

## Youth mental health context in R. Macedonia

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### Socio-economic challenges

The socio-economic circumstances in the R. Macedonia are a function of a prolonged process of transition and global crisis, accompanied by the EU accession requests. They also reflect the changes in the national health care system such as reforms, new legislation and financing

mechanisms, and privatization of health care institutions. Therefore, the system faced and still faces multiple challenges in improving access, quality, and efficiency within continuous health care reforms (Karadzinska-Bislimovska et al., 2013). To improve the quality of care in general and, particularly, mental health care, there is still a need for programmatic and social policies with on adequate emphasis on stress prevention and improvement in the mental health status of young people. According to the World Bank Group (World Bank Group, 2016), in 2004 the proportion of the population under the age of 15 years in R. Macedonia was 21%.

### Legislation context

In R. Macedonia, health care for persons with mental health problems is provided on three levels. Primary health care physicians have to detect the

problem and refer patients to higher levels of health care. Secondary health care is provided by the neuropsychiatry specialist-consultative outpatient services that functions within Health Centres throughout the country, as well as by the Institutes for Children and Youth in Skopje and Bitola. Neuropsychiatry departments within General Hospitals provide inpatient secondary care. The tertiary level is represented by psychiatric hospitals that are mainly providing care for patients with mental health problems. Additional tertiary inpatient mental health care is provided by the University Clinic of Psychiatry and Neuropsychiatry department within the General Hospital in Skopje (World Health Organization, 2009). Concerning the financing of mental health services, 3% of health care expenditures are directed towards mental health (World Health Organization, 2009).

The National Mental Health Committee and the Coordinator for mental health, both appointed by the Minister of Health, provide advice to the Government on mental health policy and legislation. Mental health policy from 2005 includes several pillars: developing community mental health services, downsizing large mental health hospitals, developing mental health services within primary health care, strengthening human resources, involvement of users and families, advocacy and promotion, human rights protection of users, equity of access to mental health services across different groups, financing, quality improvement, and monitoring system (World Health Organization, 2009). The Mental Health Law, adopted in 2006 and its changes from 2015 regulate the basic principles of mental health protection and promotion, as well as rights and

responsibilities of persons with mental illness (Mental Health Law, 2006). The improvement of mental health as well as the improvement of health services for persons with mental health problems was also included in the Strategic Plan of the Ministry of Health (Ministry of Health, 2012). The prevention and control of mental health problems were incorporated within National Strategy of R. Macedonia for prevention and control of non-communicable diseases (Ministry of Health, 2009). Additionally, the Government of the R. Macedonia in 2014 adopted the Program for active health care of mothers and children for 2015 aimed at continuous improvement of the health status of children and women in the reproductive period.

## Prevalence of mental health problems

The Institute of Public Health of RM, Skopje, reported about 6951 persons treated in mental health facilities in the country (in 2014) and 3.5% of them were children and adolescents aged below 19 years (Institute of Public Health of R. M., 2015). According to the World Health Organization data about the burden of mental disorders in R. Macedonia (in 2014, per 100,000 population), disability-adjusted life years were estimated at 3441 and the suicide rate was 6.7 (World Health Organization, 2015).

In a survey of adverse childhood experiences in 1277 students aged 18 and above from a representative sample of high schools and universities in RM (Raleva, Jordanova Peshevska, & Sethi, 2013), a high self-reported rate of physical (21%), emotional (10.8%), and sexual abuse (12.7%) was identified, as well as physical (20%) and emotional neglect (30.6%). Household dysfunction was also common: 10% witnessed violent treatment of their mother, 3.7% lived with someone who abused drugs, 10.7% lived with an

alcoholic, in 6.9% a household member had a mental illness, and in 5% a household member had been incarcerated, and 3.8% had experienced parental separation. This survey (Raleva et al., 2013) showed that adverse childhood experiences were linked to health-risk behaviours, implying an association with long-term poor health outcomes. Emotional abuse doubled the likelihood of drug abuse, tripled the likelihood of attempted suicide, and increased the likelihood of early pregnancy by a factor of 3.5. Additionally, physical abuse increased the likelihood of early pregnancy 8.3 times and doubled the likelihood of attempted suicide. The rate of current alcohol use by students was about 28% and the rate of lifetime drug use was 5.4%. Overall, suicide attempts were reported by 2.8% of respondents.

## Available services and unmet mental health care needs

In R. Macedonia there are 19 mental health outpatient facilities (World Health Organization, 2015) as well as six mental health day treatment facilities (three provide treatment for children and adolescents only) (World Health Organization, 2009). There are also four mental hospitals and 12 psychiatric units in general hospitals, including specialized units for children and adolescents (1% of beds in mental hospitals reserved for children and adolescents only) (World Health Organization, 2009; 2015). Of all outpatient mental health facilities available in the country, about 14% are specialized for children and adolescents (World Health Organization, 2009). Only 6% of all users treated in mental health outpatient facilities were children or adolescents (World Health Organization, 2009).

The percentage of mental health facility users that are children and/or adolescents varied substantially from facility to facility. The proportion of

children users was highest in mental health outpatient facilities (6%) followed by mental hospitals (i.e. 4%). The lowest proportion of children and adolescents treated was in community inpatient units (1%) (World Health Organization, 2009).

Data obtained from the "Mental health atlas - country profile 2014" (World Health Organization, 2015) show that availability and status of mental health reporting in the country is weak, indicating that mental health data are compiled only for general health statistics. Data for some core mental health indicators are available, including those related to mental health policy and law, and workforce availability. It is important that mental health policy and law are fully in line with human rights covenants. Unfortunately, there is a considerably lower quality of data for other indicators, such as items related to mental health spending, social support for persons with mental disorders, service coverage as well as continuity of care for persons with severe mental disorders. The number of NGOs in the country involved in individual assistance activities such as counselling, housing, or support groups is also unknown (World Health Organization, 2009).

Additionally, only 5% of the training for medical doctors and nurses was devoted to mental health and only 3% for primary health care physicians. Nurses and non-doctor/non-nurse primary health care workers have received at least two days of refresher training in mental health. Moreover, such training modules were insufficient and did not cover identified needs for education (World Health Organization, 2009).

The percentage of psychiatrists and nurses with at least two days of refresher training in child/adolescent mental health issues was only 8% and 2%, respectively (World Health Organization, 2009).

In terms of support for child and adolescent health, 44% of primary and secondary schools had either a part-time or full-time mental health

professional, but few primary and secondary schools have school-based activities to promote mental health and prevent mental disorders (World Health Organization, 2009).

As a conclusion, mental health care for children and youth in R. Macedonia is not satisfactory. Programs for the promotion and prevention of mental health problems for vulnerable groups are neither sufficient, nor comprehensive. Community mental health services for children and youth are still underdeveloped. There is also a lack of professional staff in the country dealing with mental health problems in children (child and adolescent psychiatrists, child and adolescent psychologists and social workers), although nowadays there is separate medical specialization in Child and Adolescent Psychiatry with a total duration of 60 months.

Child and adolescent mental health issues are of particular interest for occupational medicine specialists. Within work ability assessment, there are two specific procedures, identified as professional orientation and professional selection. Namely, professional orientation involves work ability assessment in students finishing their primary or high school education in order to choose their future career that will best suit their physiological and psychological characteristics. On the other hand, professional selection puts an emphasis on the selection of the most capable and fit persons for workplace activities. Additionally, psychological aspects of the work include psychological adaptation of the worker to the workplace activities through training and education, as well as adaptation of the work to the mental needs and capacities of the worker (Karadzinska-Bislimovska, 2011).

It is obvious that there are many unmet mental health care needs for children and youth in R. Macedonia. The most important challenges in introducing mental health preventive programs for young people in schools in the country arise from the opportunities to support young people before

the onset or at the early stages of mental health problems. Population level preventive programs that involve young adults in all stages (design, delivery and evaluation) have specific advantages over strategies that focus exclusively on the individual. Since they target a much broader audience, they have the potential to produce widespread effects at the population level, especially in circumstances characterized by underdeveloped community mental health services for children and youth. Mental health prevention in schools is particularly important within the process of further professional orientation and psychological adaptation of the student to the workplace activities.

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