to 2030<sup>13</sup>, is aimed at promoting mental well-being, preventing psychiatric disorders, providing care, enhancing recovery, promoting human rights and reducing the mortality, morbidity and disability of people with mental disorders. The WHO initiative in 2019 regarding universal health coverage (UHC) for mental health specifies that nobody should be denied access to mental health care because s/he is poor or lives in a remote place and all people should achieve the highest standard of mental health and well-being<sup>14</sup>.

Despite the existing legislative basis on congruous implementation of mental health care, the reality falls far short. Care for mental disorders in low- and middle-income countries is often limited. Despite significant rates of mental and substance use disorders in the EECA region, there has been a

12 World Health Organization. Regional Office for Europe (2005). WHO European Ministerial Conference on Mental Health: Mental Health Declaration for Europe: facing the challenges, building solutions: Helsinki, Finland, 12–15 January 2005. Copenhagen; Regional Office for Europe, World Health Organization. <https://apps.who.int/iris/bitstream/handle/10665/107625/Helsinki-decl-2005-eng.pdf> (accessed 22 May 2023).

13 World Health Organization (2021). Comprehensive Mental Health Action Plan 2013-2030. Geneva; World Health Organization. <https://www.who.int/publications/i/item/9789240031029> (accessed 22 May 2023).

14 World Health Organization (2019a). The WHO special initiative for mental health (2019-2023): universal health coverage for mental health. Geneva; World Health Organization. <https://apps.who.int/iris/handle/10665/310981> (accessed 22 May 2023).



lack of attention to the implementation of quality, contemporary mental healthcare services, and systems reform throughout the region<sup>15</sup>.

Starting in the 1990s, many countries of the CEECA region began to implement reforms of their health systems, shifting from mental hospitals to psychiatric wards in general hospitals, supported by a stronger trend to develop and improve outpatient services

and community care. The number of in-patient beds was significantly reduced, some psychiatric hospitals closed or transformed into social institutions or hospitals for chronically ill patients<sup>16</sup>. Although mental health services in most of the selected countries have undergone reforms over recent decades, published reports mention their numerous and obvious limitations<sup>17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32</sup>.

- 15 Hook K, Bogdanov S. (2021). Mental health care in Eastern Europe and Central Asia: An analysis of needs and a call for greater investment. *Lancet Reg Health Eur.* Jul 29;10:100182. <https://doi.org/10.1016/j.lanepe.2021.100182> 1
- 16 Füredi J, Mohr P, Swingler D, Bitter I, Gheorghe MD, et al. (2006). Psychiatry in selected countries of Central and Eastern Europe: an overview of the current situation. *Acta Psychiatr Scand.* 2006 Oct;114(4):223-31. <https://doi.org/10.1111/j.1600-0447.2006.00804.x>
- 17 Bomba J. (2008). Mental healthcare in Poland. *Int Psychiatry.* Jan 1;5(1):10-12. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6734813/pdf/IP-5-10.pdf> (accessed 22 May 2023).
- 18 Broulikova HM, Dlouhy M, Winkler P. (2020). Expenditures on Mental Health Care in the Czech Republic in 2015. *Psychiatr Q.* Mar;91(1):113-125. <https://doi.org/10.1007/s11126-019-09688-3>
- 19 Dlouhy M. (2004). Mental health care system and mental health expenditures in the Czech Republic. *J Ment Health Policy Econ.* Dec;7(4):159-65. [http://www.icmpe.org/test1/journal/issues/v7pdf/7-159\\_text.pdf](http://www.icmpe.org/test1/journal/issues/v7pdf/7-159_text.pdf) (accessed 22 May 2023).
- 20 Dlouhy M. (2011). Mental health services in the health accounts: the Czech Republic. *Soc Psychiatry Psychiatr Epidemiol.* Jun;46(6):447-53. <https://doi.org/10.1007/s00127-010-0210-6>
- 21 Dlouhy M. (2014). Mental health policy in Eastern Europe: a comparative analysis of seven mental health systems. *BMC Health Serv Res.* Jan 27;14:42. <https://doi.org/10.1186/1472-6963-14-42>
- 22 Formánek T, Kagström A, Cermakova P, Csémy L, Mladá K, Winkler P. (2019). Prevalence of mental disorders and associated disability: Results from the cross-sectional CZEch mental health Study (CZEMS). *Eur Psychiatry.* Aug;60:1-6. <https://doi.org/10.1016/j.eurpsy.2019.05.001>
- 23 Füredi J., et al. (2006). Ibid.
- 24 Höschl C, Winkler P, Pěč O. (2012). The state of psychiatry in the Czech Republic. *Int Rev Psychiatry.* Aug;24(4):278-85. <https://doi.org/10.3109/09540261.2012.688730>
- 25 Kagstrom A, Alexova A, Tuskova E, Csajbók Z, Schomerus G, et al. (2019). The treatment gap for mental disorders and associated factors in the Czech Republic. *Eur Psychiatry.* Jun;59:37-43. <https://doi.org/10.1016/j.eurpsy.2019.04.003>
- 26 Kleinberg A. (2008). Estonia. *Int Psychiatry.* Jul 1;5(3):62-64. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6734837/> (accessed 22 May 2023).
- 27 Pec O. (2019). Mental health reforms in the Czech Republic. *BJPsych Int.* Feb;16(1):4-6. <https://doi.org/10.1192/bji.2017.27>
- 28 Petrea I, Shields-Zeeman L, Keet R, Nica R, Kraan K, et al. (2020). Mental health system reform in Moldova: Description of the program and reflections on its implementation between 2014 and 2019. *Health Policy.* Jan;124(1):83-88. <https://doi.org/10.1016/j.healthpol.2019.11.007>
- 29 Szukalska H. (2020). Stigmatisation and medication: Poland's outdated approach to mental health. *Notes from Poland.* <https://notesfrompoland.com/2020/05/01/stigmatisation-and-medication-polands-outdated-approach-to-mental-health/> (accessed 22 May 2023).
- 30 Winkler P, Mladá K, Janoušková M, Weissová A, Tušková E, et al. (2016). Attitudes towards the people with mental illness: comparison between Czech medical doctors and general population. *Soc Psychiatry Psychiatr Epidemiol.* 2016 Sep;51(9):1265-73. <https://doi.org/10.1007/s00127-016-1263-y>
- 31 Winkler P, Formánek T, Mladá K, Cermakova P. (2018). The CZEch Mental health Study (CZEMS): Study rationale, design, and methods. *Int J Methods Psychiatr Res.* 2018 Sep;27(3):e1728. <https://doi.org/10.1002/mpr.1728> (accessed 22 May 2023).
- 32 Winkler P, Formánek T, Mladá K, Evans Lacko S. (2021). Development of public stigma toward people with mental health problems in Czechia 2013-2019. *Eur Psychiatry.* 2021 Aug 16;64(1):e52. <https://doi.org/10.1192/j.eurpsy.2021.2226>

**The drawbacks of national mental health systems of the region were (and mostly still are) as follows:**

- 01.** The heavy burden of communist history is believed to pervade most areas of mental health, as most of these services were modeled on Soviet psychiatry;
- 02.** No definitive legal protection for the rights of people with mental health disorders was provided;
- 03.** National mental health policies were absent;
- 04.** Patients with mental issues were viewed as a threat that had to be isolated;
- 05.** Stigma towards psychiatry was/is widespread;
- 06.** Most of the mental health care expenditures was spent on inpatient care;
- 07.** Over-medicalisation/biological treatment methods predominate in comparison with psychotherapy;
- 08.** Insufficient staffing, health workforce issues; and,
- 09.** Insufficient funding or improper allocation of resources; the availability of services is uneven.

**Trends in implemented reforms that were/are common to many countries of the region can be summarised as follows:**

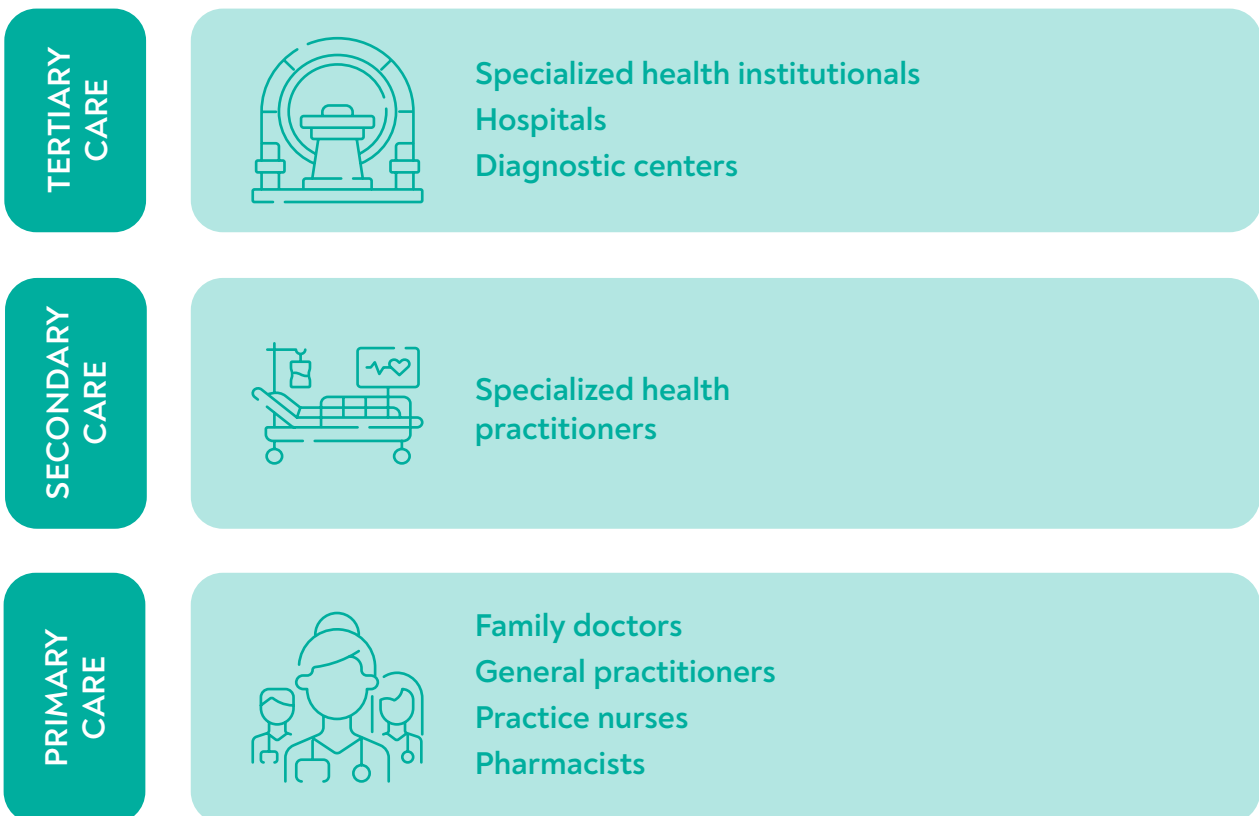
- 01.** Deinstitutionalisation;
- 02.** Reorientation from hospital-based inpatient care to outpatient daily care units and community-based services;
- 03.** Creation of so-called local mental health centres;
- 04.** Establishment of a network of mental health services;
- 05.** Anti-stigma campaigns to improve the attitude of the population towards people with mental health issues;
- 06.** Increase in accessibility of the population to psychiatric care;
- 07.** Increase in the efficiency of psychiatric care;
- 08.** Multidisciplinary case-management approach;
- 09.** Supporting the client's integration into their own social environment; and,
- 10.** Integrating people with mental disorders into their family and their community.

Other tendencies that were developing parallel to the implemented reforms (*sometimes in spite of them*) include:

- Development of private psychiatric care (both inpatient and outpatient);
- Several day hospitals, patient clubs, and day-care centres (with options of sheltered workshops and housing);
- Services are becoming more centred on the patient and are essentially targeted at improving the quality of life of the client;
- Inpatient psychiatric care is mainly used to help patients through a short-term crisis or for solving complex differential diagnostic and treatment problems; and,
- NGOs are increasingly raising their voice in addressing mental health issues and have begun to provide social rehabilitation services.

The provision of mental health care should be placed against a background of a regular **3-level general healthcare system** where primary care is a first level of support that patients receive and which covers all essential healthcare. Typically, providers are general practitioners or family doctors, practice nurses and pharmacists. Primary care providers are expected to be the first point of contact for patients when they have medical needs or concerns, such as illness or injury. Secondary care is provided when the primary care providers refer patients to a specialist or a healthcare professional who has more specific expertise in the health issues that are being faced. Tertiary care requires highly specialised and specific equipment and expertise, and is often prescribed to hospitalised patients, patients with chronic conditions and patients with severe diseases.

Figure 1. Levels of Healthcare





When healthcare relates to mental health, the secondary level is represented by psychiatrists, psychologists, and psychotherapists, with the tertiary level usually comprising psychiatric hospitals, while some sources consider hospitals as secondary-level institutions along with an ambulance service, emergency care, day-care units, crisis centres and many other relatively specialised healthcare entities.

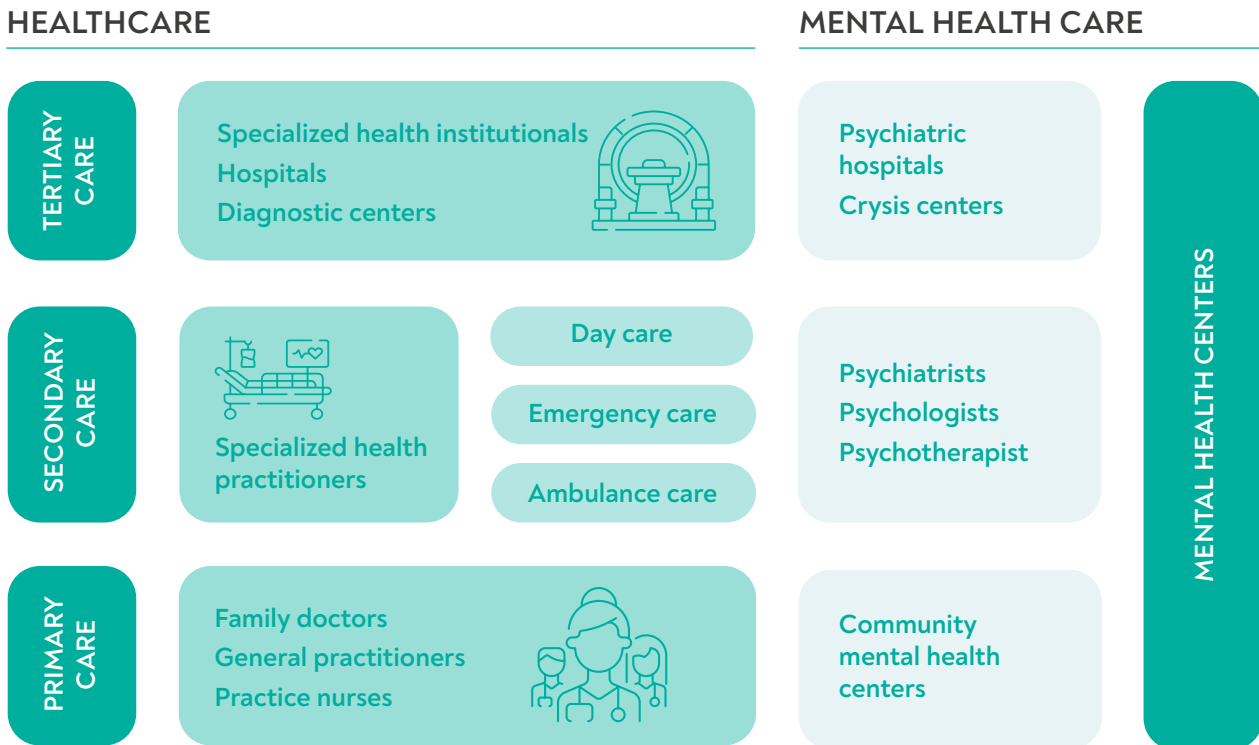
Traditionally, mental healthcare appeared at the secondary level where treatment usually took place primarily in large mental institutions; hospitalisation represented the principal form of psychiatric care<sup>33</sup>. However, at least since 2001, the necessity of providing mental healthcare at the primary level was emphasised and, following these recommendations, some countries have implemented mental health centres that might provide all three levels of mental healthcare. For example, in Czechia, mental health centres provide a bridge between primary care, including outpatient psychiatric care, and inpatient

care, both acute and specialised. Their function is to prevent or reduce hospital admissions and to help reintegrate long-term inpatients into the general community. The network of these centres can be used for hospitalisation, but it is primarily a service that seeks deinstitutionalisation as a part of mental health reform.

Other countries introduced so-called community health centres which imply that these institutions function at the community/primary level. When someone is unwell and is visiting a general practitioner or a family doctor, these health professionals need to be skilled enough to either provide help directly or to refer a patient to an appropriate health professional.

Some crisis centres can also provide acute hospitalisation, if indicated (and if there is capacity). They are low-threshold and less stigmatised but, at the same time, they are in short supply and have limited capacity.

Figure 2. Three levels of healthcare and mental healthcare



Mental health is normally considered the central issue of substance use due to the role of self-medication and coping with various traumatic events that are believed to initiate substance use in many patients. Whilst much research and opinion-based publications denote mental health and substance use as a dual diagnosis issue, the idea of providing adequate access to mental health services for people who use drugs “without framing drug use and/or dependence as mental health issues in absolute terms” is considered as a priority need to be juxtaposed with the dual diagnosis approach.

The importance of mental healthcare for people who use psychoactive substances is illustrated by a study showing that the unmet need for mental health

treatment in the past year was a risk factor for past-month use of marijuana and misuse of prescription opioids in the respective population<sup>34</sup>. There is no single model for dual disorders that explains why substance use and psychiatric illness co-occur so frequently; various theoretical models accounting for the increased rates of comorbidity between psychiatric disorders and substance use disorders have been described by different authors<sup>35</sup>.

In the majority of countries that follow the ex-Soviet healthcare model, mental health and substance use treatment are developed as isolated branches of healthcare which has resulted in frequent difficulties for substance use clients in getting mental healthcare.

- 34 Reid BE, Palamar JJ. (2022). Unmet Need in Relation to Mental Healthcare and Past-Month Drug Use among People with Mental Illness in the United States. *J Psychoactive Drugs*. 2021 Aug 17:1-8. <https://doi.org/10.1080/02791072.2021.1962577>
- 35 Mueser KT, Drake RE, Wallach MA. (1998). Dual diagnosis: a review of etiological theories. *Addict Behav*. 1998 Nov-Dec;23(6):717-34. [https://doi.org/10.1016/S0306-4603\(98\)00073-2](https://doi.org/10.1016/S0306-4603(98)00073-2)

## Mental health and OAT programmes

One of the target sub-groups selected for the purpose of this study was OAT clients who have a high level of mental health-related challenges (half of OAT clients can have serious mental health disorders<sup>36</sup>) causing problems with retention in OAT programmes themselves<sup>37</sup>.

OAT programmes have proven to be effective in various ways, including reducing illicit opiate use, HIV risk behaviours, death from overdose and criminal activity, as well as financial and other stresses on people who use opioid drugs and their families. These programmes also improve adherence to antiretroviral therapy (ART) and contact with any health services<sup>38</sup>. Discontinuation of OAT is associated with increased rates of relapse and mortality<sup>39</sup>.

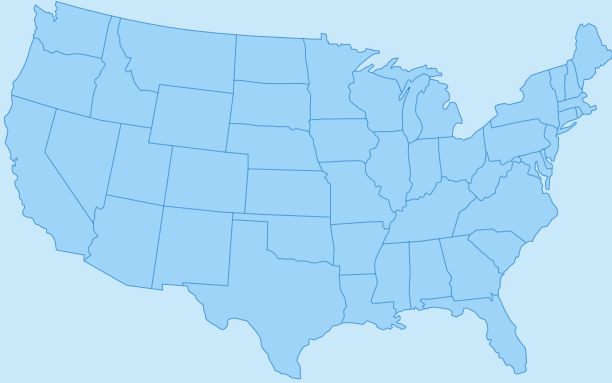


36 Marienfeld C, et al. (2015), Ibid.

37 Pisman E., et al. (2022), Ibid.


38 Kermode M, Crofts N, Kumar MS, Dorabjee J. (2011). Opioid substitution therapy in resource-poor settings. Bull World Health Organ. 2011 Apr 1;89(4):243. <https://doi.org/10.2471%2FBLT.11.086850>

39 Buresh M, Stern R, Rastegar D. (2021). Treatment of opioid use disorder in primary care. BMJ. 2021 May 19;373:n784. <https://doi.org/10.1136/bmj.n784>




**It is also known that clients with opioid dependence show a high rate of psychiatric comorbidities.**

**In a study conducted in the USA<sup>40</sup>, psychiatric comorbidity was documented in**




**47%**

**of people with opioid dependence seeking methadone maintenance.**




**47%**  
of women




**48%**  
of men

**Antisocial personality disorder**



**25.1%**

**Major depression**

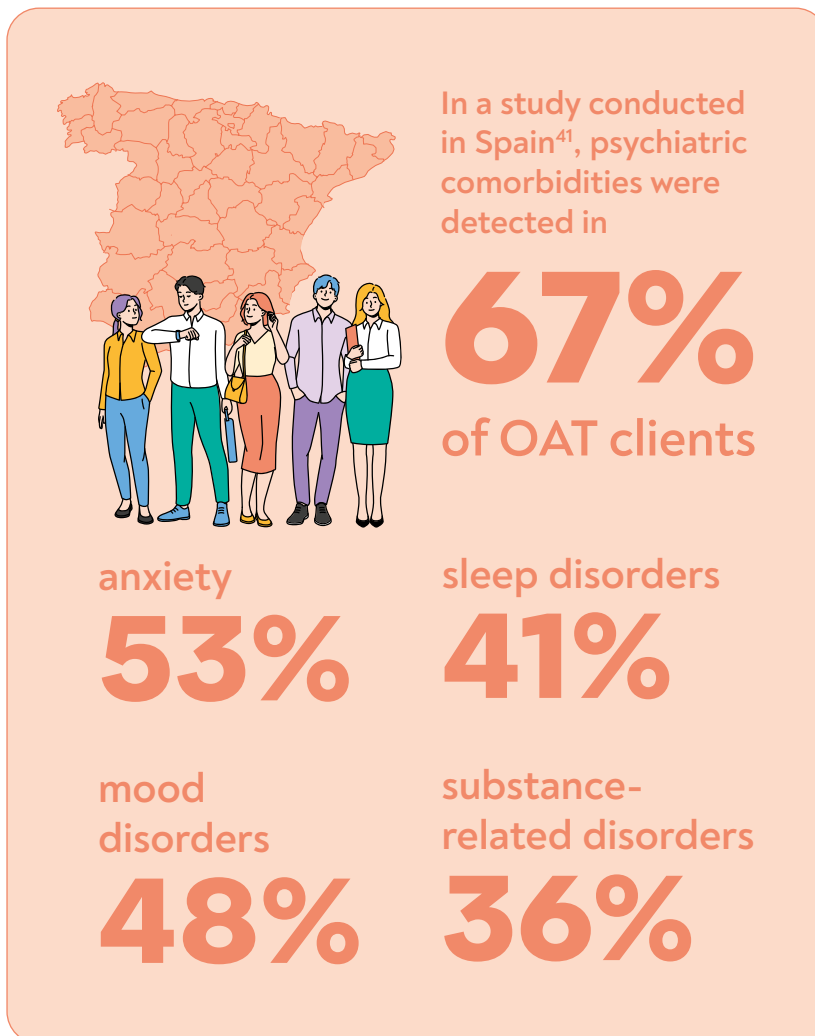


**15.8%**

**WERE THE MOST COMMON DIAGNOSES**

40 Brooner RK, King VL, Kidorf M, Schmidt CW Jr, Bigelow GE. (1997). Psychiatric and substance use comorbidity among treatment-seeking opioid abusers. Arch Gen Psychiatry. 1997 Jan;54(1):71-80. <https://doi.org/10.1001/archpsyc.1997.01830130077015>





**Thus, about half of OAT clients can be expected to have serious mental health disorders and other comorbidities, which also makes retention in OAT programmes and other social functioning more problematic for them.**

In a US-based study conducted with a sample of treatment-seeking, opioid dependent injectors referred from syringe exchange:

**21%**

post-traumatic stress disorder

**17%** major depression

**12%** bipolar disorder

were the most prevalent psychiatric disorders, and cocaine use disorder

**53%**

WERE THE MOST PREVALENT PSYCHIATRIC DISORDERS, AND COCAINE USE DISORDER<sup>42</sup>

41 Roncero C, Barral C, Rodríguez-Cintas L, Pérez-Pazos J, Martínez-Luna N, et al. (2016). Psychiatric comorbidities in opioid-dependent patients undergoing a replacement therapy programme in Spain: The PROTEUS study. *Psychiatry Res.* 2016 Sep 30;243:174-81. <https://doi.org/10.1016/j.psychres.2016.06.024>

42 Kidorf M, Solazzo S, Yan H, Brooner RK. (2018). Psychiatric and Substance Use Comorbidity in Treatment-Seeking Injection Opioid Users Referred From Syringe Exchange. *J Dual Diagn.* 2018 Oct-Dec;14(4):193-200. <https://doi.org/10.1080/15504263.2018.1510148>

The positive experiences of the first methadone<sup>43</sup> and buprenorphine<sup>44</sup> programmes in Poland were described in the early 2000's. Along with numerous improvements<sup>45, 46</sup>, researchers mentioned moderate psychopathological symptoms that were still observed in clients with double diagnosis<sup>47</sup>. Poland also took part in the WHO collaborative study on substitution therapy for opioid dependence and HIV/AIDS<sup>48</sup>. While all participating countries found a decrease in other opiate use, in Poland it was also seen that participants decreased the use of benzodiazepines and amphetamines.

Consistent with studies in other countries, factors in Poland associated with suicide attempts among methadone users included sexual abuse, depression, alcohol dependence, and impulsivity. Additionally, those clients with somatic comorbidity had an increase in odds (odds ratio = 2.6) of suicide attempts<sup>49</sup>.

In Czechia, the methadone programme started in 1997 in the General Faculty Hospital in Prague<sup>50</sup>. OAT has been available in Czechia since 2000. Buprenorphine is the leading medication, while methadone is available only in a few specialised centres. Most prescribed buprenorphine is not covered by current national health insurance schemes, and clients have to pay considerable prices to afford their treatment<sup>51</sup>. Any general practitioner has been allowed to prescribe buprenorphine (Subutex) since 2001.

Methadone maintenance therapy (MMT) was officially introduced to Estonia in 2001. As HIV/AIDS and illicit drug use in Estonia are interrelated, methadone treatment is state-financed in accordance with the national HIV/AIDS strategy. At the end of 2011, there were 5 institutions (7 centres) for OAT with 690 clients on MMT, 280 of

- 43 Kamenczak A, Chrostek Maj J, Kroch S, Groszek B. (2000). Wstępna ocena programu metadonowego w Krakowie [Preliminary evaluation of methadone programme in Kraków]. *Przegl Lek.* 2000;57(10):525-30. In Polish. [https://ruj.uj.edu.pl/xmlui/bitstream/handle/item/273140/kamenczak\\_et-al\\_wstepna\\_ocena\\_programu\\_metadonowego\\_2000.pdf](https://ruj.uj.edu.pl/xmlui/bitstream/handle/item/273140/kamenczak_et-al_wstepna_ocena_programu_metadonowego_2000.pdf) (accessed 22 May 2023).
- 44 Radomska M, Pach J, Chrostek Maj J. (2001). Zastosowanie buprenorfiny w leczeniu substytucyjnym uzależnienia od opiatów w Klinice Toksykologii--wstępne doniesienie kliniczne [Use of buprenorphine as a substitute treatment for opiate dependence in the Toxicology Clinics--introductory clinical report]. *Przegl Lek.* 2001;58(4):351-3. In Polish. [https://ruj.uj.edu.pl/xmlui/bitstream/handle/item/272464/radomska\\_pach\\_chrostek\\_maj\\_zastosowanie\\_buprenorfiny\\_w\\_leczeniu\\_substytucyjnym\\_uzaleznienia\\_od\\_opiatow\\_2001.pdf](https://ruj.uj.edu.pl/xmlui/bitstream/handle/item/272464/radomska_pach_chrostek_maj_zastosowanie_buprenorfiny_w_leczeniu_substytucyjnym_uzaleznienia_od_opiatow_2001.pdf) (accessed 22 May 2023).
- 45 Habrat B, Chmielewska K, Baran-Furga H. (2001). Stan zdrowia osób uzależnionych od opiatów przed i po roku leczenia w programie metadonowym [Health status of individuals dependent on opiates before and after a year of treatment in a methadone maintenance program]. *Przegl Lek.* 2001;58(4):245-9. In Polish. PMID: 11450345 (accessed 22 May 2023).
- 46 Szpanowska-Wohn A, Kolarzyk E, Pach D, Targosz D. (2004). Stan odżywienia osób uzależnionych od opiatów leczonych substytucyjnie metadonem [Nutritional status of opiate-dependent persons before and during methadone maintenance therapy]. *Przegl Lek.* 2004;61(4):339-44. In Polish. [https://ruj.uj.edu.pl/xmlui/bitstream/handle/item/272836/szpanowska-wohn\\_et-al\\_stan\\_odzywienia\\_osob\\_uzalezniionych\\_2004.pdf](https://ruj.uj.edu.pl/xmlui/bitstream/handle/item/272836/szpanowska-wohn_et-al_stan_odzywienia_osob_uzalezniionych_2004.pdf) (accessed 22 May 2023).
- 47 Pach J, Kamenczak A, Maj JC, Forys Z. (2001). Ocena stanu zdrowia uczestników programu metadonowego w Krakowie po roku leczenia substytucyjnego [Evaluation of health status in participants from a methadone treatment programme in Krakow after one year of maintenance treatment]. *Przegl Lek.* 2001;58(4):240-4. In Polish. [https://ruj.uj.edu.pl/xmlui/bitstream/handle/item/272453/pach\\_et-al\\_ocena\\_stanu\\_zdrowia\\_uczestnikow\\_programu\\_2001.pdf](https://ruj.uj.edu.pl/xmlui/bitstream/handle/item/272453/pach_et-al_ocena_stanu_zdrowia_uczestnikow_programu_2001.pdf) (accessed 22 May 2023).
- 48 Lawrinson P, Ali R, Buavirat A, Chiamwongpaet S, Dvoryak S, et al. (2008). Key findings from the WHO collaborative study on substitution therapy for opioid dependence and HIV/AIDS. *Addiction.* 2008 Sep;103(9):1484-92. <https://doi.org/10.1111/j.1360-0443.2008.02249.x>
- 49 Fudalej S, Ilgen M, Kołodziejczyk I, Podgórska A, Serafin P, et al. (2015). Somatic Comorbidity and Other Factors Related to Suicide Attempt Among Polish Methadone Maintenance Patients. *J Addict Med.* 2015 Nov-Dec;9(6):433-9. <https://doi.org/10.1097/adm.0000000000000153>
- 50 Wilczek H. (1998). Problematika substitucní léčby závislosti na opiátech a klinický význam metadonu [Problems with maintenance therapy in opiate dependence and the clinical importance of methadone]. *Cas Lek Cesk.* 1998 Nov 30; 137(23):725-8. Czech. PMID: 9990177.
- 51 Mravčík V, Janíková B, Drbohlavová B, Popov P, Pirona A. (2018). The complex relation between access to opioid agonist therapy and diversion of opioid medications: a case example of large-scale misuse of buprenorphine in the Czech Republic. *Harm Reduct J.* 2018 Dec 4;15(1):60. <https://doi.org/10.1186/s12954-018-0268-0>

whom were in Tallinn. Daily attendance is required for methadone clients to receive medication<sup>52</sup>. OAT included both short-term detoxification and long-term maintenance programmes in these analyses. In 2011, one-third of study participants who were people who inject drugs were on OAT<sup>53</sup>.

A methadone substitution programme in the Republic of Moldova was approved by the Ministry of Health, Labour and Social Protection in May 2003. According to Government Decision number 166 of February 15, 2005, methadone substitution treatment had been instituted in penitentiary institutions; thus, the Republic of Moldova became the first country in the Commonwealth of Independent States (CIS) states to introduce the treatment in a penitentiary system but it has faced challenges with its scale-up<sup>54</sup>. From 2002, the pharmacological treatment of opiate dependence with buprenorphine was implemented as a pilot project, and from 2004 with methadone, at the Republican Dispensary of Narcology and later extended to nine OST sites at municipal and district level, as well as 13 penitentiary institutions. Methadone/buprenorphine substitution treatment has registered an increase in geographic access, both in the civil and prison sectors, and has been fully funded domestically.

## Mental health and use of NPS

Another sub-population among people who use psychoactive substances selected for assessment and ranking high with mental health related issues were users of new psychoactive substances. NPS vary largely in effects, risks, duration, potency and appearance. Based on their effects, they are divided into aminoindanes, phencyclidine-type substances, phenyl-ethylamines, piperazines, plant-based substances, synthetic cannabinoids, synthetic cathinones, tryptamines, and a group of other substances (to which, for example, synthetic opioids belong). Little information is known about the effects and risks (short-term and long-term) of NPS, with few evidence-based health responses (for example, a perspective for action in case of NPS overdosing). Furthermore, most countries lack drug checking services, resulting in little clarity about what substances are actually present in NPS<sup>55</sup>.

Another sub-population among people who use psychoactive substances selected for assessment and ranking high with mental health related issues were users of new psychoactive substances.

- 52 Uusküla A, Des Jarlais DC, Raag M, Pinkerton SD, Feelemyer J. (2015). Combined prevention for persons who inject drugs in the HIV epidemic in a transitional country: the case of Tallinn, Estonia. *AIDS Care*. 2015;27(1):105-11. <https://doi.org/10.1080/09540121.2014.940271>
- 53 Uusküla A, et al. (2015), Ibid.
- 54 O'Hara GL, Liberman AR, Polonsky M, Azbel L, Marcus R, et al. (2022). Multi-level implementation factors that influence scale-up of methadone maintenance treatment in Moldovan prisons: A qualitative study. *J Subst Abuse Treat*. 2022 May; 136:108660. <https://doi.org/10.1016/j.jsat.2021.108660>
- 55 Eurasian Harm Reduction Association (2021). New Psychoactive Substance Use in Eastern Europe and Central Asia: Regional Report. Daan van der Gouwe. EHRA: Vilnius, Lithuania. <https://harmreductioneurasia.org/harm-reduction/new-psychoactive-substances/nps-ee-and-ca> (accessed 27 May 2023).

Some of these substances could have a specific influence on the nervous system and behaviour by affecting the brain chemistry that induces psychoactive effects, such as hallucinations and feeling 'high'<sup>56</sup>. Side effects typically include increased heart rate and palpitations, dizziness, anxiety, horror trips and headaches. Marginalised users report substantially more acute side effects, more mid- and long-term mental and physical problems, and more social problems<sup>57</sup>.

According to a systematic review<sup>58</sup>, suicidality and self-injurious behaviour appear to be frequently associated with some NPS such as cathinones, synthetic cannabinoids and new synthetic opioids. The psychopathological pattern of the 'new psychoses' appears to be extremely different from the classic presentation. Therefore, clinicians need more data on these new synthetic psychoses and recommendations on how to manage them<sup>59</sup>.

The prevalence of NPS use in general psychiatry and intensive home treatment team patients was 6.6% and 3.4%, respectively<sup>60</sup>. Users of NPS were found to have a higher level of neuroticism and higher severity of anxiety symptoms. This may point to coping motives for using NPS<sup>61</sup>.

On the other hand, a review of related literature<sup>62</sup> showed that little is known about the effects of various NPS on people with severe mental illness. Almost nothing is known about the long-term consequences of NPS use on the mental and physical health of patients with severe mental illness. Patients may lack the understanding that NPS are psychoactive drugs that can impact their mental and physical well-being. Some patients might be reluctant, or do not think it is relevant, to disclose NPS use. Commonly used illicit drug screening is unlikely to detect the presence of NPS; therefore, health and mental health professionals should directly inquire about NPS and actively encourage patients with severe mental illness to disclose such substance use.

The prevalence of NPS use in general psychiatry and intensive home treatment team patients was 6.6% and 3.4%, respectively.

- 56 Gray R, Bressington D, Hughes E, Ivanecka A. (2016). A systematic review of the effects of novel psychoactive substances 'legal highs' on people with severe mental illness. *J Psychiatr Ment Health Nurs*. Jun;23(5):267-81. <https://doi.org/10.1111/jpm.12297>
- 57 Van Hout MC, Benschop A, Bujalski M, Dąbrowska K, Demetrovics Z, et al. (2018). Health and Social Problems Associated with Recent Novel Psychoactive Substance (NPS) Use Amongst Marginalised, Nightlife and Online Users in Six European Countries. *Int J Ment Health Addict*. 16(2):480-495. <https://doi.org/10.1007/s11469-017-9824-1>
- 58 Chiappini S, Mosca A, Miuli A, Santovito MC, Orsolini L, et al. (2021). New Psychoactive Substances and Suicidality: A Systematic Review of the Current Literature. *Medicina (Kaunas)*. Jun 6;57(6):580. <https://doi.org/10.3390/medicina57060580>
- 59 Orsolini L, Chiappini S, Papanti D, De Berardis D, Corkery JM, et al. (2019). The Bridge Between Classical and «Synthetic»/Chemical Psychoses: Towards a Clinical, Psychopathological, and Therapeutic Perspective. *Front Psychiatry*. Nov 20;10:851. <https://doi.org/10.3389/fpsy.2019.00851>
- 60 Bennett KH, Hare HM, Waller RM, Alderson HL, Lawrie S. (2017). Characteristics of NPS use in patients admitted to acute psychiatric services in Southeast Scotland: a retrospective cross-sectional analysis following public health interventions. *BMJ Open*. Dec 3;7(12):e015716. <https://doi.org/10.1136/bmjopen-2016-015716>
- 61 Chmielowiec J, Chmielowiec K, Masiak J, Pawłowski T, Larysz D, et al. (2021). Analysis of Relationships between DAT1 Polymorphism Variants, Personality Dimensions, and Anxiety in New Psychoactive Substance (Designer Drug) (NPS) Users. *Genes (Basel)*. Dec 10;12(12):1977. <https://doi.org/10.3390/genes12121977>
- 62 Gray R, et al (2016), Ibid.

**NPS use could modify clinical features of severe mental illness, but these conclusions cannot be generalised. Most clinical results report acute symptom exacerbation of preexisting psychosis; paranoid mood and aggression symptoms occur more frequently<sup>63</sup>.**



NPS use was identified in 22.2% of admissions, contributing to psychiatric symptoms in 59.3%. The diagnosis of drug-induced psychosis was significantly more likely in NPS users, and the diagnosis of depression was significantly less likely. The use of cannabis was significantly more likely in NPS users, as was substitute opiate prescribing<sup>64</sup>.

Use of NPS in a young psychiatric population appears to be a frequent phenomenon and is probably still underestimated<sup>65</sup>. NPS use was significantly more common in a population group with psychiatric issues compared to a population group with no health issues matched for sex, gender and living status (NPS 9.8% versus 3%;  $P < 0.001$ ). The three psychiatric diagnoses most frequently

**The three psychiatric diagnoses most frequently associated with NPS use were bipolar disorder (23.1%), personality disorders (11.8%) and schizophrenia and related disorders (11.6%).**

associated with NPS use were bipolar disorder (23.1%), personality disorders (11.8%) and schizophrenia and related disorders (11.6%)<sup>66</sup>.

In a study conducted with a sample of people diagnosed with substance use disorders, factors associated with NPS use were youth, studentship, subsequent mental disorder diagnosis, suicide attempt history, home detention, residential care, and polysubstance dependence. There was a significant increase in the number of patients with NPS dependence admitted to the emergency departments. NPS dependence was reported as significantly higher among male patients, people who use alcohol, people who use other psychoactive substances, patients suffering from mental disorders, and teenagers in difficult socio-economic family situations<sup>67</sup>.

63 Bersani G, Preve E. (2017). Novel psychoactive substances (NPS) use in severe mental illness (SMI) patients: Potential changes in the phenomenology of psychiatric diseases. *Hum Psychopharmacol*. May;32(3). <https://doi.org/10.1002/hup.2591>

64 Stanley JL, Mogford DV, Lawrence RJ, Lawrie SM. (2016). Use of novel psychoactive substances by inpatients on general adult psychiatric wards. *BMJ Open*. May 10;6(5):e009430. <https://doi.org/10.1136/bmjopen-2015-009430>

65 Martinotti G, Lupi M, Acciavatti T, Cinosi E, Santacroce R, et al. (2014). Novel psychoactive substances in young adults with and without psychiatric comorbidities. *Biomed Res Int*. 2014;8:15424. <https://doi.org/10.1155/2014/815424>

66 Acciavatti T, Lupi M, Santacroce R, Aguglia A, Attademo L, et al. (2017). Novel psychoactive substance consumption is more represented in bipolar disorder than in psychotic disorders: A multicenter-observational study. *Hum Psychopharmacol*. 2017 May;32(3). <https://doi.org/10.1002/hup.2578>

67 Dal Farra D, Valdesalici A, Zecchinato G, De Sandre A, Saccon D, et al. (2022). Knowledge and Use of Novel Psychoactive Substances in an Italian Sample with Substance Use Disorders. *Int J Environ Res Public Health*. Jan 14;19(2):915. <https://doi.org/10.3390/ijerph19020915>



Summarising results of the study, 'New Psychoactive Substance Use in Eastern Europe and Central Asia', conducted by the School of Law, Swansea University, in collaboration with EHRA in 8 countries (Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Lithuania, Moldova, and Serbia), the regional analysis shows severe issues with mental health among NPS users. Despite the lack of knowledge on what substances are really present in NPS, many respondents mentioned a number of mental health issues associated with NPS use, especially NPS that have stimulant effects (that is, mainly cathinones). These issues include feelings of paranoia and depression and psychotic episodes during or after consumption<sup>68</sup>.

## Mental health and surviving war

Refugees and displaced persons, including people who use psychoactive substances, constitute a specific target group which was included in this study; emphasis was placed on describing the current state (as of the end of 2022) of mental health services that war refugees from Ukraine, in particular, can receive in the CEECA region.

In general, war refugees and veterans have been known to frequently develop neuropsychiatric conditions including depression, post-traumatic stress disorder (PTSD), and anxiety disorders that tend to leave a long-lasting scar and impact

a person's emotional response system. Everyone develops a coping mechanism that can involve dependence and long-term drug dependence to alcohol, drugs, violence, or gambling<sup>69</sup>.

As of June 2022, in just over 4 months following the Russian invasion, an unprecedented number of nearly 8 million people had crossed the border from Ukraine, of which over 5 million

As of June 2022, in just over 4 months following the Russian invasion, an unprecedented number of nearly 8 million people had crossed the border from Ukraine, of which over 5 million crossed into the European Union (EU).

crossed into the European Union (EU). According to reports from the United Nations High Commissioner for Refugees (UNHCR), a large majority fled to bordering EU countries. A significant number of those displaced also returned to Ukraine during that period. It should be noted that there is some uncertainty about the numbers and destinations of those fleeing the conflict in Ukraine. The majority of displaced people (approximately 90%) are reported to be women, children, and elderly citizens<sup>70</sup>.

Additional mental health issues are due to surviving violence. As the war in Ukraine rages on, the region faces an unprecedented crisis of displaced women and children. Like all wars, this one is being fought on the bodies of these women and children. Conflict related sexual violence has been documented in the form of Russian soldiers raping Ukrainian women, and women's organisations inside Ukraine report that domestic violence is also on the rise.

68 EHRA (2021), Ibid.

69 Jain N, Prasad S, Czárth ZC, Chodnekar SY, Mohan S, et al. (2022). War Psychiatry: Identifying and Managing the Neuropsychiatric Consequences of Armed Conflicts. *J Prim Care Community Health*. 2022 Jan-Dec;13:21501319221106625. <https://doi.org/10.1177/21501319221106625>

70 European Monitoring Centre for Drugs and Drug Addiction (2022). Responsiveness and preparedness in addressing drug-related needs of displaced Ukrainians in EU countries bordering Ukraine, EMCDDA trendspotter briefing. Publications Office of the European Union, Luxembourg. <https://www.emcdda.europa.eu/system/files/media/publications/documents/14753/EMCDDA%20trendspotter%20briefing-Ukraine.pdf> (accessed 27 May 2023).

As the lack of access to essential and life-saving services is directly correlated with safety and security risks, all actors must take action to meet the reception and integration needs for forcibly displaced persons (FDPs) – including the need for healthcare, psychosocial support, safe accommodation, cash and voucher assistance, livelihood support, and education<sup>71</sup>.

Provision of mental health services for migrants and refugees by the national health system of host countries is especially difficult in light of the fact that, in most if not all countries, the general level of

**Different national and regional NGOs have developed online services for crisis counselling and psychological help as part of responses to urgent mental health problems.**

mental health care provision is comparatively low and the population may have limited access to it<sup>72</sup>. It was also reported that mental health facilities in countries where refugees arrive are often unprepared for providing the help which is needed by those coming from Ukraine. Different national and regional NGOs have developed online services for crisis counselling and psychological help as part of responses to urgent mental health problems.

## COVID-19 pandemic impact on mental health

One of the objectives of this study was to explore the influence of the COVID-19 pandemic-related situation on mental health service provision in Central and Eastern Europe and Central Asia.

The COVID-19 pandemic caused an unprecedented worldwide crisis affecting several sectors, including health, social care, the economy, and society at-large. The COVID-19 pandemic is associated with increased levels of anxiety, fear, sadness, difficulty adjusting, symptoms of post-traumatic stress disorder and suicidality, both in the general population and specific subgroups<sup>73</sup>. The COVID-19 pandemic has affected the mental health of people both with and without co-morbidities, substance use of those people who had mental health issues, as well as the provision of mental healthcare services.

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71 VOICE (2022). Waiting for the Sky to Close: The Unprecedented Crisis Facing Women and Girls Fleeing Ukraine. Regional Assessment Report / Ukraine Crisis Response. VOICE Amplified. <https://voiceamplified.org/waiting-for-the-sky-to-close/#tve-jump-18100ca5b1d> (accessed 27 May 2023).

72 Shoib S, Zharkova A, Pal A, Jain N, Saleem SM, et al. (2022). Refugees and Mental health crisis in Ukraine. Asian J Psychiatr. Aug;74:103169. <https://doi.org/10.1016/j.ajp.2022.103169>

73 Mellos E, Paparrigopoulos T. (2022). Substance use during the COVID-19 pandemic: What is really happening? Psychiatriki. Mar 28;33(1):17-20. English, Greek, Modern. <https://doi.org/10.22365/jpsych.2022.072>

Representative panel surveys conducted among adults aged

**≥18 years**

across the United States during June 24-30, 2020, showed that

 **13.3%**

of respondents started or increased substance use to cope with stress or emotions related to COVID-19<sup>74</sup>.

Combined prevalence estimates of current depression, initiating or increasing substance use, and suicidal thoughts/ideation were

→ **28.6%**

→ **18.2%**

→ **8.4%**

respectively<sup>75</sup>.

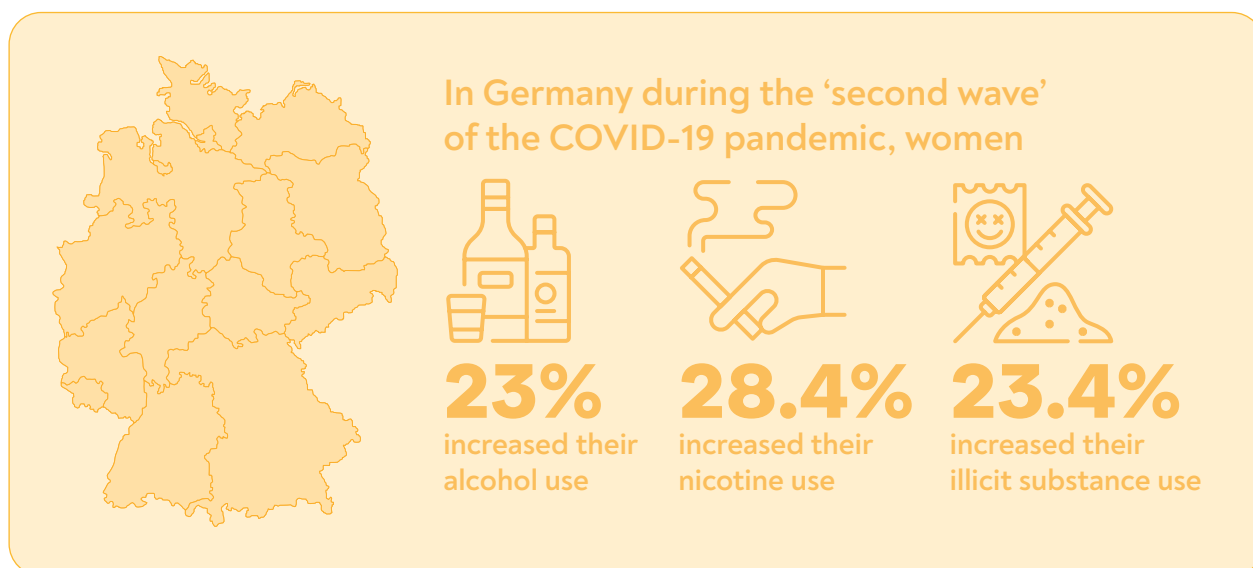
**In a study of a large sample of United States veterans, there was a decrease in alcohol and cannabis use among the overall sample, but veterans who screened for depression prior to the pandemic exhibited higher levels of substance use after the pandemic's onset<sup>76</sup>.**



74 Czeisler MÉ, Lane RI, Petrosky E, Wiley JF, Christensen A, et al. (2020). Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic - United States, June 24-30, 2020. *MMWR Morb Mortal Wkly Rep.* Aug 14;69(32):1049-1057. <https://doi.org/10.15585/mmwr.mm6932a1>

75 McKnight-Eily LR, Okoro CA, Strine TW, Verlenden J, Hollis ND, et al. (2021). Racial and Ethnic Disparities in the Prevalence of Stress and Worry, Mental Health Conditions, and Increased Substance Use Among Adults During the COVID-19 Pandemic - United States, April and May 2020. *MMWR Morb Mortal Wkly Rep.* Feb 5;70(5):162-166. <https://doi.org/10.15585/mmwr.mm7005a3>

76 Fitzke RE, Wang J, Davis JP, Pedersen ER. (2021). Substance use, depression, and loneliness among American veterans during the COVID-19 pandemic. *Am J Addict.* Nov;30(6):552-559. <https://doi.org/10.1111/ajad.13211>



Twenty percent reported major depressive symptoms and

**23.4%** reported symptoms of generalised anxiety.

Generalised anxiety proved to be a significant predictor of increases in alcohol and nicotine use using logistic regression<sup>77</sup>. Mental health factors were the most common correlates or triggers for increased use of both alcohol and other substances<sup>78</sup>.

According to a mental health survey conducted in Estonia<sup>79</sup>, the manifestation of mental health problems is influenced by a range of environmental and genetic risk factors. In the pre-pandemic period, diagnosis of depression was most strongly associated with gender and genetic risk scores, followed by lifestyle factors

SMOKING	DRUG	ALCOHOL USE

77 Schecke H, Fink M, Bäuerle A, Skoda EM, Schweda A, et al. (2021). Changes in Substance Use and Mental Health Burden among Women during the Second Wave of COVID-19 in Germany. *Int J Environ Res Public Health*. Sep 15;18(18):9728. <https://doi.org/10.3390/ijerph18189728>

78 Roberts A, Rogers J, Mason R, Siriwardena AN, Hogue T, et al. (2021). Alcohol and other substance use during the COVID-19 pandemic: A systematic review. *Drug Alcohol Depend*. Dec 1;229(Pt A):109150.

79 Kleinberg A. (2008), Ibid.

The self-reported depression risk (at the time of the pandemic) was associated with younger age, gender, genetic predisposition, and substance use.



Higher levels of mental health problems are also reported by women and adults living alone.



In general, the vulnerable groups for mental disorders are adolescents and young adults, respondents with lower education and lower incomes, and the unemployed.





During the COVID-19 pandemic, many interactions between drug traffickers and buyers have moved online<sup>80</sup>, which changed the usual drug market in the CEECA region, thereby influencing drug use behaviour and needs in harm reduction services<sup>81</sup>.

Persons with substance use disorders are a particularly vulnerable population because of their unique social and healthcare needs. They face significant harm from both the pandemic itself and its social and economic consequences,

including marginalisation in healthcare and social systems<sup>82</sup>. COVID-19 decreased treatment access and its quality for people with drug dependence. Those with high sociodemographic vulnerability reported greater pandemic-related increases in depression and demonstrated greater mood symptoms. Unmet basic needs were significantly associated with lower treatment access and quality, greater mood symptoms, and higher substance use<sup>83</sup>.

80 Napoletano S, Basile G, Lo Faro AF, Negro F. (2022). New Psychoactive Substances and receding COVID-19 pandemic: really going back to «normal»? *Acta Biomed.* May 11;93(2):e2022186. <https://doi.org/10.23750%2Fabm.v93i2.13008>

81 Tanguay P, Lakhov A. (2022). The impact of COVID-19 on drug use and drug markets in Central and Eastern Europe and Central Asia. Vilnius; Eurasian Harm Reduction Association. <https://ehra-uploads.s3.eu-central-1.amazonaws.com/38d1016a-4263-4bf6-94a5-16e634487c1c.pdf> (accessed 28 May 2023).

82 Melamed OC, Hauck TS, Buckley L, Selby P, Mulsant BH. (2020). COVID-19 and persons with substance use disorders: Inequities and mitigation strategies. *Subst Abus.* 41(3):286-291. <https://doi.org/10.1080/08897077.2020.1784363>

83 Banks DE, Paschke ME, Li X, Fentem A, Rich A, et al. (2022). Opioid Use Disorder and COVID-19: Treatment and Recovery Factors among Vulnerable Populations at the Intersection of Two U.S. Epidemics. *J Psychoactive Drugs.* May 26:1-9. <https://doi.org/10.1080/02791072.2022.2079443>



# Assessment results

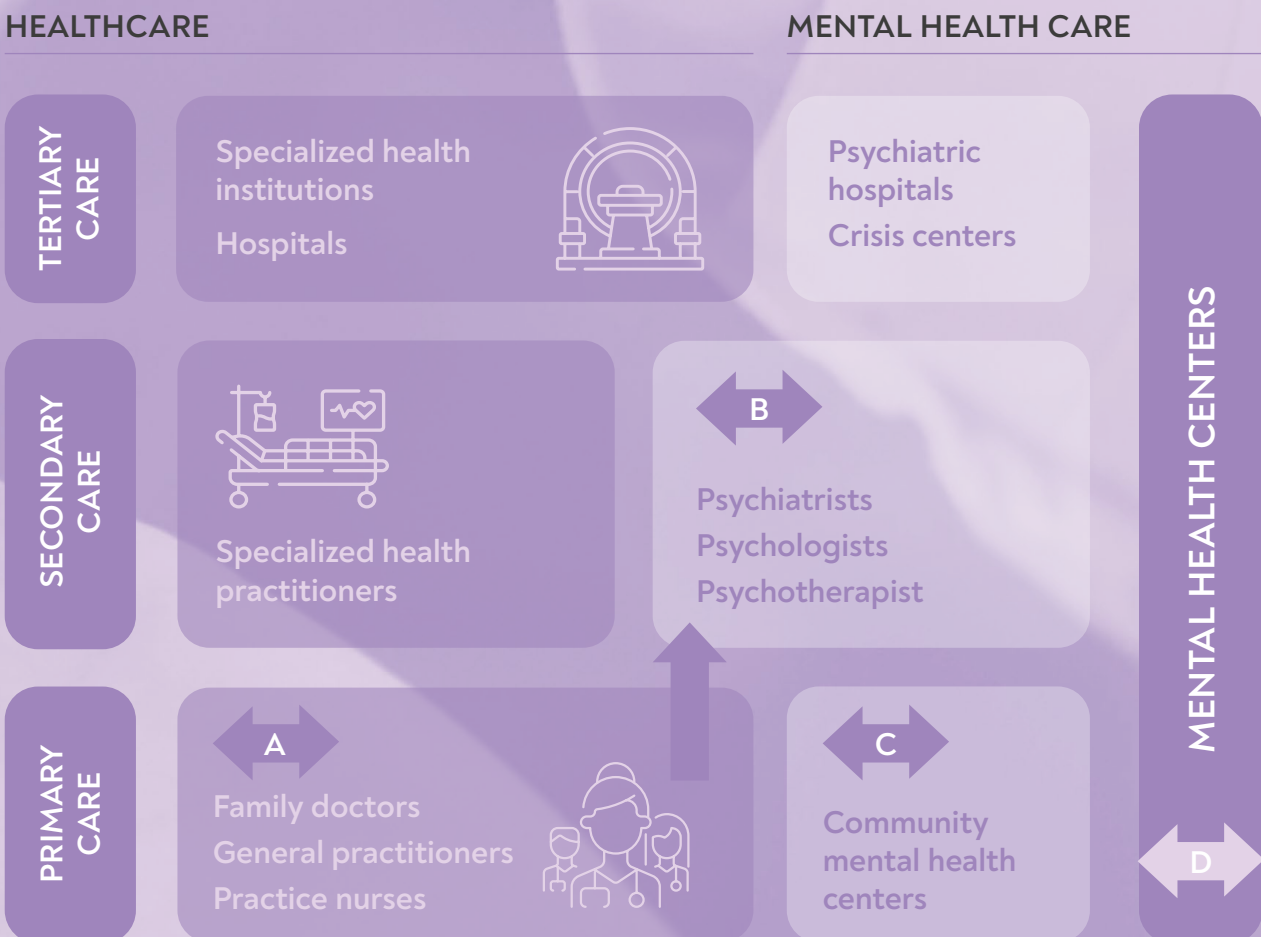
## Mental healthcare provision to the general population

General practitioners/family doctors are considered the primary contact when health issues arise. All four countries of the study mentioned registration with a general practitioner or a family doctor as a first step and general rule for accessing mental health services. All four countries have some sort of health insurance system; however, the conditions of whether a patient needs to be insured before visiting primary care differs.

General practitioners/family doctors/primary health care centres can provide help with psychological or emotional problems in Czechia and Estonia, but not in Moldova and Poland. Estonia puts a great emphasis on primary care in general, with the coordination of all treatment procedures by family doctors and nurses.

Psychiatrists are considered appropriate health professionals for solving mental health issues in all four countries. Referral for seeing a psychiatrist is not obligatory in either country. A special mode of contacting other health professionals besides the general practitioner, called e-consultation, is used in Estonia.

Figure 3. Most frequent points for primary mental health contact with health professionals and referral pathways



The scheme recommended by WHO, in which a primary healthcare practitioner (family doctor) deals with mental health issues, was found in Estonia and Czechia.

Thus, the primary contact with a health professional able to conduct diagnostic procedures and possibly start providing care, depending on the country, might take place at a primary health centre or general practitioners office or, (a) a patient can apply to a psychiatrist directly (no referral is needed in all involved countries); (b) a patient can apply to a community mental health centre; (c) or mental health centre; or, (d) a patient can be referred to a psychiatrist by a general practitioner (the vertical arrow in Figure 3).

The scheme recommended by WHO, in which a primary healthcare practitioner (family doctor) deals with mental health issues, was found in Estonia and Czechia. Obviously, to apply directly to a psychiatrist or to mental health centres, a patient is expected to self-diagnose a mental disorder.

The approach adopted by Estonia with a strong emphasis on primary healthcare shows its results, among other things, in how stigma is addressed. While mental health

People often have good contact with their family doctor and/or family nurse and they feel better able to approach them. If necessary, the family doctor can carry out e-consultations with a psychiatrist to find out the best intervention for the patient.

issues are still stigmatised, primary care services are more accessible than most services provided by mental health professionals. As they are general health services, they are easier for people, who are afraid of stigma, to use than other specialist mental health services. People often have good contact with their family doctor and/or family nurse and they feel better able to approach them. If necessary, the family doctor can carry out e-consultations with a psychiatrist to find out the best intervention for the patient.

To visit/see/contact a psychologist, the procedure is more complicated. While referral is still not needed in Czechia, a family doctor/general practitioner needs to refer a patient in the other three countries if the consultation is to be paid from health insurance funds. However, the insurance situation might differ, and psychological services might not be covered by medical insurance, as was seen in Moldova.

In case of acute, urgent, or severe mental health problems, there are many typical entry points for the patient which are common for all four countries. These can be general practitioners/family doctors in all four countries, and a specific figure of a mental health nurse recently introduced in Estonia. These are also mental health centres or community mental health centres, emergency care or emergency psychiatric services, a psychiatric hospital, and ambulance service.

Other services are present in only some countries and there they can serve as entry points for urgent care as well. These include centres of crisis intervention found in Czechia and Poland, and outreach mobile psychiatric teams which are present on a small scale in Moldova and Czechia.

Crisis hotlines can function as entry points as well. This was seen in Czechia, Estonia and Poland. However, they are not shown in the scheme above as they are usually not considered healthcare entities. As the observations in Czechia show, helplines are set up in large numbers, each with a different focus (including a suicide helpline) or general psychological help/crisis intervention lines.



Crisis hotlines are often considered as a tool for suicide prevention. Reaching their targets depends on good coordination of the variety of hotlines, mental health clinics, and police. Suicide prevention and the approach used for it could be a good example of coordinated work within the field of mental health. However, the long-term perspective of suicide prevention needs to be emphasised here.

However, as the collected observations show, the numbers and capacities of outpatient care services, crisis centres, and daycare centres are insufficient. There is often a lack of continuity between services and their interconnection (networking), especially after hospitalisation for a psychiatric diagnosis. Data shows the problem of high suicide rates just after discharge from hospitals for mental illness<sup>84</sup>.

Figure 4. Possible entry points for urgent mental health problems (marked by stars)



84 Winkler P, Mladá K, Csémy L, Nechanská B, Höschl C. (2015). Suicides following inpatient psychiatric hospitalization: a nationwide case control study. Journal of Affective Disorders. 184, 164– 169. <https://doi.org/10.1016/j.jad.2015.05.039>



**Currently, Czechia implements the Action Plan for Suicide Prevention 2020-2030 which aims at:**

- 1) increased service interconnection;
- 2) an increased number of facilities that can detect, diagnose, treat or refer people at risk of suicide to other services;
- 3) evidence-based interventions and increased education of professionals and lay people (self-help);
- 4) care for the family and other bereaved;
- 5) destigmatisation of the issue; and,
- 6) the question of prescription drugs, their prescription, cooperation with a toxicology centre, etc.

Chronic or non-acute conditions can be addressed within in-patient care facilities and outpatient care, including psychotherapeutic and psychological services present in all countries with varying capacities. Acute problems that do not require hospitalisation can also be addressed at the primary outpatient psychiatric or other supportive care service.

As seen in Czechia, psychotherapy is provided in both municipal or state health institutions, or as a private counseling business, including within the framework of

Day centres are a form of care present in all four countries. A referral from other services might be required. However, therapeutic communities are seen only in Czechia and Poland.

state-established care (such as in psychiatric hospitals), in non-profit organisations (i.e. not only in health services but also in social services), and privately. It is possible to apply for private psychotherapy supported by health insurance or to pay for it directly. Within some organisations, it is also possible to provide part of the service on insurance

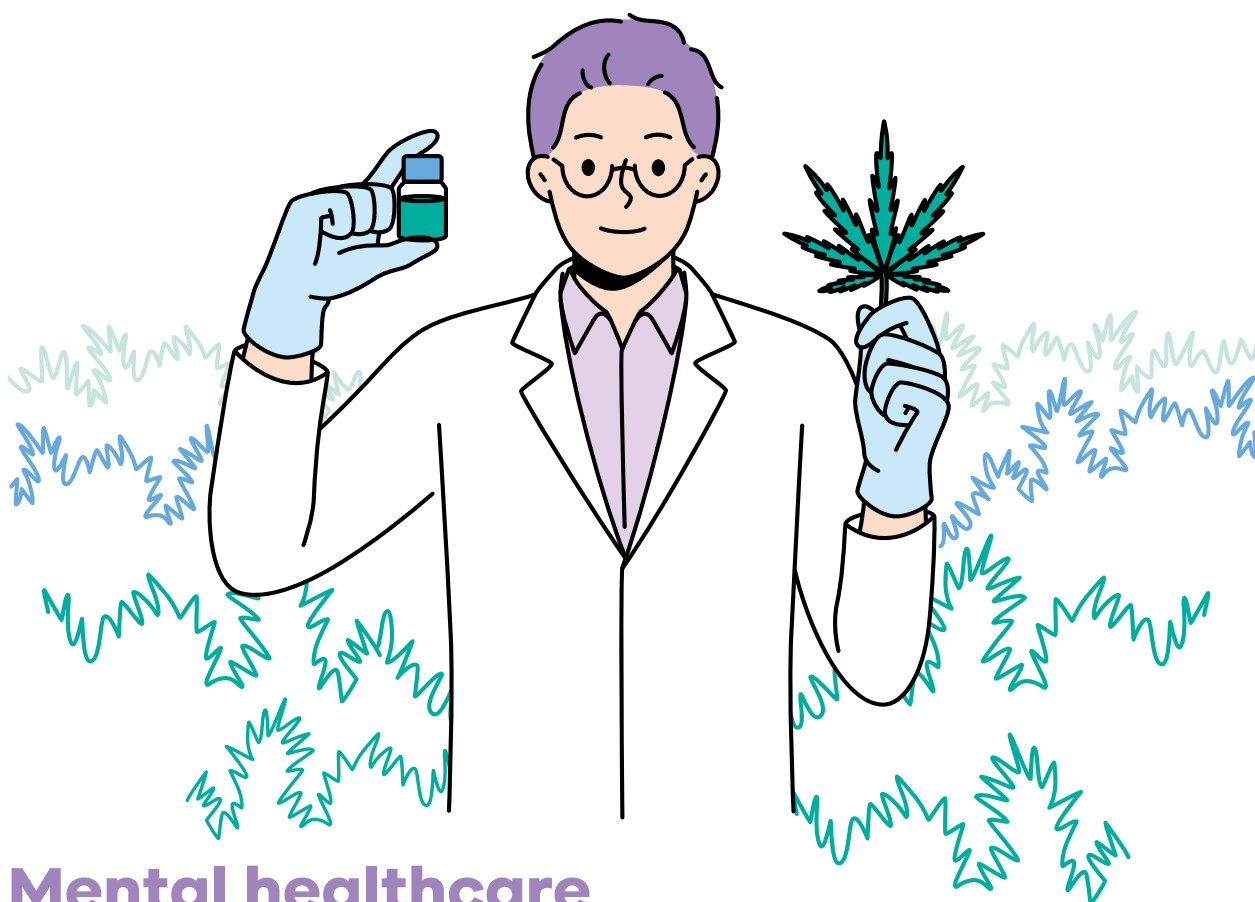
and part on direct payment (such as family therapy, etc.); the forms, possibilities and combinations are various.

Day centres are a form of care present in all four countries. A referral from other services might be required. However, therapeutic communities are seen only in Czechia and Poland.

Follow-up care is usually organised as outpatient or residential. Social rehabilitation is provided by NGOs and by state institutions.

Service funding is rather mixed overall. More traditional services and those related to acute/urgent conditions, such as ambulance and in-patient care, are financed from governmental/public sources and health insurance, if available. Services provided by psychologists and psychotherapists are paid from a mixture of private and public sources. There are many limitations and conditions regarding whether these services can be paid from insurance or not.

Services that were found to be more developed in post-socialist but not in post-soviet countries are more likely to be paid from public sources, as seen with centres of crises interventions implemented mainly by NGOs in Czechia and Poland. In-patient, long-term care facilities in these countries can be at least partly paid from social benefits in Czechia, and up to one year of therapy is covered by the national fund in Poland. In contrast, such services seem to be more likely to be paid for by the patient or one's family in post-soviet Estonia and Moldova. However, a mixture of sources, including those related to local government, might also play a role.



## Mental healthcare provision to people who use psychoactive substances

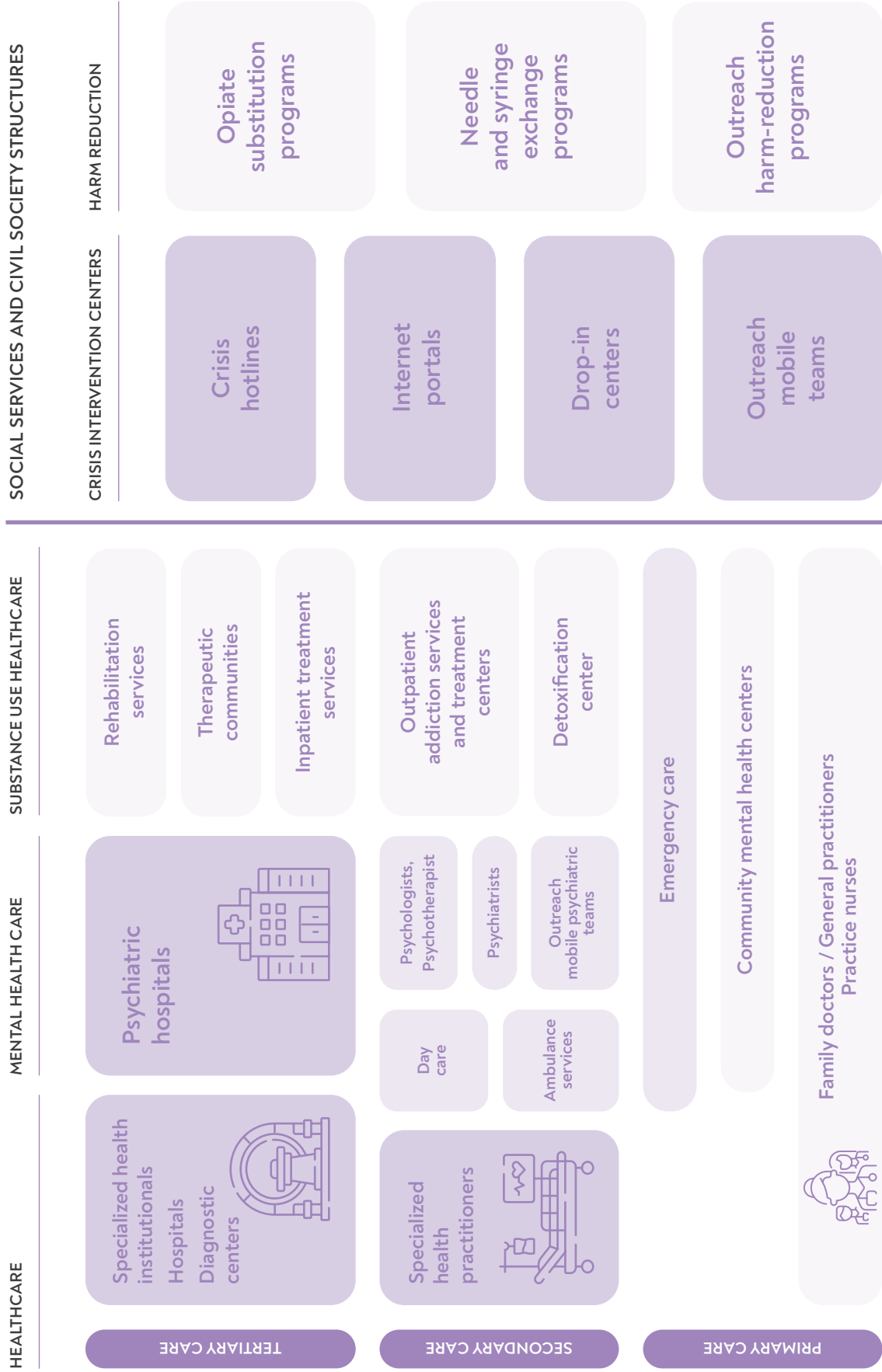
### Service structure

As seen in Figure 5 below, services aimed at providing interventions to people who use psychoactive substances only partially belong to the health system. In all the involved countries, more services belong to the harm reduction spectrum which usually grows from civil society initiatives and then, in some countries, may become financially supported by the government. Many related care institutions might be considered not healthcare but rather as social service

entities. These include outreach mobile teams, drop-in centres, crisis centres, as well as more or less specialised crisis hotlines.

However, even though these facilities have varying histories of their establishment, research conducted in various countries explains drug treatment and harm reduction services together. Moreover, several of the included countries issued specific policies proclaiming the integral development of services for substance users and their governmental funding.

Figure 5. Healthcare and social services aimed at users of psychoactive substances



The provision of health services to people who use drugs is based on access to a network of outpatient and in-patient facilities that have the status of public or non-public healthcare institutions.

In Poland, at least four different specialist drug treatment settings are functional. These are in-patient therapeutic communities, outpatient programmes, OAT, and harm reduction programmes (drop-in/needle exchange/support)<sup>85</sup>. Treatment of drug dependence is regulated by the Act of 29 July 2005 on Counteracting Drug Dependence (Ustawa z dnia 29 lipca 2005 r. o przeciwdziałaniu narkomanii). The Act states that treatment, rehabilitation and reintegration services are provided to the drug dependent person free of charge, regardless of their place of residence in the country. The provision of health services to people who use drugs is based on access to a network of outpatient and in-patient facilities that have the status of public or non-public healthcare institutions.

All participating countries have a relatively standard set of services for people who use psychoactive substances. These are harm reduction programmes, including outreach, syringe exchange, and OAT.

In Estonia, according to the National Institute for Health Development, harm reduction services (including substitution treatment for opioid dependence), as well as detoxification and rehabilitation services, are available to a person experiencing drug dependence. All services are funded by the state and are free for the client. The services offered in Estonia are based on the personal motivation of the client and to enter the services related to harm reduction and other drug dependence, the client does not require any referral letter<sup>86</sup>.

All participating countries have a relatively standard set of services for people who use psychoactive substances. These are harm reduction programmes, including outreach,

syringe exchange, and OAT. Other facilities provide detoxification services, social rehabilitation, relapse prevention, and group and individual therapy. These services can be hospital-based as well as provided in outpatient clinics, day centres, and therapeutic communities.

Short-term detoxification in-patient treatment is aimed at immediate or gradual termination of the narcotic drug and the prevention or alleviation of the resulting withdrawal symptoms. Short-term withdrawal treatment is suitable for all drugs that cause severe intoxication. Detoxification usually lasts up to 30 days and is based on psychopharmacotherapy.

Some services are provided via the internet. At least three of the four countries with established telephone helplines also have specific counseling services for cannabis users and provide psychotherapeutic interventions and community-based treatment services. Estonia established a specific service of people who provide individual support; however, case managers working in other countries are likely to render quite similar aid.

Specific services aimed at drug dependence treatment or services for people who use drugs might have high and low thresholds, and participating countries revealed substantially varying pictures in this regard.

In contrast to various countries of Western Europe whose example could be followed whereby detoxification is conducted 'cold turkey' with an emphasis on behavioural and psychotherapeutic modalities, in many of

85 Klingemann J. (2017). The rights of drug treatment patients: Experience of addiction treatment in Poland from a human rights perspective. *Int J Drug Policy*. May;43:67-73. <https://doi.org/10.1016/j.drugpo.2017.01.015>

86 <https://www.narko.ee/> (accessed 28 May 2023).

the participating countries detoxification is usually based on psychopharmacotherapy, while supportive and motivating counseling sessions by psychologists, social workers and experienced counselors are also in place.

As seen in Moldova, for insured persons who do not want to disclose their identity, detoxification is paid out-of-pocket because the use of the medical insurance policy excludes anonymity.

As observed in Poland – but is actually seen in many other countries of the region – an abstinence-based approach prevails<sup>87</sup>, which makes substitution programmes less accepted by health professionals than they could be.

Outreach harm reduction programmes can also serve as an entry point to the drug service system, as well as the network of drop-in centres. People who do not attend low-threshold services may as well use outpatient drug dependence services or treatment centres.

Regarding access to the above-mentioned services, there appears to be a lot of difference between the countries. While in Moldova and Estonia, many of the services are characterised

as those easy to access, paid for by the government and free for the client, the impressions of both health professionals and service users in Poland and Czechia were found to be much less optimistic, though in Poland these services are stated to be free for the clients as well.

Along with governmental sources, some services might be paid from private sources, especially when the client wants to keep their name secret. This means that even when a service is intended to be available for free, patients may choose to use a paid service that is anonymous. Drug registries, at

least in some countries, are initially intended to prevent the double use of substitution drugs. However, they result in substantial violations of the human rights of people who use psychoactive substances.

As seen in Moldova, when a person is identified by a narcologist as a drug user (usually after examining biological fluids for the presence of drugs and/or metabolites), registration in the narcological register of the Republican Dispensary of Narcology is mandatory. There are two main ways to register: if a person has tested positive for drug metabolites in saliva or urine in police-requested tests; or by contacting the health system (voluntary hospitalisation for treatment or accidental detection during preventive examinations). Registered individuals are subsequently referred to a local narcologist for diagnosis and treatment.

These registries need to be distinguished from the system of monitoring harm reduction service provision available for clients all around the country, also used for collecting statistics on harm reduction services to get an overview of the operation of the service and the volume of the service. The data is published in an anonymous form. Currently, such systems exist in Kazakhstan, Moldova and Ukraine.

Entry points to these services differ by country. In all or most participating countries, a client can get into treatment after being referred by a court due to drug-related crimes, through outreach harm reduction programmes, or by applying

87 Bartnik M, Kwiatkowska A. (2015). Iniekcijni użytkownicy substancji psychoaktywnych – identyfikacja problemów i potrzeb na przykładzie pięciu polskich miast: Warszawa, Kraków, Gdańsk, Poznań i Lublin. Warszawa. In Polish. [https://krytykapolityczna.pl/wp-content/uploads/2015/10/RAPORT-Fundacja-R edukcji-Szko%CC%81d\\_IDU\\_Identyfikacja-problemow-i-potrzeb-1.pdf](https://krytykapolityczna.pl/wp-content/uploads/2015/10/RAPORT-Fundacja-R edukcji-Szko%CC%81d_IDU_Identyfikacja-problemow-i-potrzeb-1.pdf) (accessed 28 May 2023).



personally for detoxification or other in-patient treatment services. In Czechia and Poland, people who use drugs can also apply through drop-in centres and emergency care. General practitioners are deemed to be a plausible entry point in Czechia and Moldova, but they often refer to psychiatric hospitals, outpatient clinics or non-profit organizations, rather than helping the client directly. Outreach harm reduction programmes can also serve as an entry point to the drug service system, as well as the network of drop-in centres. People who do not attend low-threshold services may as well use outpatient drug dependence services or treatment centres. It also varies according to the substance used. Drop-in centres are certainly one of the first points of contact for a large group of at-risk people or injecting, but there is also a large 'hidden population' and there are also many people who have the ability to make an appointment for their first visit anywhere that they can find on the internet.

## Mental health service provision

In terms of mental health care services within institutions providing services to people who use drugs, the situation is rather uneven. Despite being educated as mental health professionals, many psychiatrists working in drug dependence treatment facilities are only dealing with drug dependence issues. This division of responsibilities between two branches of the healthcare system and institutions results in mental health issues of people who use drugs not being addressed by any such institutions.

Compared to many countries of Western Europe and North America, where mental health and substance use are considered parts of one whole, many health professionals

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We can have one and the same institution that can offer drug dependence treatment services and more broadly mental health services, but they may not be related to the understanding that mental health services should also include drug dependence treatment services. We have separate mental health services, and we have services for substance users. We have parallel lines of activity. And it is a separate issue if we have a person with mental health problems and drug dependence who still needs social services, then they is also a parallel structure.”

**Health authority professional in charge of substance use services, Estonia**

in the CEECA region observe mental health and substance use as separate issues.

In contrast, within harm reduction services, it is quite common that they have mental health nurses, psychologists, or social workers within their multidisciplinary teams. Detention facilities also usually have mental health nurses on their staff. As seen in Estonia, various service providers have different specialists in their team – some have a mental health nurse and others have a general nurse or a psychologist. In addition to a psychologist, those at a rehabilitation centre also have the option of consulting a psychiatrist.

When people who use drugs and clients of the above-mentioned services reveal mental health problems, they can be referred to those services which exist for the general population. Visiting a psychiatrist or a mental health nurse usually does not anticipate getting a referral from a family doctor, while visiting a psychologist or a psychotherapist

usually requires such a referral. As already explained in the previous subsection, using these services is paid from insurance funds. Compared to harm reduction services that are generally easy to access without any referral and free for the users, mental health services, conversely, are insurance-based, some require a referral and might be associated with a long waiting time.

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In order for a person with a substance use disorder to receive mental health help outside the services intended for them, they must have health insurance, but they often do not have it, and that is a common cause of why they do not receive the service. Special services for people with a substance use disorder are financed by the National Institute for Health Development and the person does not have to be insured by the health insurance fund to receive the services.”

*Drug rehabilitation centre professional,  
Estonia*

As seen in several countries, some advanced services aimed at substance users might include a mental health component. Conversely, purely psychiatric services rarely consider drug dependence within their realm.

## Specific mental health issues for people who use psychoactive substances

Some people enter the mental health care system because of an acute condition that requires hospitalisation (sometimes involuntary), such as when they experience

a substance-induced psychosis.

The insufficiency of competent psychiatrists is among the main challenges. Firstly, several countries in the region report the insufficient number of psychiatrists in general. Secondly, there are even fewer psychiatrists specialising in the issues related to substance use and drug dependence. Thirdly, it is even more difficult to find care for people with drug dependence, which has already negatively affected their social situation, etc. These people usually need low-threshold psychiatric care which is in absolute short supply, or practically non-existent with exceptions. Additionally, not every psychiatrist understands OAT or knows how to (or wants to) work with less motivated clients, people with dual diagnoses, etc. As seen in Estonia, drug dependence is briefly covered in colleges, but not enough. Additional training is provided by the Health Development Institute and training is provided by existing specialists within the organisation where the specialist works.

Due to the high prevalence of opioid drug use in the region, most state-funded services are targeted toward opioid users. Thus, harm reduction and other support for stimulant users are a challenge.

Health insurance is usually needed for patients to get mental health services; however, people who use drugs usually do not have health insurance.

## Specific mental health care for OAT clients

All four participating countries have OAT with the use of methadone in the form of syrup and buprenorphine represented as Suboxone or Subutex. An OAT prescription

is provided by either psychiatrists or narcologists. In Estonia, Moldova and Poland, the majority of programmes provide methadone while buprenorphine is used to a lesser extent. Both medicines are covered by government support in Moldova and Poland. In Estonia, methadone is paid for by the government, while the use of buprenorphine may require a fee.

Conversely, Czechia has many more OAT clients who use buprenorphine which, in the form of Suboxone, can be prescribed by either psychiatrists or general practitioners and partially paid for by health insurance. Other preparations that do not contain naloxone (Subutex, Ravata) are not covered by health insurance at all. Czechia also differs in terms of various modes of OAT provision. Models of OAT include (a) a basic care model; (b) a minimal care model; and, (c) a complex care model.

Admission to OAT programmes is subject to several criteria. There is an age limit (usually 18 years) which, however, differs by country and medicine used in a programme. Buprenorphine clients can be as young as 15 years old, as in Czechia. Confirmed opioid drug dependence is another strict criterion. Previous experience of drug treatment repeatedly without success, or a long drug use history, is usually also taken into account.

There are also several other common characteristics of opioid users which might be either considered a criterion or just a correlate. These often include concomitant diseases and health problems generated by intravenous use (hepatitis, septicemia, HIV/AIDS).

OAT programmes usually have rather strict rules which are hard to follow. These rules often become the obstacles that service users mentioned in interviews. The user

needs to show the desire to change their dependent behaviour; be in regular, usually daily, contact with the medical workers involved in programme; and stop the consumption of narcotic substances except for those used for substitution. Intoxication with alcohol is usually considered a reason to be excluded from a programme. Control of abstinence from drugs is conducted by means of urine tests.

All the countries have their national registries of people in their respective OAT programme in order to avoid people registering for more than one programme.

The regimen of participation in an OAT programme, with exceptions seen in some institutions, usually includes the initial period when a client has to attend the programme daily and get single doses. This period is used to establish the necessary dosage of the substitution substance and to reach stability in the client's wellbeing. After this initial period, which unfortunately might be a very long one, some clients are allowed to attend the programme less often. However, the conditions for this change are numerous and depend on the particular service, as observed in all participating countries.

The exclusion criteria are a substantial obstacle for OAT participants. It is very common for clients to undergo tests for the presence of drugs in their urine, which may result in exclusion from the programme.

Mandatory registration in the narcological registry (as well as in the mental health registry) is another challenge as it creates an obstacle to further employment, studying, driving and obtaining a driving license, etc.

All the countries have their national registries of people in their respective OAT programme in order to avoid people registering for more than one programme.

According to the results of the interviews with people who use drugs and are, or are not, in the OAT programme, the main barriers for people who use opioid drugs to join an OAT programme include the following:

01. Mandatory medical records and registration as a person who uses drugs;
02. Reduced psychosocial support for clients on OAT;
03. Employment restrictions, discrimination by employers, as well as travel restrictions abroad; and,
04. Limited access to OAT in medical facilities during inpatient hospitalisation.

The medical professionals working in the narcology system in Moldova have also added some other considerations to the challenges which people who use drugs face when entering OAT programmes:

01. Lack of interest of medical institutions to open OAT offices/sites;
02. Lack of narcologists in administrative-territorial units;
03. Insufficient funding by the National Medical Insurance Company (at least until 2019); and
04. Lack of funding from the National Medical Insurance Company for psychosocial support for clients undergoing OAT.

In terms of **mental health services**, OAT clients can be referred or self-referred in the same way as the general population, as described above. In Estonia, a referral letter to a psychiatrist is not required. A family doctor or a specialist (psychiatrist) can refer a person to a psychologist and a referral is not required for a paid consultation.

Mental health care is provided in Moldova to people with or without referral. The family doctor or another specialist can make the referral, but a person can go to the Community Mental Health Centre (CMHC) independently. CMHCs are public services and their services are covered by the National Programme for Mental Health (services plus some medicines) and some medicines are fully or partially covered by medical insurance.

In Poland, a referral is not needed to see a psychiatrist. To visit a psychologist, a person needs a referral from a general practitioner or other doctor. If an individual visits public facilities, or facilities with a National Health Fund, the visits are free and covered by medical insurance.

Usually, however, the advantage is that mental health care for clients of an OAT programme can be provided in the form of psychological and social support which is generally considered a natural component of such programmes. However, as in many other cases, this general rule might be followed differently in various individual programmes.

In Estonia, the OAT team is staffed by a psychiatrist (who prescribes substitution treatment) and clinical the protocol stipulates that the substitution treatment must include an assessment of various mental disorders as an integral part of the assessment of the client affected by opioid dependence.

Simultaneously occurring mental and drug dependence disorders must be treated together. Psychosocial care must be provided to all clients who receive substitution treatment with methadone or another drug. The most common psychological methods in drug dependence treatment are cognitive-behavioural therapy (CBT), motivational interviewing, and contingency management. Receiving psychological help is optional for the client.

Simultaneously occurring mental and drug dependence disorders must be treated together.

In Poland, the work and duties of psychologists in an OAT programme differs by site, but usually they conduct an initial screening with not much attention being dedicated to mental health.

In Czechia, a referral is usually not needed, with the client indicated by the substitution treatment centre itself. There are different ways of providing social and psychological support in these complex programmes. This can be done in the form of regular sessions with a psychologist, dependence specialist, psychotherapist, or social worker, or in the form of intensive case management. This varies according to the type of facility, the type of care provided and the needs of the client.

The client is examined by a psychiatrist (certified for OAT) before entering the service (and during the treatment), his medical history is taken, etc., so mental health screening is definitely happening. Specific psychological examinations are more likely to be indicated for individuals, as needed, to clarify the client's condition. The standards of substitution treatment do not impose an obligation of a psychological examination. Thus, psychologists may have a diagnostic role, but also only a counseling role according to the specific plan and therapeutic contract with the client.



According to the National Clinical Protocol, 'Pharmacological treatment of opiate dependence', adopted in Moldova, the medical and psychosocial support for people receiving OAT should include:

01. Psychological support services in the provision of group psychotherapy services for beneficiaries and their family members;
02. Mutual assistance groups ('peer-to-peer');
03. Information programmes;
04. Psychological and psychiatric assistance services in the diagnosis and treatment of mental disorders;
05. Social assistance services in solving livelihood problems, assistance in the employment process, solving legal issues and overcoming discrimination, etc.

Although OAT programmes have been shown to be effective in improving various aspects of the health and life of their clients, the existing rules do not take into account the specifics of programme clients and diminish their potential for positive impact.

Clients of OAT programmes constitute the most vulnerable population of all those mentioned thus far. About half of such people have serious psychiatric comorbidities, to mention just those that meet diagnostic criteria for established psychiatric diseases and personality disorders. Those with early traumatic disorders might constitute the absolute majority of people in OAT programmes. These comorbidities make these people especially vulnerable to the barriers of programme retention. Inclusion and exclusion criteria applied to OAT

programmes in most countries of the region create an additional set of barriers that are hard to overcome.

Although OAT programmes have been shown to be effective in improving various aspects of the health and life of their clients, the existing rules do not take into account the specifics of programme clients and diminish their potential for positive impact.

It is extremely commendable that many programmes in the involved countries have actually established their own mental health services, and this work is recommended to be strengthened and made the foundation for the provided substitution treatment.

## Mental health care for NPS users

In all four countries, new psychoactive substances (NPS) use does not appear to be considered as a premise for treatment provision, but rather as an emergency and regulation issue.

In Estonia, patterns of fentanyl use is seen, with hundreds of overdose deaths. This characterised fentanyl substances as 'low use but high risk/harm'. Evidence shows that Estonia stands out as having an endemic problem, while the use of fentanyls in other European countries appears to be geographically localised<sup>88</sup>. In Poland, NPS use was found to be one of the new ways of committing suicide<sup>89</sup>.

A number of potential harms from NPS use include paranoia, panic attacks, convulsions, overdose, unprotected sexual intercourse, physical and mental exhaustion, and psychotic conditions; strokes and heart attacks could occur as a result of high blood pressure when using synthetic drugs. Other reported harms include unsafe injecting practices (heightened due to the frequency of injecting NPS), injection-related vein damage and bacterial infections, and a risk of blood-borne virus transmission<sup>90</sup>. Non-medical risks of NPS use included police pressure applied to people who use NPS in order to turn consumers into informants.

Respondents in all countries described concerns about the dangers of NPS overdose and described various physical and psychological symptoms. 'Salts' overdose could cause agitation, confusion and loss of consciousness, fever, fluctuating blood pressure, increased heart rate and pressure, and pain in the chest area. Their mental state was characterised as aggressive and panicked. Death could have occurred either from heart failure or cerebral edema.

Despite the common experience of overdose risk and the lack of medically appropriate responses, respondents in most countries expressed a reluctance to call an ambulance due to the impact of repressive laws and policies. Only in Moldova and Georgia did people who use drugs identify calling an ambulance as a standard overdose response.

There are no specific services for NPS users, but they can use all the services which are intended for people affected by drug dependence. In Moldova, there is a roll-out of training for staff working with clients affected by drug dependence on the implementation of the national clinical protocol, 'New substance use disorders with psychoactive and stimulant properties in adults and adolescents'. The training is provided to dependence specialists,

Only in Moldova and Georgia did people who use drugs identify calling an ambulance as a standard overdose response.

88 Mouteney J, Giraudon I, Denissov G, Griffiths P. (2015). Fentanyls: Are we missing the signs? Highly potent and on the rise in Europe. *Int J Drug Policy*. Jul;26(7):626-31. <https://doi.org/10.1016/j.drugpo.2015.04.003>

89 Lasota D, Mirowska-Guzel D, Goniewicz K. (2021). Analysis of Suicide Methods and Substances Influencing the State of Consciousness of Their Victims in Poland. *Int J Environ Res Public Health*. May 6;18(9):4936. <https://doi.org/10.3390%2Fijerph18094936>

90 Kurcevič E, Lines R. (2020). New psychoactive substances in Eurasia: a qualitative study of people who use drugs and harm reduction services in six countries. *Harm Reduct J*. Nov 30;17(1):94. <https://doi.org/10.1186/s12954-020-00448-2>

Among those services which might be most helpful (but are not explicitly intended for NPS users) are harm reduction programmes in nightlife settings (provided in Croatia, Georgia, Lithuania, Serbia, Slovenia and Ukraine). These services are functional in Czechia where they are targeted at dance event attendees, and Poland; similar services are planned to be piloted in Estonia. In several other countries of the region, services for NPS users are available in the form of drug checking and counselling<sup>91</sup>.

There are also no services for testing substances in any participating country, though in Estonia and Poland there are a few initiatives where people can test their substances themselves. One more specific service is provided by the Psychedelic clinic in Prague, where they focus on the use of psychedelic substances in mental health care, but also on working with people who use psychedelics recreationally, helping them to integrate the challenging psychedelic experience. 'psychological help for complications and issues that may have arisen out of previous use of psychedelic substances' (PSYON, n.d.)

## Mental healthcare provision to refugees during war

Conditions of providing healthcare to people displaced from Ukraine because of Russian aggression are rather similar in many countries of the region, but the details might differ and change over time.

In four studied countries, the refugees are subject to public insurance which is provided free of charge. However, the duration of this insurance might differ. Urgent care is also provided to refugees with no health insurance, which is seen in all four countries.

Refugees can visit any health facility, rules for which are the same as for citizens, and essential medical care is guaranteed for them. Essential dental care is also mentioned as guaranteed; however, there are differences with regard to what is included and how urgent the case should be. The period of health insurance protection in Czechia at the time of data collection (September-October 2022) was set at 150 days after which it is required to sign up for insurance and to pay for it as standard. If a refugee is covered by public health insurance, has commercial insurance, or can pay for their own treatment, then they can – in principle – visit any health facility. As observed in Moldova, this help is stated to be free of charge for refugees. Refugees can approach any public mental health services in the country and they will receive the necessary care, free of charge. Unfortunately, psychiatric medicines are not financially covered for refugees. According to the Estonian Health Board, all war refugees arriving from Ukraine are guaranteed essential medical care, including essential dental care. Urgent medical services are free for Ukrainians. Starting in March 2022, all services financed by the National Institute of Health Development, aimed at people affected by drug use, HIV

Refugees can visit any health facility, rules for which are the same as for citizens, and essential medical care is guaranteed for them. Essential dental care is also mentioned as guaranteed; however, there are differences with regard to what is included and how urgent the case should be.

91 Stöver H. (2022). Regional analysis of the provision of drug checking services in the Central and Eastern Europe and Central Asia region. Vilnius; Eurasian Harm Reduction Association. <https://ehra-uploads.s3.eu-central-1.amazonaws.com/dbd39b8d-b541-40fb-9534-7554b282f207.pdf> (accessed 28 May 2023).

and tuberculosis, will also be open to war refugees. The services are free for those in need.

Access to health services depends on the legal status of the immigrant; different groups of immigrants have different legal rights. In Poland, immigrants with regular residency status have the same conditions for access to medical care as Polish citizens;

All four countries have governmental and non-governmental webpages that inform which psychologists and psychotherapists are ready to work in the Ukrainian or Russian languages.

foreigners applying for international protection, on the other hand, have free access to basic health care provided by doctors employed in the centres and outpatient healthcare only in selected facilities and on the basis of a referral issued by a doctor working in a refugee centre. By far,

undocumented migrants are the group of people whose access to medical services is most difficult. They have free access only to emergency medicine, while all other services require full payment<sup>92</sup>. Citizens of Ukraine who have arrived in Poland since 24 February 2022 are entitled to medical benefits and reimbursement of medicines on analogous terms to those insured in Poland; this includes antiretroviral treatment and OAT programmes.

In some countries (in Czechia and Estonia, in this case), there is a specific administrative body for the registration and insurance of refugees from Ukraine. In Czechia, Regional Centers (KACPU) have been established as coordination bodies where people from Ukraine can get 'one-stop services': register, apply for temporary protection, and obtain health insurance.

Poland, Estonia and Czechia have established telephone helplines for refugees from Ukraine and consulting on health care for citizens from Ukraine in Czech, Ukrainian and Russian languages. The establishment of telephone helplines has proven to be very useful. Other helplines are also set up by NGO's that can help with more specific topics, such as drug dependence or social care. There are also 'crisis helplines' where it is possible to get psychological support.

Ukrainians in Poland are eligible to use Mój obywatel (my citizen) and Mój Pacjent (my patient) online applications. These are services that offer mobile versions of documents in the form of digital services, that allow the monitoring of treatment, the making of appointments with doctors, and to apply for vaccinations. Adults can create profiles online but minors (children over 13 years old can create accounts) must visit the office.

**Mental health services** for refugees are provided, depending on the country, by psychologists and psychotherapists, psychiatrists, and mental health nurses.

In Estonia, for mental health issues, a person using drugs can contact a mental health nurse for phone or online counseling. Psychotherapeutic services are provided by Czech health professionals in person and online, not only in Czechia but also directly in Ukraine. The support network is also provided by many volunteers who help people from Ukraine to orient in an unfamiliar country.

92 Jabłecka B. (2012). Strukturalne i kulturowe bariery w dostępie imigrantów do ochrony zdrowia [Structural and cultural barriers to immigrant access to health care]. Warszawa; Instytut Spraw Publicznych. In Polish. <https://www.isp.org.pl/uploads/drive/oldfiles/B.JabeckaStrukturalneikulturowebarierywdostpieimigra ntwdoochronyzdrowia.pdf> (accessed 28 May 2023).

All four countries have governmental and non-governmental webpages that inform which psychologists and psychotherapists are ready to work in the Ukrainian or Russian languages. The Czech Association of Psychotherapists emphasises the education of professionals in the field of post-traumatic issues and also brings together psychotherapists working in the Ukrainian or Russian language. Information and contacts for psychologists who provide help covered by health insurance are available on the web of the Ministry of Homeland Security.

With regard to the language in which healthcare services are provided, there is a difference between former soviet Moldova and Estonia which have services in the Russian language, on the one hand, and Poland and Czechia, on the other, which have at least some places for health services in the Ukrainian language. So-called 'UA points' have been established in Czechia as places which provide emergency medical services in the Ukrainian language, of which there are 24 of these medical points located in more than half of the Czech regions.

All four countries provide OAT programmes for refugees from Ukraine if needed. From the moment when refugees began to enter the territory of Moldova, a coordination group was created, including representatives of the drug dispensary and the non-governmental sector in which a mechanism was built and standard procedures developed. In this regard, it was decided that service provision will be ensured for refugees on OAT following the recommendations of the national clinical protocol. Based on the national protocol, an exception was made that the refugees would be able to receive methadone or

buprenorphine for a seven day supply in case they leave Moldova and need the medicine to be available until their next destination. In Moldova, interviewees reported that about 15 beneficiaries of the OAT programme from Ukraine has approached the service in Moldova. OAT programme users from Ukraine have the same basic needs and problems as any other refugees, including PTSD, a high level of anxiety, the need for shelter and food, insomnia, etc. However, none of the services available are known to address any mental health issues, although some have received psychological counselling at the narcology level.

While demand for drug services from those displaced from Ukraine has been modest, potential barriers to providing care include linguistic and cultural barriers; administrative preconditions for accessing services without charge; limited OAT medication quotas and supplies in some bordering countries; difficulties in determining OAT medication equivalents between those commonly prescribed in Ukraine and those prescribed in the host countries; ensuring continuity of care to those in a temporary situation or in transit within the EU; stigma resulting in a reluctance to disclose drug use and to seek help; child protection fears resulting from the disclosure of drug use; and uncertainty for service providers around funding and reimbursement for services delivered. In addition, responding adequately and ensuring continuity of care is made more challenging by the pre-existing low availability of OAT and harm reduction services in many of the countries bordering Ukraine<sup>93</sup>.

Responding adequately and ensuring continuity of care is made more challenging by the pre-existing low availability of OAT and harm reduction services in many of the countries bordering Ukraine.



## Mental healthcare provision impacted by the COVID-19 pandemic

Various mental health problems and coping strategies emerged in the context of the COVID-19 pandemic.

Comparison with earlier population reference data indicates an increase in stress levels (especially among younger age groups) by the second quarter of 2021. Findings from the qualitative study revealed that an information environment characterised by rapidly changing and frequently conflicting narratives further affected mental health during the crisis<sup>94, 95</sup>.

Several common changes were observed during the COVID-19 pandemic in all, or most, of the participating countries. The most important finding is that because of

One of the challenges was to provide services online to people who were not connected to the internet or were unable to access the online platforms (such as the elderly or people in difficult socio-economic situations).

the crisis, innovative approaches needed to be developed for service provision that were then maintained even after the elimination of pandemic restrictions. One of the immediate outcomes was that in most European countries, traditional face-to-face visits were replaced by online remote consultations. Distance care and online counseling have been introduced or made more widespread than before. One of the challenges was to provide services online to people who were not connected to the

internet or were unable to access the online platforms (such as the elderly or people in difficult socio-economic situations). Introducing online counseling also required financial resources to buy equipment, which was not included into existing budgets.

There was a decline in the availability of psychological support, daycare services, and some activities stopped. Programmes had restricted visits. Together with increased demand, restrictions in providing consultations led to a decline in the availability of psychological support.

In three of the four countries, special telephone hotlines were established. In Czechia, this was originally set up to provide practical information, but at the same time, the ability to use the helpline to share concerns and get answers to questions proved to be an important factor in maintaining mental health in terms of reducing anxiety and worries.

Standard crisis and counseling helplines had to expand their working hours or the number of calls served, while staff capacity was a limiting factor.

Psychiatric care was partially transferred or limited to telephone consultations and e-prescribing (sent by text message), and psychotherapy started to be provided as e-consultations. 'E-mental health' is a promising service option for the future and can help manage the increase in patients with mental health problems.

94 Tervise Arengu Instituut. (2022). Tugiteenused Ukraina Sõjapõgenikele [Support services for Ukrainian refugees]. In Estonian. <https://tai.ee/et/uudised/tugiteenused-ukraina-sojapogenikele> (accessed 29 May 2023).

95 Eesti rahvastiku vaimse tervise uuringu konsortsium (2022). Eesti rahvastiku vaimse tervise uuringu lõpparuanne. Tallinn, Tartu; Tervise Arengu Instituut, Tartu Ülikool [Estonian population mental health survey]. In Estonian. <https://tai.ee/sites/default/files/2022-06/Eesti%20rahvastiku%20vaimse%20tervise%20uuring.pdf> (accessed 29 May 2023).

OAT programmes in many countries reported providing clients with substitute medicines for several days.

Significant changes applied to all methadone and buprenorphine dispensing sites. Some facilities allowed methadone to be distributed through family members if the client could not attend personally due to illness (an official paper was required).

Some services, as mentioned in Estonia for example, started providing methadone at home, in hospitals, and in psychiatric clinics. After the delivery method was introduced, and it became clear that such remote monitoring is suitable for certain patients, there is now a mobile application that allows patients to shift from “direct observed treatment” to “video observed treatment”. The application is designated for patients who have difficulties getting to OAT sites for various reasons.

OAT programmes in many countries reported providing clients with substitute medicines for several days. For example, as

mentioned in an interview in Estonia, “OAT centres provided clients with methadone for several days to ensure the health of clients and employees as much as possible.” However, it gradually became clear that this is not really suitable for all clients because 30-40% of clients still needed daily contact with a doctor, a psychosocial worker, and not only a phone consultation.

Some OAT facilities introduced a special regimen of distribution so that every client comes in one’s own time, with 15-minute intervals between clients so that they do not crowd within a facility, as was observed in Poland. During the pandemic, there was a more limited possibility to access OAT services as often, as was necessary for people living in rural or remote areas, as observed in Moldova.

Many services kept working despite the lack of required staff. As the study conducted in Estonia revealed, during the spring emergency of 2020, there were relatively few who missed mental health services **(only 5.5% of adult respondents)**



Nearly

**80%**



of respondents did not realise the need for help or the obstacles to receiving help.

In turn,

**70%**



of those who needed help at some point solved the problems themselves<sup>96</sup>.

To prevent the spread of infection, it was temporarily forbidden to provide counseling services outside the health sector during certain periods of the pandemic. Some of the activities have been stopped, such as the Patients' Club, to minimise contact between patients. During the lockdown, there were no admissions to most programmes as this involved a diagnostic visit. However, harm reduction services mostly kept working and syringe exchange services in most places did not stop.

“

It has been clear that our services must continue, the availability of services was 100%. We used personal protective equipment. We also have an opportunity to give methadone at home, or we have also had a loved-one come to pick up the medicine based on an official paper. Furthermore, we also brought methadone to the hospital and psychiatric clinic. Meetings are online, meeting through a video bridge, which is very convenient. We also have a separate area for the client so that if the specialist is not present, but the client wants to communicate with the specialist, they can use a video bridge. Many people agree to get a consultation through the video bridge, most of our clients have smartphones.”

*A healthcare provider working  
in an OAT programme*

One of the greatest sources of stress for healthcare workers during the pandemic was constantly changing processes related to work organisation and environment. The source of additional tensions was a lack of doctors and nurses, so it might have been necessary to work in several departments or healthcare institutions at the same time, resulting in professional burnout<sup>97</sup>.



# Barriers influencing access to mental health care

As mentioned in earlier sections of this report, barriers hampering optimal access to, or impacting the provision of, relevant mental health care services for the selected target groups were identified and analysed based on a concept joining levels of an ecological perspective model with components related to information, attitudes, activities and resources.



Table 1. Summary of barriers influencing access to mental health care for the general population and key affected populations

Level	Components			
	Information	Attitudes	Activities	Resources
<b>Public policy at supranational level</b>	Technologies considered best practices	Values of human rights and quality of life	International events to share effective approaches	Experts ready to share knowledge and technologies
<b>Public policy at the national level</b>		Understanding of substance use and drug dependence by psychiatrists	<ul style="list-style-type: none"> <li>→ Drug laws and their enforcement;</li> <li>→ Criminalisation of substance use;</li> <li>→ Human rights restrictions</li> </ul>	
<b>Societal level</b>	<ul style="list-style-type: none"> <li>→ Information campaigns;</li> <li>→ Health literacy;</li> <li>→ Medication;</li> <li>→ Lack of knowledge about available help;</li> <li>→ Misconceptions regarding psychiatry;</li> <li>→ Misconceptions regarding medication and treatment</li> </ul>	<ul style="list-style-type: none"> <li>→ Stigma of both patients and service providers,</li> <li>→ discrimination, inclusion, etc.;</li> <li>→ Blaming of certain services;</li> <li>→ Socially-excluded localities and population groups</li> </ul>	Legal barriers	Social well-being
<b>Professional community level</b>	Education, information, knowledge and skills of the professional community	<ul style="list-style-type: none"> <li>→ Ideas and beliefs;</li> <li>→ Research-related barriers;</li> <li>→ Insufficient use of evidence-based solutions</li> </ul>	Whether professional community and related NGOs try to change the situation	Resources and capacities of professional NGOs



Level	Components			
	Information	Attitudes	Activities	Resources
<b>Institutional and organisational level</b>	<ul style="list-style-type: none"> <li>→ Technologies, protocols, and treatment options;</li> <li>→ Outdated approaches;</li> <li>→ Abstinence-based paradigm;</li> <li>→ Lack of drug-checking services</li> </ul>	<ul style="list-style-type: none"> <li>→ Mission and vision;</li> <li>→ How the service-user is considered;</li> <li>→ Paternalistic approach;</li> <li>→ Lack of client-centred approach;</li> <li>→ Stigmatisation</li> </ul>	<ul style="list-style-type: none"> <li>→ Regulation and processes;</li> <li>→ Logistics and service streamlining;</li> <li>→ Lack of service coordination and multidisciplinary referrals;</li> <li>→ Over-regulation of entry requirements to certain services;</li> <li>→ Excessive regulatory requirements that hinder the establishment of the needed services;</li> <li>→ Poorly organised or missing a referral system;</li> <li>→ Lack of service integration</li> </ul>	<ul style="list-style-type: none"> <li>→ Capacities;</li> <li>→ Quantitative characteristics;</li> <li>→ Number of employees, clinics, etc.;</li> <li>→ Quantitative workforce barriers;</li> <li>→ Lack of mental health professionals, and a high overload of work;</li> <li>→ Financial barriers;</li> <li>→ Out-of-pocket payment issues;</li> <li>→ Waiting-time barriers;</li> <li>→ Transportation issues;</li> <li>→ Geographic distribution and accessibility of services</li> </ul>
<b>Interpersonal level</b>		<ul style="list-style-type: none"> <li>→ Myths spread in social networks;</li> <li>→ Mutual stigmatisation</li> </ul>	<ul style="list-style-type: none"> <li>→ Contacts between health professionals and patients;</li> <li>→ Language barriers</li> </ul>	
<b>Individual, or intrapersonal level</b>	<ul style="list-style-type: none"> <li>→ Misconceptions regarding health, treatment, substance use;</li> <li>→ Fears of drugs and medicines</li> </ul>	<ul style="list-style-type: none"> <li>→ Self-stigma;</li> <li>→ Masculinity</li> </ul>	Motivation-related barriers	<ul style="list-style-type: none"> <li>→ Social determinants of health;</li> <li>→ Difficulties related to the change of place of residence;</li> <li>→ Poverty;</li> <li>→ Housing</li> </ul>

Following are more details on key barriers, with a focus on people who use drugs, with responses from interviews collected during the research.

## 01. Lack of holistic, client-centred approach to drug dependence and mental health treatment

One of the biggest systemic barriers mentioned is a lack of an holistic, client-centred approach toward working with patients with dual diagnosis or people who are using drugs and experiencing mental health problems and trying to seek appropriate help.

The system of services for people who might experience mental health problems is divided into two spheres. Some services are set up as social services and some as health services. Although the two spheres overlap in the scope of work, this affects the range of care provided.

“Provision of mental health services and drug dependence in the Republic of Moldova are separate systems. This situation is inherited from the times of the Soviet Union in which psychiatry and narcology were separate systems.”

*Report from Moldova*

The issue of dual diagnosis – no matter whether officially established or not – appears to be problematic in all involved countries as only a few facilities deal with patients with co-occurring diagnoses. The use of psychoactive substances is often a form of self-medication – coping with mental illness and disorders, the experience of trauma, and violence.

“The division between the psychiatric treatment system and the drug dependence treatment system is very visible today and causes problems, such as with the treatment of people

with dual diagnoses. In 1997...health funds were introduced...facilitating competition between the treatment facilities. As a result, the system faces a lack of cooperation between different service providers and a competitive attitude between them”.

*Report from Poland*

“There is no facility for double diagnosis (drug dependence and mental health). It is a well-known phenomenon that the consumption of psychoactive substances leads to major mental health disorders and vice-versa. It often happens that patients are being transferred from one service to another.”

*Report from Poland*

As was observed in Czechia, a lack of multidisciplinary interconnected teams creates problems for an all-inclusive approach toward patients and even people working with one patient do not exchange information about them and do not cooperate in their treatment.

“We're not very connected overall, we don't know much about each other. In my opinion, mental health services, services for homeless people, and services for people who use drugs don't interact enough. I don't know

about any regular meetings going on, it's more about those contacts that particular caseworkers build up on their own initiative. But I am not aware of any systematic networking. It seems to me that each service keeps their clients and tries to provide holistic and integrated care, but the interconnectivity between the particular parts of the mental health care system isn't quite there."

“ This is a big problem, because most of these patients are also under psychiatric treatment; therefore, without having some contact with the doctors, it is also difficult to consult with them, to discuss something, even though it is a counseling centre and a lot of people work there, it is not teamwork. There is no place to meet, no social room, no opportunity to exchange experiences, and no opportunity to discuss the patient...”

*Psychotherapist working in a public mental health clinic, Poland*

As reported from Czechia, in recent years, practically all available drug services have been adapted to treat dual diagnosis. Conversely, in services that focus on non-dependence diagnoses (such as in facilities focusing on psychotic, anxiety, or affective disorders, for example), a co-existing drug dependence diagnosis is an absolute contraindication in most cases. This represents a significant barrier to people who use drugs entering the mental healthcare system.

Therefore, the treatment of dual diagnosis most often takes place in drug dependence services or in several facilities at the same time. Another option is a 'sequential' treatment, which means that one of the mental health conditions is treated first (typically the one that is more acute) and after its stabilisation is the focus put on the others<sup>98, 99</sup> (Kamenová, 2017; Torrens, Mestre-Pintó & Domingo-Salvany, 2015).

It is problematic that mental health issues are often viewed only from a medical perspective. More and more programmes are being developed that provide truly holistic care, but this is not yet the norm in all areas, as confirmed by the experts interviewed:

“ The concept of mental health is still burdened with a medical view of the person, even when we say the word 'patient'. The care is very much focused on medical conditions and the other issues (social, spiritual, psychological) are neglected. That's a deficit in our system.”

*Mental Health expert, Czechia*



98 Kamenova, 2017

99 Torrens, Mestre-Pinto & Domingo-Salvany, 2015

## 02. Lack of mental health professional staff

Due to the lack of mental health professionals, there is a high overload of work and psychiatrists and/or psychologists tend to refer the patients that they consider as ‘not our clients’ to the narcologists. Sometimes narcologists are seen by their psychiatry peers as ‘a little bit less qualified psychiatrists’.

“**Opioid drug dependence substitution treatment centres do not offer treatment for mental health, the person has to go to several different places where the work is organised differently in each place and, at some point, it becomes difficult for them to manage it all, and the more difficult a person’s mental health problem is, the more difficult it is to cope with this variety of services.**”

***Health authority professional in charge of substance use services, Estonia***

One of the barriers preventing people from getting treatment is the availability of professionals and the competencies of the professional community, including such issues as education, knowledge and attitude.

The lack or insufficiency of qualified drug dependence treatment specialists is a known obstacle to prescribing medications and other needed services<sup>100</sup>. **Specific manifestations of this barrier might be various, including the:**

- Absence of needed health professionals in healthcare institutions;
- Lack of necessary medical or nonmedical personnel; and/or,
- Uneven distribution of personnel across the country, the lack of personnel in some areas.

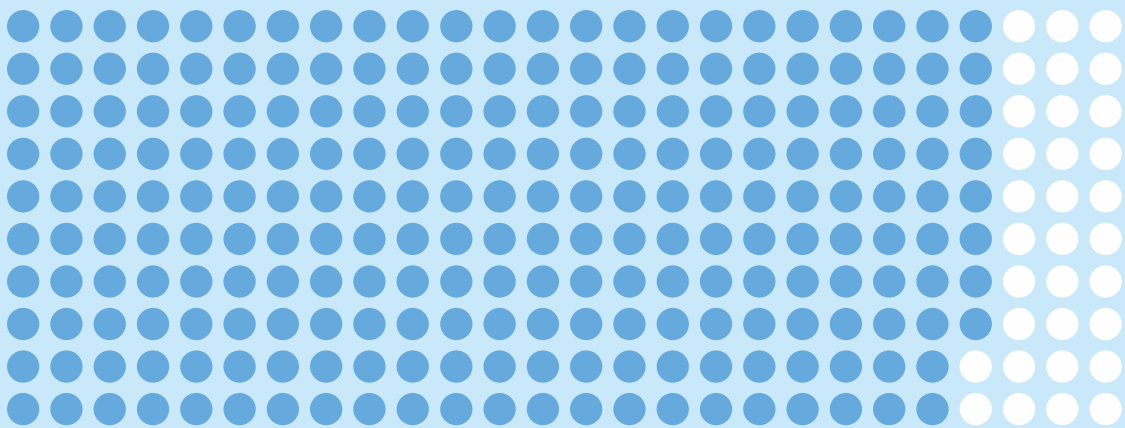
“**There are psychiatric hospitals run by the state where there is no supervision, the staff is overloaded and burnt out. There’s a shortage of doctors, they’re often overwhelmed with work...it can lead to the shortening or speeding up of some important interventions. So, for example, people who need psychotherapy are medicated with benzodiazepines or antidepressants, even if other forms of help might be more appropriate for them.**”

***Healthcare professional working in a NGO, Czechia***

100 Haffajee RL, Andraka-Christou B, Attermann J, Cupito A, Buche J, et al. (2020). A mixed-method comparison of physician-reported beliefs about and barriers to treatment with medications for opioid use disorder. *Subst Abuse Treat Prev Policy*. Sep 14;15(1):69. <https://doi.org/10.1186/s13011-020-00312-3>

The case of Estonia shows that there are 228 psychiatrists working, while the optimal number of psychiatrists is estimated to be 260.

Thus, **32 psychiatrists** are assessed to be currently missing.

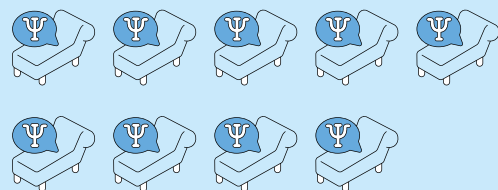


In Poland, according to the Supreme Chamber of Physicians<sup>101</sup> (Nil, 2020),

**4,274**  
practicing psychiatrists

(plus 455 child and adolescent psychiatrists) are available.

This is one of the **lowest numbers** of psychiatrists in the EU relative to population size<sup>102</sup>



101 Nil, 2020

102 Eurostat, 2017

In Moldova, due to the fact that there is a lack of medical personnel, narcological – both doctors and nurses – patients feel a lack of continuous dialogue. There is also a lack of mental health professionals in public institutions (in fact, there is a lack of medical professionals in the entire system and the exodus of doctors is one of the biggest concerns in the country).

With regards to psychiatrists and general practitioners at the primary level, their knowledge about psychology, psychotherapy, and harm reduction might be limited. This comes from the lack of appropriate training, such as programmes hardly covering the harm reduction approach, and medical studies (including specialisation in psychiatry) do not give enough space to psychology or psychotherapy.

“The issue is still that the subject of drug dependence is not taught in universities, the education side is still weak. The National Institute for Health Development is trying to do basic training for people who work in the drug dependence field, but they cannot take on all the teaching too”.

*Harm reduction service provider, Estonia*

“There is a lack of employees who know how to work and want to work with people dependent on drugs. There are no specialisations in this field at universities, and training is difficult to access or does not exist at all. If we employ a new person in our centre, the training takes place on-site, and it is definitely an additional burden on the existing workforce.”

*Drug rehabilitation centre service provider, Estonia*

Skills of the professional community are also reflected in how the interaction between health professionals and patients develops. In several reports and interviews, it was described as a difficulty in finding a service provider who meets the client's expectations.

“Psychiatrists are currently the backbone of the provision of both mental health support and substitution programmes, yet they are identified as a group lacking empathy, often abusing their power, marginalising the importance of psychologists or psychotherapists. Sometimes their communication with patients is weak (people are afraid to ask them questions, psychiatrists don't explain how to take medicines); patients also point to short visit times which doesn't allow them to discuss their issues.”

*Health care worker, Poland*





## 03. Stigmatisation and self-stigma

The problem of stigma has been mentioned numerous times in publications and reports in its various aspects: stigma associated with turning to mental health care; the stigmatising attitude of health professionals; and self-stigma of people experiencing mental health problems and considering looking for help.

“Stigmatisation and discrimination are something that is found everywhere. So, you could say that the system is not effective. But in our case, this stigmatisation makes it difficult for users to get through even to this ineffective system, which offers very temporary help. And this is the real drama. [...] This is something that permeates all spheres of social life to the core.”

*The head of a harm reduction organisation, Poland*

Health professionals appear to ascribe lower status to working with substance users than helping other patient groups, particularly in primary care; the effect is larger in some countries than others<sup>103</sup>. International studies that focus on primary care and drug dependence within the mental health sector suggest that healthcare professionals' knowledge and attitudes regarding substance use and substance users may negatively influence the care that these patients receive<sup>104</sup>.

People with mental health issues and people who use drugs are being stigmatised. The stigma comes from the general population, but also from mental health/drug dependence treatment providers.

“What is particularly alarming is the fact that oftentimes stigma comes from the people who provide services.”

“It was noted that psychiatrists don't want to work with people who use drugs and in methadone programmes.”

“I have a colleague...and he hates drug users. He is a narcologist and he hates them. I just don't understand this.”

*A narcologist, Moldova*

Unfortunately, one of the key groups that stigmatises patients are psychiatrists who are indicated as the least emphatic group, with a large sense of superiority, overusing their power. This is in line with the attitude of doctors working with patients (especially patients who take drugs) – doctors might be upfront hostile, show a lack of interest, treat people instrumentally, and shorten visits. Patients are not involved in the process of treatment - they are being told what to do. Another problem reported by people who use drugs is a lack of trust in doctors, psychotherapists, therapists and psychologists who often share confidential information with others.

103 Gilchrist G, Moskalewicz J, Slezakova S, Okruhlica L, Torrens M, et al. (2011). Staff regard towards working with substance users: a European multi-centre study. *Addiction*. Jun;106(6):1114-25. <https://doi.org/10.1111/j.1360-0443.2011.03407.x>

104 Kelleher S. (2007). Health care professionals' knowledge and attitudes regarding substance use and substance users. *Accid Emerg Nurs*. Jul;15(3):161-5. <https://doi.org/10.1016/j.aaen.2007.05.005>

“ I could see that doctor didn't really want to talk, even though she had a positive rating and good education, additional courses indicated that with her knowledge she is up-to-date. I was telling her about my symptoms, and I could see that she was seemingly listening, but she's already got a prescription written out, and she was telling me when to come next, adding 'there's not really time to talk in-depth, it's not how this facility works. We're here to select medications and see if these medications are working and if things are better or worse after these medications.'”

***Mental health care patient, Poland***

As reported in Czechia, access to general mental health services is often difficult for people who use drugs or those who are in OAT. The provider of drug services remarked, “People with dual diagnosis are among the most complex clients, and they are also the most marginalised...There are a number of facilities where people are excluded on the basis of drug use, even though they suffer from other mental health problems. This is an important structural problem because people are then unable to use these services, even though they are entitled to them and would benefit from them. Whether it is sheltered housing, crisis intervention centres, and so on...too many facilities, it is a condition not to use addictive substances in various social care and support services.»

One of the strongest expressions of stigma is attached to mental illness itself. Representatives of the majority in society demonstrate prejudice towards psychiatry. The shame of visiting a mental health professional is a related issue.

“ They kept asking me what I was doing there. They were nice to me, but they asked me what I was doing in psychiatry if I had a college degree and looked fine.”

***A patient, Czechia***

There are misconceptions that the psychiatric services are 'dangerous', 'risky', 'you never know what they will administer to you', and other similar ideas. The general population avoids accessing mental health services as well, as there is no cultural or habitual practice to go to a mental health professional. People use informal sources of help – friends, colleagues, and families, or simply ignore any mental health symptoms. In Moldova, all nine interviewed people who use drugs (including two persons from Ukraine) reported that they have never gone to a public mental health service. Most of them declared that they do not need these services, as “they are their own best psychologist” and “nobody can understand and solve my problems better than myself”. However, in the discussion, the fear of stigma and self-stigma were revealed.

Stigma related to mental health system beneficiaries is relatively high in various countries, but a double diagnosis brings double stigma or quite often intensifies a self-stigma. In discussions with interviewees, mental health professionals and narcology professionals commented that most people who use drugs have a high level of self-stigma, this being aggravated in cases where there is a mental health need.

“ I am a drug user, and now a 'crazy' drug user?!”

Low public awareness of various mental health problems and the stigma associated with the use of psychiatric medication can become a barrier to

appropriate treatment. It might be accompanied by a search for alternative treatments or various self-medication techniques and strategies. Rituals with ayahuasca, nature-based therapies, or dark therapy were given as an example.

“ Even the use of these drugs means further stigmatisation, it is common that people refuse the meds...But what is happening is that it is being talked about more in society, in the media, and even politicians admit that they take SSRI drugs. That was something unimaginable until recently. And it's important that publicly known figures talk about it too. Maybe even about attending psychotherapy.”

*A health professional working in a mental health institution, Czechia*



## 04. Low accessibility of mental health services: geographic, information and social factors

A further set of barriers mentioned by the researchers and respondents is the accessibility of services and different factors which influence or affect the optimal access towards receiving services.

Some mental health services are provided only in big cities or towns, the access to which might be problematic – especially if one has to visit a mental health provider frequently. Access anticipates traveling, which requires time and money.

“ In addition to a psychiatrist, I also went to a psychologist, [...] and the services were located in different cities. I had to drive there, [...] because it would have been difficult to get to the service on time by bus. If I no longer had a driving license, my stepfather had to pick me up and take me and wait for me [...], but he wasn't willing to wait 2.5 hours.”

***A client who uses drugs and alcohol, Estonia***

As reported in Czechia, in some regions mental health care services were found to be hardly accessible. For people without a car or who are otherwise immobile, this makes receiving care completely inaccessible. Some OAT clients from remote locations have to travel for appropriate care, often even more than 100km's.

People living in socially excluded localities also face barriers to accessing services. Although NGOs try to cover these areas at least partially with the necessary services, people living in these localities are often socially excluded and at risk of poverty. Therefore, there is often less access to education, but also to medical, psychological, and social care, which leads

to negative health and social consequences. For example, the situation with the Roma community in Czechia with exclusion from social and medical services has been the same for many years and has deep roots in Czech society.

Limited offers in small towns also threaten anonymity – in small towns, people know each other, and there is a fear of rumors, which can deter people from getting help.

“ Even if the services are available somewhere locally, these environments are so close, they know each other so well, that it is difficult to achieve the effect of anonymity. Consequently, people prefer to go to big cities anyway, which impacts the frequency of meetings or the distances to be covered.”

***A psychotherapist, Poland***

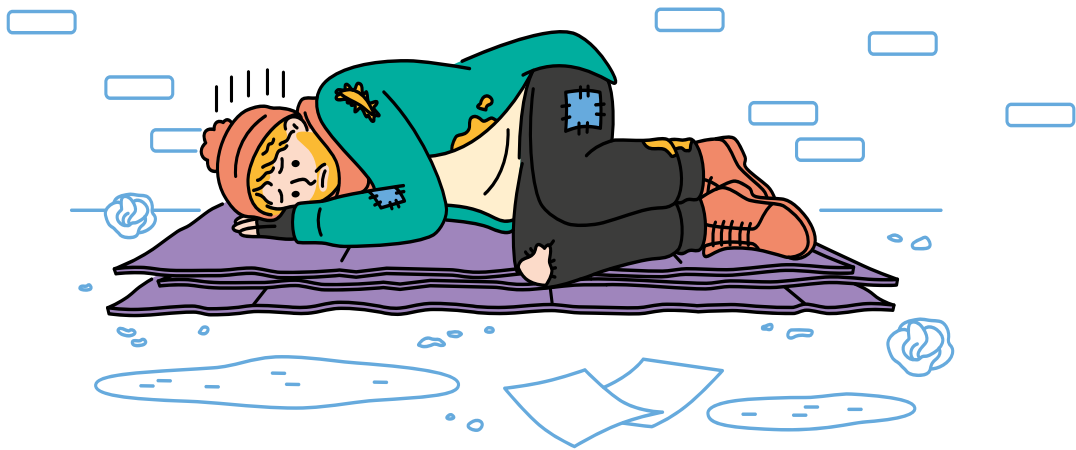
Another aspect can be problems with receiving updated and truthful information on services. As seen in Poland, a barrier might be related to a lack of, or insufficient information regarding, the treatment, such as where the services are situated and what treatment methods and services are available. Also, the information about the services is oftentimes limited. Websites either do not provide sufficient information, the information is outdated, or the design of the website makes it difficult to find relevant information.

Homelessness is also directly linked to poor access to the mental healthcare system. Commonly provided state health services are no longer available to such people. They are more likely to use social services for

the homeless where care is primarily socially focused and there is no guarantee that professionals trained in mental health and drug dependence work there. That was pointed out as very important, as stated by one of the respondents, a social worker who works with people with dual diagnosis in Czechia:

“Mental health care services exist, but many people fall through the net of the system. And that’s a huge problem.”

They’ve fallen through the net, they’re in bad shape, they have these ‘homeless habits’. Often, drug dependence adds up with living on the street. And they’ve never dealt with their diagnosis before. Yet it’s obvious they have it at first sight...they haven’t come into contact with any professional who has noticed.”



## 05. Insufficient funding for mental health care services

The environment of state-run mental health care institutions often does not undergo any renovations for decades. Emergency wards experienced by respondents were described as open spaces with beds and basic equipment. All patients are in one room space, regardless of the mental health problems and diagnoses with which they are being treated. Noise and lack of privacy can act as a stress factor, as the quote of one of the patients from Czechia shows:

“If I were more compensated, I would go crazy in there. The only reason people can handle it is that they’re so sick they know they have to stay there...I realised

this most when my friends or family came to visit me and I saw their horrified faces.”

Even for people who are included in general society and are able to access health care on their own, some types of mental health support are less accessible for financial reasons. Psychotherapy, which is not covered by health insurance, is a costly financial expense that is not affordable for everyone, as reported in Czechia. Despite the availability of psychotherapists and psychologists who provide services covered by health insurance, this is seen as a barrier.



## 06. Drug and psychiatry registry

These are usually the barriers related to the risk of punishment if certain details about the life of a person who uses drugs are revealed, such as psychiatric registration or employment difficulties in the case of narcological and mental health registration.

“Historically, in public discussion, we have considered drug use and drug dependence as a consequence of illegal activity - yes, it is a health problem, but we have long emphasised the fact that it is an illegal activity. The latter, however, causes people to fear what is going to happen if they turn to some organisation for help - they worry about

whether they can get a health certificate extended to obtain a driver's license or whether they will be issued some other certificate that they will need to face their whole life.”

*Health authority professional in charge of substance use services, Estonia*

As observed in Czechia, the experience of being treated in a health care facility may appear in the client's personal records and consequently limit the client's ability to recover. This is the case, for example, for people who recover from drug dependence and have to prove they abstain and go through the process of being approved to drive a car or engage in certain professions.

## 07. Language/communication/translation barriers

Experience of people who arrived in CEECA countries in connection with the Russian war against Ukraine has shown that while it is possible in some hospitals to admit a patient without knowledge of the local language or English, this is very often only a short-term programme focusing only on the somatic aspect of drug dependence treatment, not on its psycho-social component. The vast majority of residential treatment facilities provide services only in local languages, and there are only a few private facilities where it is also possible to receive treatment in English.

There might be non-profit organisations that can provide help with translation (online or offline) but these opportunities are very limited. In other institutions, the possibility of care in another language depends on staff resources and their

language skills. Specific barriers for migrants and refugees include the lack of relevant information materials in appropriate languages.

This barrier has been reported not only for refugees/migrants but also for some local populations trying to access services.

“In Estonia, we have a language barrier for target groups with drug dependence who have injection experience for a long time and who only know the Russian language; then, in certain areas, it is difficult to get service and get orientation in the system.”

*Health authority professional in charge of substance use services, Estonia*

A photograph of a male doctor with a beard and glasses, wearing a white lab coat. He is holding a blister pack of pills in his left hand and looking down at a document in his right hand. The background is a blurred medical setting. The entire image has a light orange tint.

# Existing innovations and best practices

Despite all of the existing barriers in the CEECA region, there are several important innovations that allow better access to mental health services for people who use drugs and key affected populations.

- 01.** **The destigmatisation campaign**, which is part of the psychiatric reform, is a specific achievement in Czechia. The initiative provides an information campaign and targets the group of people with mental illness and their family members and 'seeks to reduce stigma and discrimination against people with mental illness and improve people's access to mental health services'. The project's activities included development of a 'Destigmatisation Methodology', the development of destigmatisation measures, support for destigmatisation projects in the regions, and other initiatives. Health professionals, public authorities and social service providers also became the target groups of the campaign.
- 02.** In Estonia, since 2013, the government finances the employment of a **second family nurse** in the practices of family doctors provided that they have a separate workspace for independent appointments. The addition of a second family nurse to the family doctor's practice allows for a significant increase in the share of health promotion activities.
- 03.** In Poland, **online psychotherapy or online medical consultation** existed before the pandemic, but they were accompanied by much doubt. The pandemic forced the use of online services for both physical and mental health and, in many cases, this is beneficial for the users (allowing faster consultations, for example). However, some therapists say they preferred in-person contact, leaving online contact for emergencies only. Also, patients claim overrepresentation of telemedicine services and difficulties in reaching medical services as not all diseases can be treated online.

A number of psychological self-help instruments have been developed and are freely available on websites. Use of e-consultation is becoming widespread in Estonia. If a person cannot find suitable free time at the digital registration desk, it is possible to add oneself to the waiting list. The time finder notifies the person via SMS and e-mail when a time suitable for their preferences becomes available.

04. All the countries observe full access of all registered **war refugees from Ukraine** to all the services available for local citizens. In Moldova, strengthening of the education system's capacity to respond to, and support the mental health needs of, children and adolescents, such as trauma, was initiated, and training for volunteers is conducted to offer refugees basic psychological first aid skills and knowledge.
05. With the aim of **decentralising services**, in 2021 the Estonian state decided to allocate resources to local governments so that they could contribute to supporting mental health services. The support is given with the aim of improving the provision of psychological help at the local level and thereby mitigating the negative impact of the COVID-19 pandemic on the mental health of Estonian residents.
06. More **online web-based services** for substance users were introduced: in Poland, services called 'Fred goes net' and 'Candis' have been started, and 'Web outreach' in Moldova which allows reaching out to people who use drugs through web platforms, mainly the use of Telegram messenger or dating apps.
07. In recent years, Czechia has also been on the journey of rediscovering the potential of **psychedelics in the treatment of many mental health conditions**. The National Institute of Mental Health has been involved in clinical research in this area for a long time. In 2021, the first psychedelic treatment-focused clinic was established in Prague. Despite the fact that only ketamine-assisted treatment is available, this is a great advance for the Czech mental healthcare system. The ketamine-assisted therapy is proving effective in the treatment of serious depression.
08. **Mental health care service management**  
Czechia introduced crisis centres that can be used by people who do not know where to turn for help or do not want to/cannot visit the necessary facility in person. Mobile psychiatric outreach teams also operate in the country.

In Moldova, mental health services are now provided by a family doctor within primary healthcare institutions and by CMHCs as specialised outpatient care centres set up and available in all administrative units of the country. These centres are contracted and funded by the National Health Insurance Company.

The Moldova national mental health programme provides, among others, psychotropic drugs which are purchased in a centralised manner from state budget resources.

## 09.

### Support and mental health care services for substance users (including OAT clients and NSP users)

SÜTIK in Estonia is a support programme for people who use drugs. A support person will help find out what support or help the person needs and helps to find a suitable service provider. Support persons provide a variety of help, including finding a place of residence or work, contacting a healthcare institution, and planning drug dependence treatment. Many support persons are experienced advisers as they have been in similar situations and they have gone through the process from dependence to healing.

In Poland, the pandemic has also enforced the dispensing of methadone for longer periods (such as two weeks), but this is still very discretionary and depends on the patient's good 'performance'.

In Moldova, a distance monitoring app is being tested that aims to shift OAT users from 'directly observed treatment' to 'video observed treatment'.

With regards to NPS use, there are some innovations found in the participating countries related not to mental health service provision but to the approaches to case-finding and registration.



# Recommendations

The following recommendations are based on the understanding of necessity to ensure mental health service access for people who use drugs not only in the context of treating drug dependencies, but in the response to HIV, tuberculosis (TB) and the hepatitis C virus (HCV). Mental health interventions for key populations are one of the components of the essential package of HIV response services for key populations<sup>105</sup>.

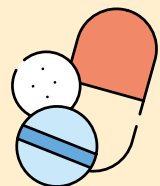
Routine screening and management for mental health issues (particularly depression and psychosocial stress) should be provided for people from key populations in keeping with the principles of consent, confidentiality and evidence-based quality. Specific mental health issues and recommendations, as well as a practical guide on addressing mental health issues in non-specialised health settings, is provided by the Mental Health GAP Action Programme<sup>106, 107</sup>.

## 1. Decriminalisation of drug use and possession for personal use

Revise drug laws and eliminate criminal penalties and sanctions for drug use and possession for personal use. These changes will open the possibility of, and prioritise, public health instead of punishment. Decriminalisation of drug use and possession for personal use is the key to removing legal barriers to enabling currently lacking essential services, such as drug checking, drug consumption rooms, and comprehensive health and social care which includes mental health services.

### REMOVING DRUG REGISTRIES

The CEECA region has a unique system of drug (treatment) registries that store the personal data of people who use drugs. Drug registries restrict civil



<sup>105</sup> World Health Organization (2022b). World mental health report: Transforming mental health for all. Geneva; World Health Organization. <https://www.who.int/publications/i/item/9789240050860> (accessed 29 May 2023).

<sup>106</sup> World Health Organization (2016). mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: mental health Gap Action Programme (mhGAP) – version 2.0. Geneva; World Health Organization. <https://www.who.int/teams/mental-health-and-substance-use/treatment-care/mental-health-gap-action-programme/evidence-centre> (accessed 29 May 2023).

<sup>107</sup> World Health Organization (2019b). mhGAP Intervention Guide - Version 2.0 for mental, neurological and substance use disorders in non-specialized health settings. Geneva; World Health Organization (available in English, Russian and Ukrainian). <https://www.who.int/publications/i/item/9789241549790> (accessed 29 May 2023).



rights; marginalise people from key populations; violate the right to privacy and confidentiality of health information; increase vulnerability to police abuse and extortion; and create a fear of seeking help and put obstacles in the way to obtaining healthcare and harm reduction services. Thus, in order to ensure that the human rights of people who use drugs are not violated, drug registries must be removed and legislation at the national level should be changed accordingly.

## 2. Information campaigns aimed at social inclusion, prevention of mental disorders and diminishing stigma

- Provide reliable information about mental health problems;
- Develop partnerships with the media (such as the example of well-known people who have had a problem but have sought help) to increase general awareness of mental health and reduce stigma around both mental health and drug dependence;
- In order to achieve changes in society, raising awareness about mental health must be consistent and adaptable to all target groups, also as a long-term activity;
- Continue and improve the campaigns and strategies to fight stigmatisation;

- Improve the system of prevention of social exclusion; and,
- Public health and harm reduction are rich with storytelling that could be used for fighting stigma and for educational purposes. Sharing first-person narratives could be used for community mobilisation and advocacy.

## 3. Information campaigns aimed at raising awareness of the available health services

- Provide comprehensive information on existing services that deal with various mental health and substance use-related disorders;
- Post information sheets at harm reduction and other service providers, as well as at primary health care institutions and online;
- At the accessibility level, there is a need for developing information sheets with a description of the activities and contact details of the health, social care, and other facilities in the area (city, county, municipalities) which would make it easier for patients to find and access these facilities and for health care providers to direct patients to the most appropriate facilities for their stage of illness and recovery.

#### 4. Informing and empowering people who use drugs in mental health literacy and access to services

- It is necessary to launch information in Ukrainian for Ukrainian patients about medical and care services and to provide free remote translation services of the conversation between the doctor (or other medical staff) and the patient;
- Relevant materials related to mental health and harm reduction are needed, both in national languages and in languages appropriate for migrants and refugees;
- Further exploration is needed as to user movements. Part of the problems stem from the lack of interest in cooperating with user organisations coming from different parties (including the ones providing harm reduction). The active participation of people who use drugs, because they have used services, can bring their knowledge and experience to contribute to the design, planning, delivery, and evaluation of services at a local, regional and national level.

#### 5. Move the professional community to client-centred evidence-based approaches

Changes to happen within the professional communities involved in providing mental health care to people who use psychoactive substances are expected to be crucial for the entire situation. It is likely that this community needs reshaping and the inclusion of new players.

Overall, the needed solutions are readily available in the professional communities of western countries where various psychological/psychotherapeutic/psychoanalytic schools have developed tools to deal with substance use considered secondary to the lack of human well-being.

#### THE COLLECTED IDEAS ARE AS FOLLOWS:

- Leave behind the paternalistic approaches;
- Promote best practices developed by NGOs in professional communities at national and international levels; and,
- Review and assess best practices developed by NGOs involved in prevention and rehabilitation services.



## 6. Mental health professional community education, capacity building and supervision

### Undergraduate training

- Add new subjects, or increase the hours of subjects, in psychotherapy, psychology, and harm reduction for future doctors (especially psychiatrists). It appears that the lack of education (insufficient knowledge about psychology and harm reduction) and proper training contributes to the stigmatising of patients; and,
- Improvements in educational curricula for mental health specialists in dependence studies and the provision of mental health care to people who use drugs. Promote best practices developed by dependence specialists, psychologists and mental health specialists in relevant professional communities at national and international levels.

### Postgraduate training

- Ensure adequate availability and state-funded training of relevant specialists (clinical psychologist, mental health nurse, dependence specialists);
- Incorporate drug dependence and mental health theory into training for social service workers; and,
- Introduce placement training for specialists to spend some time in different facilities (i.e. harm reduction facilities, drop-in centers, OAT centres, etc.).

### Professional supervision

- Introduce a system of professional peer supervision and mutual building capacities which need to be ensured by professional associations to allow systematic support to doctors, psychologists, nurses, and dependence specialists, etc.

### Communication and language skills development

- The war in Ukraine has shown how important language skills are, so when training staff, the emphasis should also be on this issue; and,
- Employ foreigners who can then provide services for people with different native languages.

## 7. Primary healthcare system improvement to ensure optimal access to mental health care

- Follow WHO recommendations to integrate mental health and substance use issues in primary health care. Some elements of the job of psychiatrists who do not want to work with people who use drugs and in methadone programmes could be taken by qualified and trained nurses. This would help to fill staffing gaps and increase the level of patient satisfaction resulting from the quality of therapeutic contact;
- Train primary health care workers the basic skills to conduct mental health tasks such as screening and treatment of anxiety and depression in primary health care and to create a stigma-free cultural space, including increasing awareness of mental health protective and risk factors and danger signs among primary care professionals to enhance early detection and reduce stigma;
- Adapt and apply evidence-based standardised assessment tools to identify primary mental health problems in people affected by drug dependence in harm reduction services; and,
- Revise service content of the mental health specialist in primary care for people with drug dependence issues.

### MENTAL HEALTH SERVICES

- Develop multidisciplinary teams that work predominantly in the community context and in the natural environment of clients as outreach teams;
- Integrate social and health services, including the involvement of dependence specialists in mental health centres;

- Continue the use of digital solutions to obtain mental health services – cooperation with some psychiatric clinics, so it enables services to be brought closer to people;
- Support research into psychedelics and the implementation of psychedelic therapy as an alternative or adjunct to mainstream psychotherapy;
- Support the introduction of evidence-based guided online self-help programmes;
- Construct new mental health centres to cover all regions;
- Introduce and develop crisis outreach teams with a psychiatrist or psychiatric nurse available;
- Create low-threshold mental health services for refugees; and,
- Establish friendly clinics to provide mental health care along with other health services.

### DRUG DEPENDENCE TREATMENT SERVICES

- Create more outpatient counseling services for people who did not develop dependence but use drugs or misuse prescription drugs;
- Shift from inpatient to outpatient programmes; open outpatient detoxification points to reduce waiting lists;
- Introduce Harm Reduction Centres and drop-in sites that provide a wide range of interventions, including social work services;
- Expand the network of drug dependence services – especially OAT programmes, drop-in centres, aftercare programmes, day treatment centres and other outpatient services that are able to provide case management;

- Increase the availability of naloxone by making it available without a prescription;
- Introduce the option of only partial detoxification;
- Promote multidisciplinary work for rehabilitation and recovery of people with mental health and drug dependence issues;
- Create services (both outpatient and in-patient) for clients with a dual diagnosis;
- Integrate social and health services, including the involvement of dependence specialists in mental health centres; and,
- Introduce a diversity of offers at different stages of treatment. On a continuous path of recovery, there should be programmes from the psychiatric treatment system and programmes from the drug dependence treatment system, between which the patient can move freely.

## 8. Recommendations on integration of mental health and harm reduction services

To ensure proper access by key populations and specifically people using drugs to all complex mental health care, starting with psychological support, mental health diagnostics, and treatment and care, interventions should be connected to and work as an integral part of a comprehensive harm reduction service.

### Recommendations to ensure integration of mental health services into OAT services

- Make available a wider range of drugs used as substitute medicines (such as heroin);

- Bring OAT facility rules into accordance with the drug scene situation;
- Make mental health services more accessible to people who use drugs and people on OAT;
- Integrate OAT into the routine practice of residential facilities; and,
- Limit the extent to which the treatment process interferes with client's leading a normal life. This fundamental demand cannot be reconciled with the obligation to report daily to the dispensing facility to receive a substitute medicine.

### Interventions to ensure the integration of mental health services into a harm reduction continuum of services is recommended as part of services implemented by NGOs and community-based organisations

- Provision of individual psychological counselling to people who use drugs on different issues related to personal, social and sexual life, relations with family, employment, etc;
- Crisis counselling and counselling on crises' coping approaches for clients who are victims of violence or life-threatening situations;
- Provision of online, web-based individual counselling by psychologists;
- Organising psychological group trainings on gaining social and health skills;
- Organising and facilitating self-support group meetings by different subgroups of people using drugs (women, young people, the aged, etc.);
- Establishing partnerships with mental health care provision at the local level to ensure referral from harm reduction sites;



- Referral to trained mental health care provision for people using drugs and ‘friendly’ psychiatrist or dependence specialists;
- Organising online outreach<sup>108</sup>, psychotherapy or online medical advice by a psychiatrist for different groups of people who use drugs. Specific support needs to be provided to people who use new psychoactive substances.
- Providing mental health medication for free or partial compensation of expenses for medication if the need is exceptional and no medical insurance is available;
- Professional supervision and postgraduate training for psychologists, social workers and outreach workers by professional psychologists as an obvious component of any of the above mentioned interventions<sup>109</sup>;
- Sharing of information and raising awareness of people using drugs and members of their families on the available health services. Provide comprehensive information on existing services that deal with various mental health and substance use-related disorders. Post information sheets at harm reduction and other service providers, as well as at primary health care institutions and online. At the accessibility level, there is a need for developing information sheets with a description of the activities and contact details of the health, social care, and other facilities in the area (city, county, municipalities) which will make it easier for patients to find and access these facilities and for health care providers to direct patients to the most appropriate facilities for their stage of illness;
- To organise community-led monitoring of access to, and quality of, the mental health care services for people using drugs by building cooperation to improve the situation; and,
- Introduce and develop crisis outreach teams with a psychiatrist or psychiatric nurse available.

## 9. Assessment, evaluation and future research

The above collection of recommendations resulting from the review of the situation in four selected countries includes statements that range from plans already mentioned in the national documents to potential interventions.

To achieve evidence-based conclusions regarding the effectiveness of the above recommendations, it is necessary to conduct experimental studies which can follow the PICO approach, which requires that the below parameters are defined:



### POPULATION

a clearly defined target group;



### INTERVENTION

it is necessary to understand what exactly is done and in which timeframe;

<sup>108</sup> United Nations Office on Drugs and Crime. (2021). Recommendations «Web – outreach for people who use drugs». United Nations Office on Drugs and Crime, Regional Programme Office for Eastern Europe. [https://www.unodc.org/res/hiv-aids/new/publications\\_drugs\\_html/RecommendOutreachENG.pdf](https://www.unodc.org/res/hiv-aids/new/publications_drugs_html/RecommendOutreachENG.pdf) (accessed 30 May 2023).

<sup>109</sup> Examples and tools are available at: Альянс общественного здоровья (Alliance for Public Health) (2018). Методический комплекс «Внедрение и функционирование системы супервизионной поддержки»: Книга 1. Алгоритм внедрения и функционирования системы супервизионной поддержки [Methodological complex «Implementation and functioning of the supervisory support system»: Book 1. Algorithm for the implementation and functioning of the supervisory support system]. Kyiv; Альянс общественного здоровья. In Russian. <https://aph.org.ua/wp-content/uploads/2016/07/supervisor-book-1.pdf> (accessed 30 May 2023).



### COMPARISON

what the intervention group is compared to and how the participants are divided into these groups;



### OUTCOME

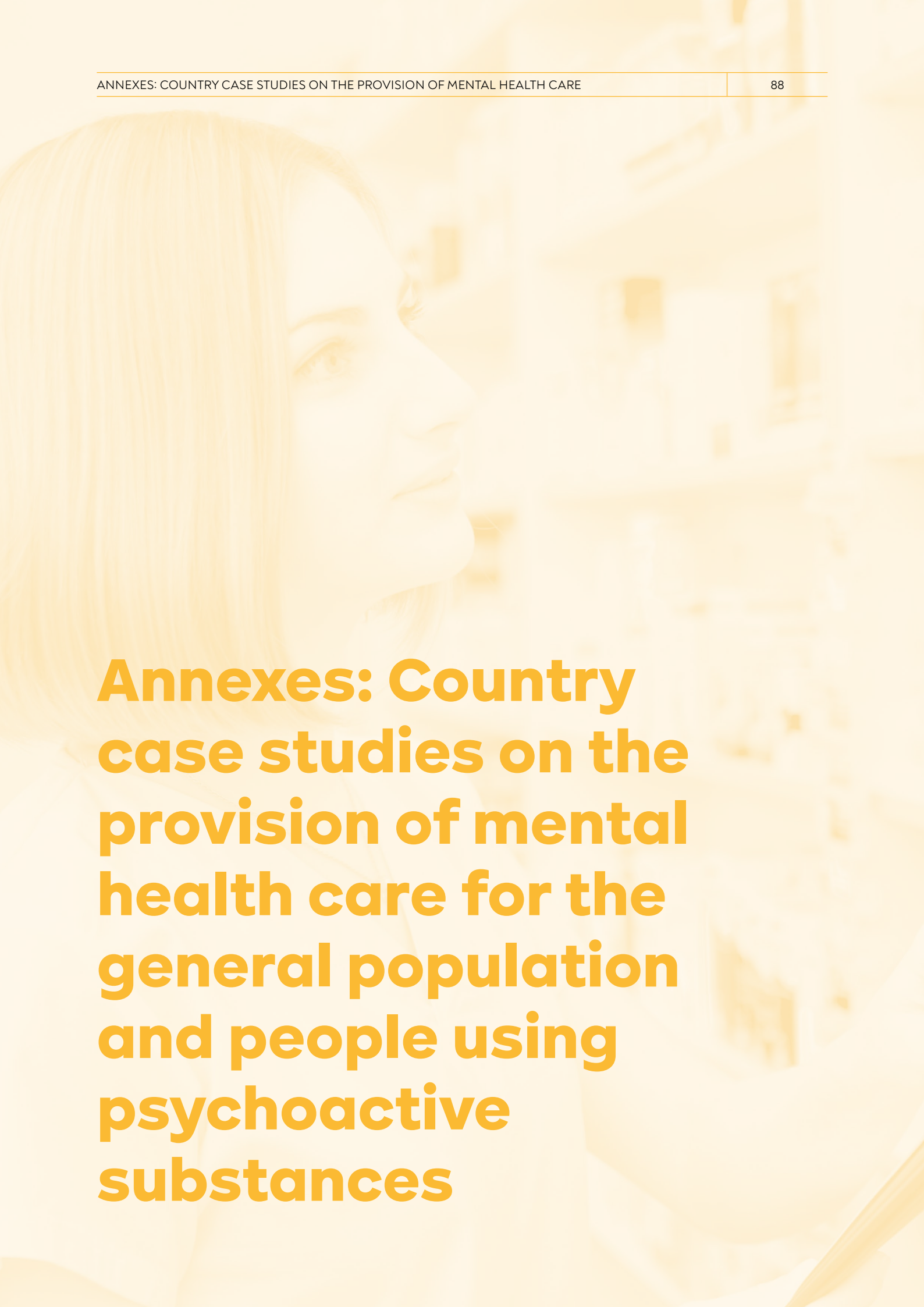
which measurements are collected from all the participants of both groups.

As interventions can include measures from any of the above levels, outcome measures are to include parameters measured on all the levels likely to be affected.

The related recommendations from the national reports are as follows:

- Assessing and measuring the quality of life and functional profile of people using drugs and other vulnerable groups of the population can complement and improve areas of the mental health system; and,
- The efficiency of the services provided must be evaluated by the satisfaction of the beneficiaries and their functionality using the clinical-epidemiological evaluation method of people with severe mental disorders in mental health services.





**Annexes: Country case studies on the provision of mental health care for the general population and people using psychoactive substances**

# Annex 1.

## Czechia country case study

### Mental health patient pathways for the mainstream population

Every citizen of Czechia (who has not opted out of health insurance) can be registered with a general practitioner free of charge. Thus, a GP practice can be the first place for mental health-focused interventions.

Stigma is one of the reasons why people seeking help with psychological or emotional problems most often turn to general practitioners (GPs), and less often to psychiatrists or psychologists<sup>110</sup>. It is also important here that it is the GP who can help the patient to seek further specialised help, for example, by providing a referral form. That is a standard procedure, although a referral is not a condition for seeing a psychologist or psychiatrist.

Regular patient pathways through the mental healthcare system vary according to their current mental condition, the diagnosis (or symptoms), and the availability of mental health services in their region.

Acute problems that do not require hospitalisation can be addressed in Mental Health Centres, centres for crisis intervention, and crisis hotlines. In addition, psychologists and psychotherapists can provide long-term psychosocial support.

Some of them provide their services through health insurance. However, many psychotherapists require direct payment.

People experiencing mental health decompensation may benefit from acute psychiatric hospital admission. In acute conditions, an ambulance can bring them to the appropriate psychiatric ward. Residential treatment can be long-term or just stabilising. This type of psychiatric care is mainly provided by state-run facilities. Follow-up care can also be residential or outpatient. Some NGOs cooperate with hospitals and offer various aftercare programmes directly to patients, who may need, for example, some social rehabilitation and long-term assistance for routine daily tasks. However, usually, patients are discharged from the psychiatric ward with only basic instructions and medicines needed for the following days. They have to register with an outpatient psychiatrist during these days. Sometimes discharged patients receive a contact list of psychiatrists available.

Alternative facilities offering immediate help are centres of crisis intervention. They provide short-term psychological and psychiatric support for people experiencing an acute crisis which may be associated with some traumatic or difficult experience or with decompensation of long-term mental health problems. Crisis centres are run by some state-run facilities or by non-profit organisations. However, their capacity is insufficient, and the location of crisis centres is limited to larger cities. Crisis lines have also been operating for a long time. These can serve people who do not know where

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to turn or do not want to/cannot visit the necessary facility in person.

The third option are outreach mobile psychiatric teams. Unfortunately, only a few such units are available in the entire country.

For people who are not currently experiencing some acute crisis or other serious health condition, the use of outpatient facilities is more relevant. Finding a psychiatrist who has the capacity to admit new patients may be difficult. The situation is the same for psychotherapeutic and psychological services.

In the environment of a therapeutic community, it is possible to focus not only on the stabilisation of symptoms, but there is an emphasis on the area of healthy relationships, long-term social stabilisation and training in daily routine skills.

## Patient pathway for people who use drugs

Drug dependence care in Czechia is provided at many different levels. There are four main pillars to the Czech drug policy:

- 1) harm reduction;
- 2) treatment;
- 3) supply control; and,
- 4) prevention.

The first contact by a professional with a person who uses psychoactive substances can take place at, for example, primary school or high school.

The pathway of adult patients offers a wider range of possibilities for treatment. The entry point to the healthcare system usually depends on the type of substance or behaviour, which represents the

dependence issues. It could be the GP practice in many cases, although typically this entry point is more specific for people using legal substances, such as alcohol or prescription drugs. People who use illicit psychoactive substances are more likely to seek help with the negative health consequences that using drugs brings. Thus, they seek a GP, for example, with a request to treat certain dermatological or (cardio) vascular problems. The referral to the psychiatrist is one of the legitimate ways to connect these types of patients with more relevant care. Unfortunately, the situation is complicated by the long-term lack of competent psychiatrists.

The entry point to the drug service system is usually the network of drop-in centres or outreach harm reduction programmes that are relatively stable and widespread in Czechia. Most of the drop-in centres in Czechia are classified as social service facilities, but they also provide health interventions.

There are many more ways to enter mental health care for people who use drugs. It is possible to find help on the internet, or to ask for recommendations from friends and family or their GP. Recently, a national helpline has been introduced that focuses on drug dependence issues. Some people enter the mental healthcare system because of an acute condition that requires hospitalisation (sometimes involuntary), such as when they experience a substance-induced psychosis. In some cases, cooperation with drug dependence services can also be ordered or recommended by a court or other authorities (such as the Authority for Social and Legal Protection of Children).

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Some of the facilities can be entered through self-referral (typically residential detoxification and in-patient treatment services).

Aftercare is the last phase in the process of change and, therefore, includes all interventions that seek to maintain the changes already induced. Structured programmes (group and individual therapy, phased, structured day) are available that can be linked to sheltered housing or employment, outpatient aftercare clinics, and services for social rehabilitation.

## Patient pathways for OAT clients

According to Czech OAT standards, there are three models of OAT delivery categorised as

- 1) a basic care model;
- 2) a minimal care model; and,
- 3) a complex care model.

Nowadays, around 68% of clients receive substitution treatment with buprenorphine and 32% with methadone.

The minimal care model is limited to the provision (supervised administration or prescription) of pharmacotherapy without further psychotherapy or counseling. This approach should be applied mostly in a short-term timeframe (such as during hospitalisation). However, in daily practice, this type of prescription is provided on a long-term basis, such as by GPs. There were 60 registered medical facilities providing some type of OAT in 2021 in the Czechia and more than 200 GPs who prescribe opioid agonists in their practice.

Nowadays, around 68% of clients receive substitution treatment with buprenorphine and 32% with methadone.

The basic OAT approach is provided in specialised facilities with a standard spectrum of services for people who use drugs which may include, for example, the treatment of secondary somatic symptoms and counseling. There are only 18 of these programmes (of a total of 60 mentioned above) of specialised and complex OAT for the whole country. The availability of OAT is better in bigger cities, but still insufficient. The coverage is unequal. Health insurance covers the treatment only partially and only in the case of Suboxone®. Methadone is purchased centrally and funded by the Ministry of Health, but some treatment facilities also require patients to contribute.

Admission criteria to the complex OAT care is based on the OAT standards as well. In general, anyone older than 18 years (in the case of methadone) and older than 15 years (in the case of buprenorphine) with a confirmed diagnosis of opioid dependence, or dependence on multiple drugs with predominant opioid use, could be admitted to the treatment. However, there are several contraindications which are determined by the potential health risks, such as acute intoxication (especially in the case of alcohol), some types of somatic diseases, and other general contraindications to opioid use. Relative contraindication may also be the past misuse of the OAT programme (such as the illegal sale of a substitute substance, etc.) or a failure to quit using illicit opioids despite a sufficiently high dose of the substitution substance. This health-related, social, legal, and other information about the patient should be obtained from the patient and their documentation during the initial sessions and, thereafter, the psychiatrist, dependence specialist, or another authorised person should report the patient to the National Treatment Register of Drug Users and. Thus, also verifies whether the



client is receiving substitution treatment at another health facility<sup>111</sup>. However, for the daily life of people who want to enter (or stay in) OAT programmes, there are more important criteria than these general ones. Every facility has its own particular rules and requirements for their OAT clients.

Furthermore, mandatory regular counseling sessions at specific times are a frequent requirement. If the client repeatedly fails to attend, they may be excluded. Usually, it is also required to observe full abstinence from other psychoactive substances (except for those prescribed by the psychiatrist). Therefore, it is very common for clients to undergo tests for the presence of drugs in their urine. If the client does not have clean toxicology, sanctions may be applied and it may also lead to exclusion.

## Patient pathways for NPS users

Procedures for identifying NPS users are derived more from the clinical experience of medical practitioners who encounter people in acute intoxication or other health-threatening conditions. If the patient or their companion has the substance used in their possession, it is subsequently sent to the

National Reference Laboratory for Forensic Toxicology, or to the Toxicology Information Centre (TIC). The TIC is a department whose representative is also a member of the working group of the Early Warning System (EWS)<sup>112</sup>.

The use of NPS is not widespread in the Czech Republic, with a reported prevalence of around 2%. Reports of NPS use are sporadic and occasional, also among clients of drug dependence services across all regions.

In addition to the previously mentioned, the availability of ‘new benzodiazepines’, which are not registered pharmaceutical products and which are sold as designer drugs, has been recently recorded. Synthetic opioids, such as fentanyl derivatives, have also become more widely available on the black market in recent years<sup>113</sup>. The use of synthetic opioid analgesics was first recorded in Czechia in 2011. In regional annual reports, the most frequently mentioned injectable drugs are fentanyl from transdermal patches and Vendal Retard®. Some people who use opiates are replacing them with these preparations<sup>114</sup>. In the context of synthetic opioids, it is important to note that in

The use of NPS is not widespread in the Czech Republic, with a reported prevalence of around 2%. Reports of NPS use are sporadic and occasional, also among clients of drug dependence services across all regions.

- 111 Popov P, Mravčík V, Dolák J, Minařík J. (2020). Standard substituční léčby, verze 3.3. [The standard of substitution treatment, version 3.3]. In Czech. [https://snncls.cz/wp/wp-content/2020/10/SSL\\_3.3.pdf](https://snncls.cz/wp/wp-content/2020/10/SSL_3.3.pdf) (accessed 30 May 2023).
- 112 Grohmannová K, Mravčík V. (2018). Nové psychoaktivní látky v Evropě a ČR [New psychoactive substances in Europe and the Czech Republic]. In Czech. <https://www.psychiatriepropraxi.cz/pdfs/psy/2018/03/02.pdf> (accessed 30 May 2023).
- 113 Chomynová P, Grohmannová K, Janíková B, Rous Z, Černíková T, et al. (2021). Summary Report on Addictions in the Czech Republic 2021. Prague; National Monitoring Centre for Drugs and Dependence. [https://www.vlada.cz/assets/ppov/zavislosti/Summary-Report-on-Addictions\\_2021\\_EN\\_web-fin.pdf](https://www.vlada.cz/assets/ppov/zavislosti/Summary-Report-on-Addictions_2021_EN_web-fin.pdf) (accessed 30 May 2023).
- 114 Mravčík V, Chomynová P, Rous Z, Černíková T, Cibulka J, et al. (2020). Výroční zpráva o stavu ve věcech drog v České republice v roce 2019 [Annual Report on the Drug Situation in the Czech Republic 2019]. Úřad vlády České republiky. In Czech. [https://www.drogy-info.cz/data/obj\\_files/33369/1076/VZdrogy\\_2019\\_v02\\_s%20obalkou.pdf](https://www.drogy-info.cz/data/obj_files/33369/1076/VZdrogy_2019_v02_s%20obalkou.pdf) (accessed 30 May 2023).

some drug dependence services since 2021, especially in needle/syringe programmes, take-home naloxone nasal spray has been available for distribution to clients and peer workers.

There are specific services in Czechia for dance event attendees. These are harm reduction programmes in nighttime entertainment settings. These outreach

Unfortunately, there are currently no official and registered programmes for testing psychoactive substances in Czechia. Despite the fact that in the past these programmes were common, since 2010 there have been none available and, therefore, there is currently no legislative support for them.

programmes are in contact with people who use synthetic (dance) drugs and probably the majority do not attend other specialised drug services such as NSP's or treatment facilities<sup>115, 116</sup>. While it cannot be said that programmes in the nightlife setting are oriented solely toward NPS users, they are part of the system of care for people who use NPS. These services are linked to professional standards and good practice guidelines which, in part, include approaches to NPS issues. Some of the services provided include first aid in intoxication; monitoring of the drug scene; provision of validated information; referral for further specialist care; basic health treatment; crisis intervention; food and vitamin services; rehydration; provision of protective equipment and harm reduction

materials; alcohol testing; infectious disease testing; and many other preventive interventions, in addition to the detection of new substances in the drug scene.

Unfortunately, there are currently no official and registered programmes for testing psychoactive substances in Czechia. Despite the fact that in the past these programmes were common, since 2010 there have been none available and, therefore, there is currently no legislative support for them<sup>117, 118</sup>. Some people interested in nightlife harm reduction try to substitute the need for drug testing by providing unofficial drug testing at some music events. This is mostly provided by volunteers and activists and the testing is carried out using simple qualitative technologies (reagent testing). On the other hand, programmes providing other types of support have been developing in the Czech Republic in recent years. One example is PsyCare, a specific service (not only) for people using NPS provided by the Czech Psychedelic Society. It applies the principles of harm reduction work, such as the distribution of information sheets, vitamins and water as well as a safe space to relax and talk. PsyCare aims to provide a supportive environment and specialised care for a music event and festival attendees who choose to use psychedelics

115 Grohmannová K, et al. (2018), Ibid.

116 Saberžanovová PC, Vacek J. (2011). Adiktologické služby v prostředí zábavy: Preventivní a harm reduction programy pro rekreační uživatele drog. Zaostřeno na drogy. [Dependence Services in the Entertainment Environment: Preventive and Harm Reduction Programmes for Recreational Drug Users. Focus on Drugs 2]. Praha: Úřad vlády [National Monitoring Centre for Drugs and Drug Dependence]. In Czech. [https://www.drogy-info.cz/data/obj\\_files/4577/558/Zaostreno\\_201102\\_adiktologicke\\_sluzby\\_v\\_prostredi\\_zabavy.pdf](https://www.drogy-info.cz/data/obj_files/4577/558/Zaostreno_201102_adiktologicke_sluzby_v_prostredi_zabavy.pdf) (accessed 30 May 2023).

117 Danda H, Leca N, Šteflová K, Syrová K, Páleníček T. (2020). Nové psychoaktivní substance. Zaostřeno 1/2020 [New psychoactive substances. Focus 1/2020]. Praha; National Drug and Dependence Monitoring Centre. In Czech. [https://www.drogy-info.cz/data/obj\\_files/33187/900/Zaostreno\\_2020-01\\_Nove-psychoaktivni-substance.pdf](https://www.drogy-info.cz/data/obj_files/33187/900/Zaostreno_2020-01_Nove-psychoaktivni-substance.pdf) (accessed 30 May 2023).

118 Saberžanovová PC, et al. (2011), Ibid.

and other psychotropic substances in the high-risk setting of the dance scene. The aim is, therefore, to enhance the quality of life of people using NSP by managing the ‘bad trip’ experience or in helping with the subsequent integration of the challenging psychedelic experience or other difficult drug-related psychological states<sup>119</sup>.

Mental health conditions associated with the use of psychoactive substances, whether NSP or more traditional drugs, can of course be consulted and treated in all components of the Czech drug dependence care system, such as at outpatient clinics or drop-in centres. One more specific service is provided by the Psychedelic Clinic in Prague where they focus on the use of psychedelic substances in mental health care, but also on working with people who use psychedelics recreationally, helping them to integrate the challenging psychedelic experience. This “psychological help for complications and issues that may have arisen out of previous use of psychedelic substances”<sup>120</sup> could also be partially classified as an intervention provided to NPS users.

## Pathways for war refugees from Ukraine

Regional Centres (known as KACPU’s) have been established as coordination bodies where people from Ukraine can register, apply for temporary protection, and obtain health insurance. KACPU’s are providing ‘one-stop services’.

All people who have immigrated to Czechia in the last six months due to the conflict in Ukraine can apply for public insurance free of charge. The period of health insurance protection is currently set at 150 days, after which it is required to sign up for insurance and pay for it as standard. If a refugee is covered by public health insurance, has commercial insurance, or can pay for their own treatment, then they can in principle visit any health facility.

Due to the crisis situation, ‘UA points’ have been established. These places provide emergency medical services in the Ukrainian language. There are 24 of these medical points in the country and they are located in more than half of the Czech regions. Urgent care is also provided to refugees with no health insurance. However, the costs for these treatments are quite high.

In relation to the mental health care area, information and contacts for psychologists who provide help covered by the health insurance are available on the website of the Ministry of Homeland Security. The Czech Association of Psychotherapists emphasises the education of professionals in the field of post-traumatic issues, and also brings together psychotherapists working in the Ukrainian or Russian languages. Psychotherapeutic services are provided in person and online and not only in Czechia, but also directly in Ukraine.

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119 CZEPS (n.d.). Cíle psycare. Czech Psychedelic Society. In Czech. <http://psycare.cz/cile/> (accessed 30 May 2023).

120 Psyon (n.d.). Outpatient psychiatry clinic. <https://www.psyon.cz/en/services/#ipe> (accessed 30 May 2023).

There was tremendous pressure on standard crisis and counseling helplines and it was necessary to expand staff capacity.

The establishment of telephone helplines has shown as being very useful. The state is setting up a helpline for questions about health care for citizens from Ukraine, providing their service in Czech, Ukrainian and Russian languages. Other helplines have also been set up by NGO's that can help with more specific topics, such as drug dependence or social care. There are also the 'crisis helplines' where it is possible to get psychological support. The support network is also provided by many volunteers who help people from Ukraine to orient themselves to an unfamiliar country.

## The impact of COVID-19 pandemic restrictions on mental health service provision

Along with a greater need for psychological and psychiatric care, the barriers to accessing such care increased during quarantine measures. Some psychotherapeutic and psychological services switched to distance care by introducing online counseling. Psychiatric care was limited to telephone consultations and e-prescribing (sent by text message) for some patients. 'E-mental

health' is a promising service option for the future and can help manage the increase in patients with mental health issues.

To prevent the spread of infection, it was temporarily forbidden to provide counseling services outside the health sector during certain periods of the pandemic. Together with increased demand, this led to a decline in the availability of psychological support. It was also problematic to provide online therapies to people who were not connected to the internet or were unable to access the online platforms (such as the elderly or people in a difficult socio-economic situation).

In direct response to the ongoing pandemic and restrictions on movement and visits to various institutions, the government set up a special telephone hotline. This was originally established to provide practical information, but at the same time, the ability to use the helpline to share concerns and get answers to questions proved to be an important factor in maintaining mental health in terms of reducing anxiety and worries. In general, there was tremendous pressure on standard crisis and counseling helplines and it was necessary to expand staff capacity.



## Annex 2. Estonia country case study

### Mental health patient pathways for the mainstream population

The Ministry of Social Affairs webpage attracts attention to the preventive activities that everyone needs to take:

To promote universal mental health, each individual is the best specialist in their own mental health. A person can contribute to maintaining mental health and preventing problems. A person's skills and knowledge of mental health hygiene are important tools to prevent mental health problems and to live their lives happily and to cope with stress and crisis situations<sup>121</sup>.



*A patient of mental health care services, a woman aged 31 years, said:*

“ I've been in pretty good mental health, I've always been able to discuss various difficulties in my life with my family and close friends, but after a while, things started piling up – divorce, moving, and I kept withdrawing into myself.”

In case of illness, a person's first point of contact is a primary health centre or a family doctor's practice where a family doctor, together with a family nurse and a supporting team, provides general medical care and advises on preventive activities and treatment. In the form of a family doctor's team, it is a matter of competent specialists who can help a person with most health concerns, including a family doctor who can be the first person to identify mental health problems and risks, diagnose, and treat minor mental disorders, and to monitor the treatment of patients with chronic medical conditions, as well as support the maintenance of treatment results. A family nurse undertakes the promotion of people's health, including mental health which includes, among other things, the assessment of health risk factors, health education, counseling and health status monitoring, etc. (Sotsiaalministeerium, 2022).

Studies have shown that a healthcare system with a strong primary level is more efficient and has better health outcomes than a system with a focus on specialist care<sup>121, 122</sup>. In countries with primary healthcare, both direct and indirect costs per patient are lower and the population is healthier. The cooperation of family doctors with specialists is very important in providing timely and high-quality care. In cases that do not fall within the competence of

121 Sotsiaalministeerium (2020). Vaimse tervise roheline raamat [Ministry of Social Affairs. The Green Paper on Mental Health]. Tallinn; Ministry of Social Affairs. In Estonian. <https://sm.ee/media/2132/download> (accessed 30 May 2023).

122 Starfield B, Shi L, Macinko J. (2005). Contribution of primary care to health systems and health. *Milbank Q.* 83(3):457-502. <https://doi.org/10.1111%2Fj.1468-0009.2005.00409.x>

123 Shi L. (2012). The impact of primary care: a focused review. *Scientifica* (Cairo). 2012:432892. <https://doi.org/10.6064/2012/432892>

the primary level or go beyond it, the family doctor can refer to a specialist.

**A patient of mental health care services, a woman aged 31 years, said:**

“ I have good contact with my family nurse, so I first turned to her to talk about the fact that I don't want to do anything anymore, I'm powerless and don't care about everything. She gave me an emotional well-being questionnaire and the symptoms of depression came out of it. The family nurse recommended seeing my family doctor and starting treatment.”

Since 2017, family doctors have had the opportunity to use e-consultation with a psychiatrist through the health information system to specify the diagnosis of their patient and prescribe treatment. According to the Estonian Health Insurance Fund, this option was used 246 times in the first nine months of 2019<sup>124</sup>.

Since 2015, family doctors have had the opportunity to use the ‘therapy fund’ which aims to increase the role of the family doctor as a coordinator of the patient's treatment process from beginning to end. The therapy fund enables the family doctor, if necessary, to order the services of a clinical psychologist, speech therapist, and physiotherapist for a patient on their list without a prior visit to a specialist and to pay the service provider for their interventions.

In 2019, 417 family medicine practices made use of the therapy fund. In the opinion of specialists, bottlenecks of the therapy fund include the shortage of money available in the therapy fund; the rigidity

of the terms of use; the lack of service providers (clinical psychologists, therapists, etc.); and the variability of the patient's co-payment depending on the service provider<sup>125</sup>.

**A patient of mental health care services, a woman aged 31 years, said:**

“ I had to meet two people because I agreed to the medicines prescribed by the family doctor and the family nurse supported me mentally. Unfortunately, I don't know if I would have been able to wait for an appointment with a psychologist or a psychiatrist because they have queues that are several months long, and I don't have the money to go to a private psychiatrist”.

## Patient pathway for people who use drugs

According to the National Institute for Health Development, harm reduction services (including OAT) as well as detoxification and rehabilitation services are available to a person suffering from drug dependence. All services are funded by the state and are free for the client. The services offered in Estonia are based on the personal motivation of the client and to enter the services related to harm reduction and other drug dependence, the client does not require any referral letter<sup>126</sup>.

**A harm reduction service provider said:**

“ Getting the harm reduction service is easy – client walks in the door and immediately gets the service, they don't have to register if they don't want to. If

124 Sotsiaalministeerium (2020), Ibid.

125 Sotsiaalministeerium (2020), Op.cit.

126 <https://www.narko.ee/>



a person is willing to publish their data, we code them. And, for example, clients should get to methadone replacement therapy in 1-2 days. Every person who walks in our door is a potential client. From time-to-time, those younger than 18-year-olds also appear, they rather seek counseling than a syringe exchange.”

***A professional working in a drug rehabilitation centre said:***

“ In order to receive in-patient detox and rehabilitation services, the client must register in the queue, they do not need any referral letter anywhere, and they do not need health insurance. The queues are not long because we have enough treatment places for both men and women.”

Due to the high prevalence of fentanyl use, most state-funded services have targeted opioid users. The situation has changed, but there are few, or no, help options for other drug users<sup>127</sup>.

***A health authority professional in charge of substance use services said:***

“ We can have one and the same institution that can offer drug dependence treatment services and more broadly mental health services, but they may not be related to the understanding that mental health services should also include drug dependence treatment

services. We have separate mental health services, and we have services for substance users. We have parallel lines of activity. And it is a separate issue if we have a person with mental health problems and drug dependence who still needs social services, then they are also a parallel structure.”

It is also possible to consult a psychologist, a mental health nurse, or a psychiatrist for support.

The cost of treatment for people with health insurance is paid by the Health Insurance Fund, in which case the patient has to pay a co-payment visit fee of €5.

A referral from a family doctor is required to see a psychologist; a referral is not needed to see a mental health nurse and a psychiatrist. Treatment is paid for uninsured people<sup>128</sup>.

***A professional working at a drug rehabilitation centre said:***

“ In order for a person with a substance use disorder to receive mental health help outside the services intended for them, they must have health insurance, but they often do not have it, and that is a common cause why they do not receive the service. Special services for people with a substance use disorder are financed by the National Institute for Health Development, and the person does not have to be insured by the health insurance fund to receive the services.”

<sup>127</sup> Siseministeerium (2019). Eesti Narkopoliitika aastani 2030. Valge raamat [Ministry of the Interior. Estonian drug policy until 2030. White paper]. Tallinn; Ministry of the Interior. In Estonian.

<sup>128</sup> Sotsiaalministeerium (2020), Op.cit

According to the National Institute for Health Development, SÜTIK (which means “lighter” or “easier” in Estonian) is a personal support programme for people who have problematic drug use. The support programme can help find out what support or help the person needs and find a suitable service provider. Supporters provide a variety of help, including finding a place of residence or work, contacting healthcare institutions, and planning drug dependence treatment. Many support persons are also skilled advisers. Many of them have been in a situation similar to the person who is experiencing drug dependence, and they have gone through the process from dependence to healing. Support persons do not condemn a person but are looking for solutions with the person. The support programme works in Tallinn and Harju County, Rakvere and Lääne-Viru (West Estonia) County, and Ida-Viru (East Estonia) County. Clients all over Estonia can turn to SÜTIK. While many helping opportunities are related to registration, or mentioning the address of residence, SÜTIK also tries to help those who have no registration or are registered at a different place from the actual place of residence<sup>129</sup>. Since 2019, in the case of a suspected or accused person committing a drug-related crime, the procedure may be terminated and replaced by treatment or other auxiliary services. The aim is to reduce the number of repeated offenses and, thus, the costs of law enforcement authorities, as well as to help people who use drug treatment, counseling, or harm reduction to reduce their drug use and the risks associated with it. In practice, this opportunity is rarely used<sup>130</sup>.

**A harm reduction service provider said:**

“ The harm reduction service consultant can recommend the client to join the SÜTIK programme if it turns out that the client has social problems (with debts, lack of housing, material problems, or hunger), these problems can be solved with the help of a support person. The client is motivated to change their lifestyle and give up drugs. War refugees can turn to a SÜTIK support person too”.

## Patient pathways to harm reduction

Syringe exchange began in Estonia in 1997. Over-the-counter sterile syringes are available in Estonian pharmacies without prescription. Both syringe exchange programmes (SEPs) and pharmacy sales of syringes are available in Estonia despite the high incidence and high prevalence of HIV among people who inject drugs<sup>131</sup>.

As of 2018, Estonia was believed to have the highest prevalence of HIV among people who inject drugs and the highest overdose mortality in the European Union<sup>132</sup>.

129 <https://www.narko.ee/>

130 Siseministeerium (2019), Ibid.

131 Vorobjov S, Uusküla A, Abel-Ollo K, Talu A, Jarlais DD. (2009a). Should pharmacists have a role in harm reduction services for IDUs? A qualitative study in Tallinn, Estonia. *J Urban Health*. Nov;86(6):918-28. <https://doi.org/10.1007/s11524-009-9400-5>

132 Kontautaitte A, Matyushina-Ocheret D, Plotko M, Golichenko M, Kalvet M, et al. (2018). Study of human rights violations faced by women who use drugs in Estonia. *Harm Reduct J*. Nov 6;15(1):54. <https://doi.org/10.1186/s12954-018-0259-1>

**A harm reduction service provider said:**

“The following harm reduction services are available in Estonia: sharing and exchanging syringes; advice from an experienced counselor, psychologist and social work services; opioid substitution service (methadone – national programme), Suboxone replacement treatment service (on a paid basis); and support person services (psychosocial support programme, SÜTIK). The services are implemented by NGOs and medical institutions and are fully financed by the state, The National Institute for Health Development.”

According to the conducted study, in a series of focus groups with pharmacists and people who inject drugs in Tallinn, Estonia, to explore their attitudes toward the role of pharmacists in HIV prevention activities, it was found that many, but not all, pharmacists reported readiness to sell syringes to people who inject drugs to help prevent HIV transmission. However, negative attitudes toward people who inject drugs in general, and syringe sales to them specifically, were identified as important factors restricting such sales. The idea of free distribution of clean syringes or other injecting equipment, and disposal of used syringes in pharmacies, elicited strong resistance. People who inject drugs stated that pharmacies were convenient for acquiring syringes due to their extended opening hours and local distribution. People who inject drugs were positive toward pharmacies, although they were aware of stigma from pharmacists and other customers. They also emphasised the need

for distilled water and other injection paraphernalia. In conclusion, there are no formal or legislative obstacles to providing HIV prevention services for people who inject drugs at pharmacies<sup>133</sup>. Data suggests that those who use pharmacies are at a less ‘advanced’ stage of their injecting career and had lower HIV prevalence than SEP users. This suggests that pharmacies could participate in HIV prevention and in linking people who inject drugs with existing harm reduction services<sup>134</sup>. The harm reduction service at the pharmacy is additional to other harm reduction services. It distributes injection accessories to clients (syringes, needles, filters, heating containers, disinfectants, dry wipes) and collects used syringes and needles, and also provides condoms, lubricant, and pregnancy tests if necessary. Brief counseling of clients and the sharing of information about harm reduction services is also possible. This is offered by two pharmacies in Tartu and one in Rakvere. Recently, several harm reduction organisations have added a mental health nurse to their team, and counseling is also offered online<sup>135</sup>.



133 Vorobjov S, et al. (2009a), Ibid.

134 Vorobjov S, Uusküla A, Abel-Ollo K, Talu A, Rüütel K, et al. (2009b). Comparison of injecting drug users who obtain syringes from pharmacies and syringe exchange programs in Tallinn, Estonia. *Harm Reduct J.* Feb 20;6:3. <https://doi.org/10.1186/1477-7517-6-3>

135 <https://www.narko.ee/>

**A harm reduction service provider said:**

“ In Estonia, harm reduction services are mainly provided by NGOs, medical institutions, in some areas pharmacies where syringes can be replaced. The service is commissioned by the National Institute for Health Development. Services are fully funded by the state. As a rule, there are experienced counselors, psychologists and social workers in the harm reduction centres to help the customer identify and help them solve their problems. Specialists who work in the programme, together with the client, identify objectives and tasks that are important for the client.”

From 2007 to 2016, HIV incidence decreased in Estonia



by  
**61%**  
overall

for all exposure groups, and particularly for males who inject drugs (by 97%), **except for men who have sex with men.**

Median time to diagnosis decreased for males who inject drugs in Estonia

from **3.5** years to **2.6** years



Coverage of services had been higher in Estonia than in Latvia; for example, by 2016, for people who inject drugs in Estonia, there were

**>200**

**needles and syringes distributed per person annually,**

and HIV testing and ART coverage reached

**≈50% and 76% respectively.**

Estonia has turned the tide of its epidemic – large scale-up of prevention and care programmes probably contributed to it. In Estonia, the number of needles and syringes distributed annually and the number of OAT clients increased rapidly in the late 2000s, and then remained rather stable<sup>136</sup>. Mobile harm reduction services are also available. This comprises a van-type bus with special equipment and a counseling room. The mobile service is primarily intended for people who use drugs and, for some reason, have no access to a harm reduction centre<sup>137</sup>.

**A harm reduction service provider in Estonia said:**

“**In addition to stationary harm reduction services, there is a mobile service that is open daily from 9am until 11pm. Like in Tallinn, it is the same story in Ida-Virumaa, that it is easily accessible. Northern Estonia is very well covered by the service. In addition, the mobile bus also travels to Pärnu and Tartu; Southern Estonia is a bit more poorly covered in terms of harm reduction services. In Tartu, one or two pharmacies exchange syringes as well.**”



In the case of opioid drug dependence (fentanyl, heroin, methadone, morphine, opium, etc.), outpatient OAT is also provided in Estonia.

## Patient pathways to detoxification

Short-term in-patient detoxification treatment is aimed at immediate or gradual termination of the narcotic drug and the prevention or alleviation of the resulting withdrawal symptoms. Short-term withdrawal treatment is suitable for all drugs that cause severe intoxication. Detoxification usually lasts up to 30 days and is based on psychopharmacotherapy. In-patient detox is free of charge in some institutions; in others, patients have to pay a so-called ‘own’ contribution. This means that the patient pays a fee of €2.50 per day for up to 10 days. The rest of the amount is paid by the state. If treatment lasts longer than 10 days, the patient does not have to pay more. The detox service is offered in Estonia by two institutions, and one is fully financed by the National Institute for Health Development and is free for the client<sup>138</sup>.

## Patient pathways to rehabilitation

According to the National Institute for Health Development, the aim of the long-term treatment and rehabilitation service is to stop drug use, as well as to restore of the patient’s physical and mental health. Treatment begins by addressing withdrawal symptoms, if necessary, and continues with rehabilitation services where professionals use different forms of counseling and therapy to implement permanent changes in the human psyche and the client’s attitudes and behaviour patterns. Cognitive behavioural therapy, individual

136 Marty L, Lemsalu L, Kivite-Urtane A, Costagliola D, HERMETIC study group, et al. (2021). Revealing HIV epidemic dynamics and contrasting responses in two WHO Eastern European countries: insights from modeling and data triangulation. *AIDS*. Mar 15;35(4):675-680. <https://doi.org/10.1097/qad.0000000000002778>

137 <https://www.narko.ee/>

138 <https://www.narko.ee/>

counseling and group therapy, are mostly used for this purpose. The service is not subject-specific and is, therefore, suitable for different persons who use drugs, including cannabis and stimulant users. The preparation of the treatment and rehabilitation programme is always based on the individual needs of the patient, so the duration of the treatment programme varies and, depending on the patient's condition and readiness, can last up to 9 months. The service is free of charge for all without the health insurance fund<sup>139</sup>.

## Patient pathways to outpatient rehabilitation

Relapse prevention (post-treatment counseling service) is provided to people who have undergone long-term treatment or rehabilitation in freedom or detention facilities and aims to prevent relapse and support human social adaptation. The service is provided based on the principle of case management and includes psychological, social and experience counseling. The service is aimed at both healing users of psychoactive substances and their relatives<sup>140</sup>.

**A drug rehabilitation centre health professional said:**

“ I think that mental health services are even more accessible to people with drug dependence than the regular population, as almost all services for people with drug dependence they have in a team a psychologist and, in good cases, a psychiatrist. The queues for receiving the service are not long,

**and the availability of the service is not dependent on the existence of health insurance.”**

## Counseling programme for cannabis users (VALIK)

VALIK ('Choice' in Estonian) is a counseling programme for people who use cannabis or its analogs, who feel that it affects their daily life, whether it is related to complicated relationships with loved ones, decreased ability to concentrate, difficulty falling asleep, or a constant increase in the amount of money spent on purchasing cannabis. The purpose of the programme is to motivate and support people to help initiate and plan to reduce or quit their current cannabis use. VALIK is an outpatient programme consisting of one-to-six counseling sessions. The appropriate number of meetings is decided together with the counselor during the meeting process. Counseling is carried out both as a physical meeting and in the form of online counseling. The programme is free for the client<sup>141</sup>.

According to the Estonian Mental Health Green Book, primary mental health services must also be provided to people in a detention facility (prison, detention house, detention centre). These are services aimed at reducing people's negative mental health and thereby reducing future offenses. In detention houses and chambers where people (including those who are sober) are detained for a short time, mental health services are not provided. At the same time, this is a potential place where people with a substance use disorder could be found, and the implementation of services to help them deal with their mental health problems<sup>142</sup>.

139 <https://www.narko.ee/>

140 <https://www.narko.ee/>

141 <https://peaasi.ee/>

142 Sotsiaalministeerium, 2022



## Patient pathways for OAT clients

Methadone-based substitution therapy is free for all without the health insurance fund, i.e. uninsured clients. A substitute therapy based on Buprenorphine (Subutex, Suboxone) is offered for a fee<sup>143</sup>. According to the clinical protocol issued by the National Institute for Health Development, the primary appointment lasts for about 60 minutes. It includes the first evaluation, the necessary analyses, and the treatment prescription. No referral is needed.

***A person working in an opioid substitution programme said:***

“ For opioid replacement treatment, the psychiatrist meets the patient and prescribes a replacement drug dose, methadone in the form of syrup...Once the initial dose is determined, the patient visits daily, we wait for the first few days for the patient to be under our eyes and take part in the counseling service. If stability is established and the methadone dose is in place, and if the person is officially at work and has submitted a work schedule and contract to us, then we can agree that it is not necessary to attend every day.”

## Patient pathways for NPS users

In Estonia, there are no specific services for NPS users, but they can use all of the services which are intended for people experiencing drug dependence.

## Pathways for war refugees from Ukraine

According to the Estonian Health Board, all war refugees arriving from Ukraine are guaranteed essential medical care, including essential dental care. Urgent medical services are free for Ukrainians. Since March 2022, all services financed by the National Institute of Health Development, aimed at people affected by drug use, HIV, and tuberculosis, are also open to war refugees. The services are free for those in need. For mental health issues, a person using drugs can contact a mental health nurse for phone or online counseling.

## The impact of COVID-19 pandemic restrictions on mental health service provision

According to a mental health survey conducted in Estonia, the manifestation of mental health problems is influenced by a range of environmental and genetic risk factors. In the pre-pandemic period, diagnosis of depression was most strongly associated with gender and genetic risk scores, followed by lifestyle factors (smoking, drugs, and alcohol use). Self-reported depression risk (at the time of the pandemic) was associated with younger age, gender, genetic predisposition, and substance use. In general, the vulnerable groups for mental disorders are adolescents and young adults, respondents with lower education and lower incomes, and the unemployed. Higher levels of mental health problems are also reported by women and adults living alone.

Various mental health problems and coping strategies emerged in the context of the COVID-19 pandemic. A comparison with earlier population

reference data indicates an increase in stress levels (especially among younger age groups) by the second quarter of 2021. Stress and its negative consequences can be alleviated through emotion regulation and positive health behaviours (adequate sleep time and physical activity). When in need of mental health support, more than 2/3 of the respondents preferred to manage on their own instead of seeking help. In addition to several self-help techniques, the (mental) health services most frequently used to deal with the COVID-19 crisis were consulting with a family doctor, psychiatrist, psychologist or psychotherapist. The main obstacles to seeking help were restrictions due to the health care system (queues too long, restrictions on scheduled treatment, cost of services) and barriers due to knowledge or attitudes (did not believe that anything would help; did not know where to turn). The gap between the need for and use of mental health services is particularly marked in older age groups, men, and those with low incomes. Findings from the qualitative study revealed that an information environment characterised by rapidly changing, frequently conflicting narratives further affected mental health during the crisis<sup>144</sup>.

**A health professional working at a harm reduction service said:**

“ During the pandemic, the harm reduction services worked according to all precautions. Where it was possible, the work was transferred to teleworking (social counseling, psychological counseling). Syringe exchange services did not stop their job. The opioid replacement therapy centres provided clients with methadone for several days to ensure the health of clients and employees as much as possible.”

**Most respondents considered it necessary to improve the availability of mental health services in a crisis situation despite the lack of staff needed for services.**

Also, during the spring emergency of 2020, there were relatively few who missed mental health services



**only 5.5%**  
of adult respondents

**Nearly 80%**      **In turn 70%**

of respondents did not realise the need for help or the obstacles to receiving help.

of those who needed help at some point solved the problems themselves.

Other obstacles were highlighted several times, the most important of which were long waiting lists<sup>145</sup>.

<sup>144</sup> Tervise Arengu Instituut (2022), Ibid.

<sup>145</sup> Tervise Arengu Instituut (2022), Op.cit.

***A woman aged 31, who is a patient of mental health care services, said:***

“ I went to a doctor for mental health help before the COVID-19 pandemic, so I can only say that even before that, the queues were quite long. I believe that during COVID-19 they became even longer and e-consultations were preferred instead of going to the place.”

***A health care provider working in an opioid substitution programme said:***

“ It has been clear that our services must continue, the availability of services was 100%. We used personal protective equipment. We have also an opportunity to give methadone at home, or we have also had a loved one come to pick up the medicine based on an official paper. Furthermore, we also brought methadone to the hospital and psychiatric clinic. Meetings are online, meeting through a video bridge, which is very convenient. We also have a separate area for the client, so that if the specialist is not present, but the client wants to communicate with the specialist, you can use a video bridge. Many people agree to get a consultation through the video bridge, most of our clients have smartphones.”

According to the conducted study, given the lack of specialists (such as a nurse, a clinical psychologist, and a psychiatrist) it is also necessary to develop these services as a long-term mental health e-service. Due to the emergency in March 2020, the need for remote services in specialist medical care arose. The Health Insurance Fund temporarily funded clinical psychotherapy as e-consultation. Comparing different healthcare specialties, e-consultations were offered the most in psychiatry (65%). Since September 2020, the list of health services includes a remote e-service provided by a psychiatrist<sup>146</sup>.

In addition to infection and spreading infection to the family, one of the greatest sources of stress was constantly changing work processes for health professionals. At the beginning of the pandemic, in the spring of 2020, the rules related to work organisation and environment could change several times a day. It was necessary to react quickly and often develop the methods themselves during the work. The source of additional tension was the lack of doctors and nurses, so it might have been necessary to work in several departments or healthcare institutions at the same time. Later, the workload was increased by vaccination, with tension caused by the information accompanying them and the lack of public communication. Another difficult period was from February to April 2021 when burnout was often experienced<sup>147</sup>.

146 Sotsiaalministeerium (2020), Op.cit.

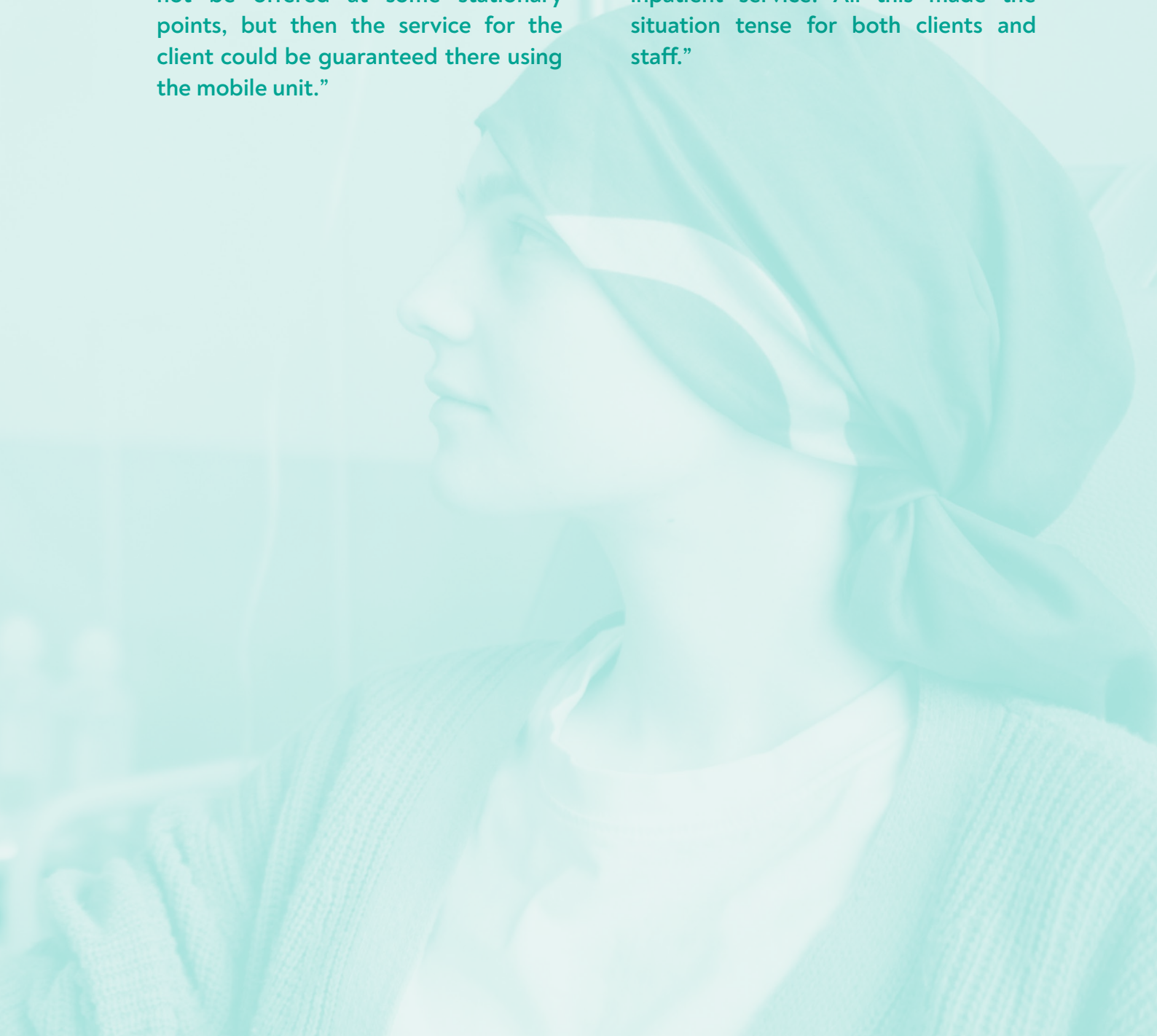
147 Tervise Arengu Instituut (2022), Op.cit.

*A health professional working in a harm reduction service said:*

“During COVID-19, the provision of face-to-face consulting services may have decreased, especially regarding the mobile unit. Broadly speaking, I wouldn't say that it affected our work from a client point of view very much. There were a few days when, in case of employees falling ill, the service could not be offered at some stationary points, but then the service for the client could be guaranteed there using the mobile unit.”

*A professional working in a drug rehabilitation centre said:*

“We offer our inpatient rehabilitation service in the hospital, and during COVID-19 we had strict rules that we had to follow so that a patient with COVID-19 could not come into the department – we had pre-testing before coming to the service, being in isolation at the beginning of an inpatient service. All this made the situation tense for both clients and staff.”





## Annex 3. Moldova country case study

### Mental health patient pathways for the mainstream population

The mental health pathway of care starts at the level of the family doctor's office and ends in the community.

Entrance to the mental health system can be:



a family doctor;



directly (without a mandatory referral) to a Community Mental Health Centres (CMHC); or,



via emergency care (in acute cases, such as psychosis).

Some people prefer to go directly to a hospital, but it is complicated to be hospitalised without concrete directions to do so (such as a referral from a CMHC).

Community Mental Health Centres in the Republic of Moldova provides services to people with mild and moderate mental health problems, severe cases, and chronic (severe) cases, particularly those discharged from institutions. The range of services is different according to the situation of the CMHC

(mostly dependent on the availability of human resources and financial resources), but they should include:

- **Provide diagnosis** as per recommendations in clinical protocols;
- **Development and implementation of the treatment plan** with the client and carers;
- **Engagement with a community network** (such as employers, family, schools, police);
- **Periodically re-assess and re-evaluate** the treatment plan;
- **Collaborate more intensively with a social worker on social care interventions** including housing, income and employment;
- **Collaborate with a non-governmental organisations;**
- **Interventions according to clinical protocols;** and,
- **Collaboration with neurologists or work closely with GPs** in the case of epilepsy and neurological disorders.

### Patient pathway for people who use drugs

People who use drugs who do not have a mandatory medical insurance policy benefit for specialised outpatient and hospital emergency medical care are covered by the funds of the mandatory medical insurance according to the Programme of Mandatory Medical Insurance and the Methodological Norms. For insured persons who do not want to disclose their identity, detoxification is paid out-of-pocket because the use of the medical insurance policy excludes anonymity.

When a person is identified by a narcologist as a person who uses drugs (usually after examining biological fluids for the presence of drugs and/or metabolites), registration in the narcological register of the Republican Dispensary of Narcology (RND) is mandatory. There are two main ways to register: if a person has tested positive for drug metabolites in saliva or urine in police-requested

tests; or by contacting the health system (voluntary hospitalisation for treatment or accidental detection during preventive examinations). Registered individuals are subsequently referred to a local narcologist for diagnosis and treatment. Treatment is prescribed according to the diagnosis and the patient's desire to undergo treatment.

Services for people who use psychoactive substances include primary care and specialised services that include the following:

- Day centres;
- Therapeutic communities;
- Outreach workers;
- Psychotherapeutic interventions; and,
- Community-based treatment services.

The Psychosocial Rehabilitation Centre for drug dependent people operates within the Republican Dispensary of Narcology. The implementation of the programme includes the following strategic objectives:

- Psychological and social support;
- Recovering and maintaining long-term abstinence;
- Social and professional integration;
- Improving relations with those around the individual and family integration;
- Formation of interests that contribute to a healthy lifestyle; and,
- Access to programmes for beneficiaries.

During 2020, rehabilitation services were provided to



And there was an increase in the number of women compared to the previous reporting year

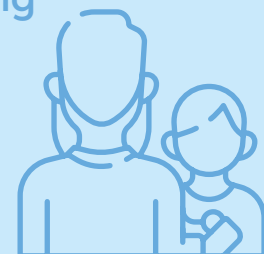


The average age at the time of initiation was **30-45 years**

Of the total number of people in 2020 who started the rehabilitation course,

**211 (89%)**  
successfully completed it,

a number that is decreasing compared to 2019



**92.5%**



## Patient pathways for OAT clients

When a person is identified by a narcologist as a person who uses drugs (usually after examining biological fluids for the presence of drugs and/or metabolites), registration in the narcological register of the RND is mandatory. There are two main ways to register: if a person has tested positive for drug metabolites in saliva or urine in police-requested tests; or by contacting the health system (voluntary hospitalisation for treatment or accidental detection during preventive examinations). Registered individuals are subsequently referred to a local narcologist for diagnosis and treatment. Treatment is prescribed according to the diagnosis and the patient's desire to undergo treatment.

OAT starts at the recommendation of the narcologist based on the evaluation of the needs of the client and according to the criteria established in the national clinical protocol.

The basic criteria for inclusion in the OAT programme are as follows:

- **Registered drug dependence** through opioid consumption;
- **Health problems generated** by the intravenous use of narcotic substances (opioids) (hepatitis, septicemia, HIV/AIDS, etc.);
- **Concomitant diseases** (malignant diseases, diabetes, mental disorders, pulmonary tuberculosis, etc.);
- **Repeated previous attempts** at drug treatment without success;
- **The desire to change dependence behaviour** as determined by the intravenous use of narcotic substances (opioids);
- **Permanent contact with medical workers** involved in OAT; and,
- **Stopping the consumption of narcotic substances** (opioids) and other psychotropic substances.

After entering the public healthcare system, the narcologist, at the level of specialised care, is main contact for the client. Depending on the location and available resources, the client may benefit from psychosocial rehabilitation services, employment support, peer support, etc. However, this is subject to the availability of these services. The most developed and diverse services are in two large municipalities – Chisinau and Balti. In parallel, the beneficiaries of the OAT programme can also be part of harm reduction programmes provided by different NGOs in the country.

The methadone substitution treatment programme in Moldova was approved by the Ministry of Health, Labour and Social Protection by Order 159 of May 20, 2003. According to Government Decision 166 of February 15, 2005, methadone substitution treatment is instituted in penitentiary institutions; thus, Moldova became the first country in the Commonwealth of Independent States (CIS) to introduce such treatment in penitentiaries.

Order 283 of the Ministry of Health dated July 12, 2007, 'Regarding the improvement of the forms and methods of applying substitution therapy to drug dependent patients', excluded some restrictive enrollment criteria (evidence to the narcologist of the case of dependent consumption), thus increasing access to substitution therapy. Based on Order 107 of the Ministry of Health, Labour and Social Protection dated January 26, 2018, regarding the approval of the National Clinical Protocol, 'Pharmacological treatment of opiate addiction', current international clinical guidelines on opiate drug dependence were put in place.

From 2002, the pharmacological treatment of opiate drug dependence with buprenorphine was implemented as part of a project in the Republican Dispensary of Narcology (RND) and, from 2004, pharmacological treatment with methadone was also implemented through the RND and later extended to nine OAT sites in Balti municipality, as well as several districts and also 13 penitentiary

institutions. The OAT programme is implemented by creating synergies between the governmental and non-governmental sectors. The RND, together with other medical institutions, ensures the implementation of the medical component, and the involved NGOs complement it with psychosocial and support services to increase treatment adherence.

According to the National Clinical Protocol, 'Pharmacological treatment of opiate dependence', the medical and psychosocial support for people receiving OAT should include:

- **Psychological support services** in the provision of group psychotherapy services for beneficiaries and their family members;
- **Mutual assistance groups ('peer-to-peer');**
- **Information programmes;**
- **Psychological and psychiatric assistance services** in the diagnosis and treatment of mental disorders; and,
- **Social assistance services** in solving livelihood problems, assistance in the employment process, solving of legal issues and overcoming discrimination, etc.

Within the prevention service, methadone/buprenorphine substitution treatment has observed an increase in geographic access over the course of the programme, both in the civil and prison sectors, and has been fully funded domestically.

According to the results of the interviews with people who use drugs and who are, or are not, in the OAT programme, the main barriers for people who use drugs to join the programme include the following:

- **Mandatory medical records and registration** as a person who uses drugs;
- **Reduced psychosocial support** for clients on OAT;
- **Employment restrictions, discrimination by employers,** as well as travel restrictions abroad; and,

- **Limited access to OAT** in medical facilities during in-patient hospitalisation.

The medical professionals working in the narcology system have additional opinions on the barriers faced by people affected by drug dependence in entering the OAT programme:

- **The lack of interest** of medical institutions to open OAT offices;
- **The lack of narcologists** in administrative-territorial units of the country;
- Until 2019, **there was insufficient funding from the National Medical Insurance Company;** and,
- **The lack of funding from the National Medical Insurance Company** for psychosocial support for clients undergoing OAT.

Speaking about the pathway of care in the mental health system for OAT clients, it does not theoretically differ from the general population. But in reality, OAT clients usually do not approach public mental health services.

## Patient pathways for NPS users

According to the information revealed during interviews and based on the desk analysis, no specific pathways were identified for NPS users in Moldova. They usually have the same level of access to all the necessary health care services. However, it was noted that the profile of people who use drugs has changed in recent years. Currently, more NPS users are becoming clients of drug dependence treatment services. Notably, the users are mostly teenagers or youngsters, but no data or current studies are available to confirm this statement.

## Pathways for war refugees from Ukraine

From the moment when refugees began to enter the territory of Moldova, a coordination group was created that included representatives of the drug dispensary and the non-governmental sector; a mechanism was built and standard procedures were developed. In this regard, it was also decided that service provision will be ensured for refugees on OAT, following the recommendations of the national clinical protocol. There was an exception: that the refugees would be able to receive a seven day supply of methadone or buprenorphine in case they leave Moldova and would need the medicine to be available until their next destination. It was reported in interviews that about 15 beneficiaries of the OAT programme in Ukraine utilised the services in Moldova. OAT programme clients from Ukraine have the same basic needs as any other refugees – PTSD, high level of anxiety, need for shelter and food, insomnia, etc. However, none of them are known to access any mental health service, although some of them have received psychological counseling at the narcology level.

## The impact of COVID-19 pandemic restrictions on mental health service provision

The restrictions adopted in 2020 led to the understanding that, in most cases, patients can receive adequate assistance within the CMHCs and in-patient admission is unnecessary. This situation was maintained even after the elimination of pandemic restrictions. The services provided to people who use drugs also had innovative approaches during the pandemic.

At some point when there were restrictions on attending medical institutions due to methadone and buprenorphine therapy being a daily therapy, clients could not go every day. The services were

organised and almost 90% of clients received therapy supplies at home, as it is written in the protocol, for seven days. This happened at all methadone and buprenorphine dispensing points. However, it gradually became clear that this is not really suitable for all clients because 30-40% of them still need daily contact with a doctor, a psychosocial worker, and not only by phone. Based on observation, it was noted that most doctors were comfortable providing OAT supplies to their clients for a longer period of time.

A further issue with OAT therapy during the pandemic was the supply to people living in rural or remote areas who were unable to access the services as often as was necessary.

One additional innovative approach was the delivery of methadone at home for some clients. After the delivery method was introduced, and it became clear that such remote monitoring is suitable for certain clients, a mobile application is under development that allows clients to shift from 'directly observed treatment' (DOT) to 'video observed treatment' (VOT). The application is designated for clients on pharmacotherapy with methadone or buprenorphine who have difficulties getting to the OAT site for some reason.

Three crisis centres for women who use drugs were also launched during the pandemic.



## Annex 4. Poland country case study

### Mental health patient pathways for the mainstream population

Psychiatric care is designed for patients with mental disorders. Depending on the condition, the patient can be treated in the below-listed institutions<sup>148</sup>:

#### OUTPATIENT CLINIC:

The patient is provided with all the necessary diagnostic examinations, therapeutic services and family education and consultation activities;

#### DAY CENTRE (REFERRAL REQUIRED):

The patient stays at the centre for several hours a day and is provided with the necessary diagnostic tests, specialised consultations, medicines, food, therapeutic and rehabilitation services and educational and consultative activities;

#### HOSPITAL (referral and written consent are required; in acute conditions, no referral is required):

The patient is provided with the necessary diagnostic examinations, specialist consultations, preventive, therapeutic, nursing, and rehabilitation services, medicines, food, therapeutic and rehabilitation services and educational and consultancy activities.

#### OUTPATIENT CLINIC:

In order to access a psychiatrist, an individual must find a relevant Centrum Zdrowia Psychicznego (Mental Health Centre), Poradnia Zdrowia Psychicznego (Mental Health Clinic), or Poradnia Psychiatryczna (Psychiatric Clinic).

A referral to visit a psychiatrist is not required. Psychiatrists write a referral to an in-patient centre, a closed ward, etc. In the case of an emergency, an individual can visit a 24-hour emergency psychiatric service (in a hospital), or a psychiatric hospital.

To access a psychologist, an individual must find a relevant Centrum Zdrowia Psychicznego (Mental Health Centre) or Poradnia Zdrowia Psychicznego (Mental Health Clinic). A referral from a health insurance doctor is required (meaning any doctor providing services under a contract with the National Health Fund (NFZ)).

The following are the medical care components for chronically ill patients who are drug dependent and who, due to their illness, need continuous medical care but who do not need to stay in a specialised ward.

The patient can benefit from:

- **An in-patient long-term care facility;**
- **Long-term care in the patient's home.**

The length of the treatments depend on the patient's diagnosis, but NFZ covers up to one year of therapy.

Access to mental health services vary. In the case of psychiatrists, it is relatively fast (2-4 weeks) and in the case of a psychotherapist, waiting lists are even a year or more.

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Narodowy Fundusz Zdrowia (NFZ) [National Health Fund in Poland]. In Polish. <https://www.nfz.gov.pl/> (accessed 6 June 2023).

## Patient pathway for people who use drugs

Depending on the condition, a patient can be treated for substance use disorders in:

- **An outpatient clinic:** the patient is provided with all the necessary diagnostic examinations, therapeutic services, family education and consultation activities;
- **A day centre (referral required):** the patient stays at the centre for several hours a day and is provided with the necessary diagnostic tests, specialised consultations, medicines, food, therapeutic and rehabilitation services and educational and consultative activities;
- **Hospital (referral and written consent is required; in acute conditions, no referral is required):** the patient is provided with the necessary diagnostic examinations, specialist consultations, preventive, therapeutic, nursing and rehabilitation services, medicines, food, therapeutic and rehabilitation services and educational and consultancy activities.

In case of in-patient treatment, or detoxification, a referral can be made by both a GP and a psychiatrist and is valid for 14 days from the date of issue. The cost of treatment for insured persons is covered by the National Health Fund. There is no distinction in the treatment of NPS and other drugs. The length of the treatment depends on the treatment type, from 7-10 days in the case of detoxification and up to 12 months in the case of in-patient facilities. The most current list of drug dependence treatment clinics is provided by the National Drug Prevention Bureau: <https://www.kbpn.gov.pl/portal?id=110979> (a downloadable PDF is available at the end of the page).

148 Narodowy Fundusz Zdrowia (NFZ) [National Health Fund in Poland]. In Polish. <https://www.nfz.gov.pl/> (accessed 6 June 2023).

150 Charmast J. (2022). Raport Biura Rzecznika Praw Osób Uzależnionych 2022 [Report of the Office of the Ombudsman for drug dependent people, 2022]. Warszawa; Association Jump '93. In Polish. <https://www.narkomania.org.pl/wp-content/uploads/pdf/RaportRzecznika2022.pdf> (accessed 6 June 2023).

## Patient pathways for OAT clients

The first methadone substitution programme was launched at the Institute of Psychiatry and Neurology in Warsaw in 1992. In May 2022, a total

of **25**  
**OAT facilities**  
provided treatment for  
**2,878**  
**clients.**<sup>150</sup>

More than

**1,400**  
**people**

**are being treated in six programmes in Warsaw, with well over three hundred in just two of them.**

**The NFZ's expenditure on substitution, apart from Warsaw, Wrocław and Łódź (which are large cities), is growing very slowly<sup>151</sup>.**

In Poland, methadone is taken by more than

**90%**

**of people in OAT programmes**



Buprenorphine with naloxone by the remaining

**10%**

**And is particularly recommended for younger clients, those with shorter-term drug dependence and those with better social functioning.**



The Ombudsman for People Who Use Drugs, who is a vocal supporter of methadone by prescription, pointed out that in 2015, the Agencja Oceny Technologii Medycznych i Taryfikacji (AOTMiT) (Agency for Health Technology Assessment and Tariffs) proposed a higher scoring of methadone than buprenorphine in the tariff for the guaranteed benefit of the 'substitution treatment programme'. This proposal fell short of the expectations of specialists because, in practice, it excluded buprenorphine/buprenorphine with naloxone from use (the level of buprenorphine use in Poland is among the lowest in Europe) and these are drugs with a higher safety profile than methadone.

The Agency's proposed tariff was perceived as an attempt to strike at the substitution-related draft amendment to the Anti-Drug Dependence Act of 2014 which envisaged allowing safe drugs to be prescribed in regular medical practices of selected specialties. The draft thus aimed to broaden the spectrum of drugs used and expand access to treatment, but it has never been passed as a law.

According to the OPWUD report<sup>152</sup>, clients in substitution programmes in Poland are mainly elderly people with a relatively long history of drug dependence and are often socially excluded. The average age of people undergoing substitution

<sup>151</sup> Charmast J. (2022), Ibid.

<sup>152</sup> Charmast J. (2022), Op.cit.



treatment is significantly higher than clients in rehabilitation centres where people in their thirties predominate. The latest homelessness survey of 2019 nevertheless showed that even then, 14% of Warsaw's homeless indicated drug dependence as the cause of their vulnerability.

Criteria for admission to the OAT programme might vary depending on the place; some are more high threshold than others, **but usually their requirements include the following:**

- Opiate drug dependence;
- At least 18 years of age (or 21 depending on the place);
- Signing a consent to participate in the programme and to receive a substitute and to process personal data necessary for registration in the central list of persons undergoing substitution treatment that is maintained by the National Bureau for Drug Prevention in Warsaw; and,
- Signing of a contract and rules of the substitution programme.

**Participation in the programme means:**

- **Determination of the maintenance dose of the substitute** in an in-patient or outpatient setting by a psychiatrist;
- **Daily dispensing of single doses** of the substitute in the presence of medical staff; in justified cases, there is a possibility of dispensing the substitute at home;
- **Control of abstinence from drugs** other than the substitute (urine drug test) once a month or on suspicion and breathalyzer for alcohol on suspicion;
- **Implementation of an individual therapy plan** (individual, group) – (in many places in theory); and,
- **Monitoring of somatic and mental health.**

To access the OAT programme, no referral is required. Clients are qualified for the substitution programme by the Head of the Counselling Centre or a psychiatrist at the request of the person concerned.

## Patient pathways for NPS users

Based on the literature and collected data, NPS use in Poland does not appear to be considered as a premise for treatment provision, but rather as an emergency and regulatory issue.

## Pathways for war refugees from Ukraine

Refugees from Ukraine are included in the Polish healthcare system. They are subject to the same rules as Polish citizens.

Access to health services depends on the legal status of the immigrant; different groups of immigrants have different legal rights. In Poland, immigrants with regular residency status have the same conditions for access to medical care as Polish citizens; foreigners applying for international protection, on the other hand, have free access to basic health care provided by doctors employed in the centres and outpatient health care only in selected facilities and on the basis of a referral issued by a doctor working in a refugee centre.

By far, undocumented migrants are the group of people whose access to medical services is most difficult. They have free access only to emergency medicine, while all other services require full payment<sup>153</sup>.

Pursuant to the Act of 12 March 2022 on Assistance to Citizens of Ukraine in Connection with the Armed Conflict on the Territory of Ukraine (Ustawa o pomocy obywatelom Ukrainy w związku z konfliktem

153 Jablecka B. (2012), Ibid.

zbrojnym na terytorium tego państwa), citizens of Ukraine who have arrived in Poland since 24 February 2022 are entitled to medical benefits and reimbursement of medicines on analogous terms to those insured in Poland. This includes Antiretroviral Treatment and OAT. However, some people from Ukraine living with HIV or taking drugs are afraid to disclose their status, fearing they might be forced back to their country. Ukrainians in Poland are eligible to use *Mój obywatel* (my citizen) and *Mój Pacjent* (my patient) applications. These are services that offer mobile versions of documents in the form of digital services, allow treatment monitoring, making of appointments with doctors and to subscribe for vaccination. Adults can create profiles online, but minors (children over 13 years old can create accounts), visiting the office is required. In some cases, it might be difficult due to a lack of knowledge by office clerks.

## The impact of COVID-19 pandemic restrictions on mental health service provision

As part of its monitoring of the situation related to drug dependence support and prevention activities during the COVID-19 pandemic, the National Office for Drug Prevention conducted two analyses of the situation in 2020: quantitative studies among treatment facilities and three online group discussions<sup>154</sup>.

Harm reduction facilities were largely affected by the COVID-19 pandemic in the provision of drug dependence support. Some facilities reduced or even stopped their activities at the beginning of the COVID-19 pandemic, i.e. in March and April 2020. In-patient and daycare facilities were particularly affected, but outpatient facilities were also heavily

affected by the new situation. Harm reduction programmes also mostly closed their daycare centres and significantly reduced the activities carried out by street workers. However, quite quickly most of them introduced new methods of working with people who use drugs, primarily using information and computer technology systems. However, introducing online counseling was also problematic and required financial resources to buy equipment, which was not included in existing budgets.

Due to sanitary requirements, client admission times to treatment facilities have increased, as people were only admitted after receiving a test result for COVID-19. One facility had a special room for quarantine, where a client would spend 7 days and then could be admitted to the centre.

Some activities have been stopped, such as the Patients' Club, to minimise contact between clients. During the lockdown, there were no admissions to most programmes as this involved a diagnostic visit. Programmes had restricted visits, set a specific time to pick up methadone every 15 minutes to avoid people congregating, and introduced allowing clients into the outpatient clinics one at a time. In substitution programme, treatment groups were suspended, while all individual meetings functioned as before.

Since the facilities had to cover the costs of the testing, tests were performed selectively. Regarding staff, only those that worked in hospital-based programmes were tested regularly.

The COVID-19 pandemic has not resulted in a significant increase in the number of clients receiving substitution treatment. However, there has been a trend of more first-time clients enrolling in some programmes. Some of this stems from the fact that people lost their source of income (such as theft and sex work).

154 Malczewski A, Bezv M, Dalmata M, Jędruszek Ł, Kidawa M. (2020). Raport o stanie narkomanii w Polsce 2020 [Report on the state of drug dependence in Poland 2020]. Warszawa; Krajowe Biuro ds. Przeciwdziałania Narkomanii. In Polish. [https://www.cinn.gov.pl/portal?id=15&res\\_id=1837081](https://www.cinn.gov.pl/portal?id=15&res_id=1837081) (accessed 6 June 2023).

