Due to the lack of nationally epidemiological studies in Romania, very little is known about the general population prevalence or severity of DSM-IV mental disorders. In the last years, all over the world, important changes have occurred in the philosophy and practice of mental health treatment [1].

The survey estimates that 8.2% of the adult population in Romania meets criteria for any 12-month DSM mental disorder [2,3].

Twelve-month prevalence estimates were: any anxiety, 4.9%; mood disorders, 2.3%; impulse control, 1.4%; substance use disorders, 1%.

Of 12-months cases, 28.1% were classified as severe, 28.7% as moderate; and 43.2% as mild.

From 12 months disorders 71.7% percent carried only a single diagnosis; 21.9%, 2 diagnoses; and 6.8%, 3 or more diagnoses.

Of 12-month cases, almost one fourth (23.6%) received some treatment in the past 12 months distributed as follows: 22.8% health care and 0.8% non health care.

Received any mental health care only a tenth (11.5%), actually 9.3% being treated by a psychiatrist and 4% by a no psychiatrist mental health specialist. 13.5% were treated by a general medical provider and 0.8% by a human services provider.

Almost anybody was treated by complementary and alternative medicine.

For those with any disorder, the median number of visits in any 1.7, meanwhile the mean number of visits health care was for health care and any treatment 6.

Objectives:
To estimate 12-month prevalence, severity, and treatment patterns of DSM-IV anxiety, mood, impulse control, and substance disorders in Mental Health Study Romania 2007.

Design and Setting:
Nationally representative face to face household survey conducted between 2005 and 2006 using a fully structured diagnostic interview, the World Health Organization’s World Mental Health Survey Initiative version of the Composite International Diagnostic Interview [4].

Participants:
2357 Romanian-speaking respondents 18 years and older.

Main Outcome Measures:
The prevalence of twelve-month DSM-IV disorders.
Proportions of respondents with 12-month DSM-IV anxiety, mood, impulse control, and substance disorders who received treatment in the 12 months before the interview in any of 4 service sectors (specialty mental health, general medical, human services, and complementary and alternative medicine).

The current report presents WMHCIDI data on prevalence, treatment, and severity of 12-month DSM-IV disorders from Mental Health Study [5,6] the WMH survey carried out in Romania.

Sample
Mental Health Study in Romania is a nationally representative household survey of Romanian speakers 18 years and older.

The respondents were selected from a multistage clustered area probability sample of households.

Face-to-face interviews were carried out in 2005-2006 by trained interviewers.

The overall response rate was 70.9%.

Diagnostic Assessment
DSM-IV diagnoses were based on the World Health Organization’s World Mental Health (WMH) Survey Initiative version of the Composite International Diagnostic Interview (CIDI),WMH-CIDI [4], a fully structured lay interview that generates diagnoses according to International Classification of Diseases, 10th Revision [7] and DSM-IV [8] criteria.

DSM-IV criteria are used herein. Twelve-month disorders considered herein include anxiety disorders (panic disorder, generalized anxiety disorder, agoraphobia without panic disorder, specific phobia, social phobia, posttraumatic stress disorder, obsessive-compulsive disorder, separation anxiety disorder), mood disorders (major depressive disorder, dysthymia, bipolar disorder I or II), impulse control disorders (oppositional defiant disorder, conduct disorder, attention-deficit/hyperactivity disorder), and substance use disorders (alcohol and drug abuse and dependence).

The disorders assessed included the 4 childhood disorders (separation anxiety disorder, oppositional defiant disorder, conduct disorder, and attention deficit/hyperactivity disorder), posttraumatic stress disorder, obsessive-compulsive disorder, and the substance use disorders.

Assessment of the childhood disorders was limited to respondents in the age range 18 to 44 years based on concerns about recall bias among older respondents.

Severity
In the article are presented the 12-month prevalence for all WMH-CIDI DSM-IV disorders as well as the percentage of those with a disorder by severity.

Severity was categorized as severe, moderate and mild; respondents were categorized as having severe mental illness if they were diagnosed with 12-month bipolar I, if they attempted suicide in the last 12-months and had any 12-month diagnosis, if they have substance dependence with physiological symptoms or if they have more than one 12-month diagnosis and a high level of impairment on the Sheehan scales.

Among those who are not categorized as severe, respondents were labeled moderate if they have at least one disorder and a moderate level of impairment or they have substance dependence without physiological signs.

The remaining respondents with any 12-month disorder are categorized as mild. The Sheehan Disability Scale assessed disability in work role performance, household maintenance, social life, and intimate relationships on 0-10 visual analog scales with verbal descriptors and associated scale scores of none, 0; mild, 1-3; moderate, 4-6; severe, 7-9; and very severe, 10.

To assess the meaning of the severity ratings, were compared number of days in the past 12 months respondents were totally unable to carry out their normal daily activities because of mental or substance problems.

Analysis methods
Weights were used to adjust for differences in within household probability of selection, non-response, and differences between the sample and the XXX census on socio-demographic variables (table 1).

Prevalence was expressed by the proportion of those with a certain diagnosis. In order to examine the patterns of service use were computed the proportions of those receiving a type of treatment.

RESULTS
PREVALENCE AND SEVERITY
Twelve-month prevalence of any disorder was 8.2%.

Among the main categories of disorders (anxiety, mood, impulse-control and substance use disorders), the most prevalent category of 12 month disorder was that of anxiety disorders with 4.9%, followed by the mood disorders with 2.3%. Similar low rates showed the impulse disorders (1.4%) and substance use disorders (1%).

Going beyond the main categories, and considering the disorders within the categories, can be seen that the more prevalent 12-month disorders was specific phobia 3.3%, the intermittent explosive disorder and the major depressive disorder showing rates twice lower (1.3-1.5%).

Had a low prevalence, under 1% but above 0.5% the following disorders: social phobia (1.0%), bipolar disorder (broad) (0.9%), alcohol abuse (0.9%), post-traumatic stress disorder (0.7%).

Much lower rates (under 0.5%) had: panic disorder (0.4%), dysthymia, alcohol dependence, adult separation anxiety disorder, agoraphobia
without panic (0.3% each one), generalized anxiety disorder (0.2%) meanwhile obsessive-compulsive disorder, oppositional-defiant disorder, attention deficit disorder, drug dependence had 0.1% each one.

12 months prevalence had zero value for conduct disorder and drug abuse.

As mentioned before, twelve-month prevalence of any disorder was 8.2%; 6.0% from the total sample met criteria for only 1 disorder and about 5-10 times smaller proportions for 2 or more disorders (1.5% and respectively 0.7%).

Severity and comorbidity
Severity was strongly related to comorbidity; were classified as severe 20.0% of respondents with 1 diagnosis, 45.0% with 2 diagnoses, and 60.5% with 3 or more diagnoses.

The percent of moderate cases varied from one fourth (25.4%) among those with one disorder to 37-38% among those with more than 2 disorders (38%) and 3 disorders (36.9%).

The percent of mild cases was 2 fifths (43.2%) among those with any disorder, more than half (54.7%) among those with one disorder but decreases dramatically, about three times for those with 2 disorders (16.9%) reaching the low value of 2.7% among those with 3 or more disorders.

Severity by categories
If for anxiety category disorder, each of the three severities covered around of one third of cases (30.3% severe, 33.1% moderate and 36.6% mild), for mood disorders, the cases were mostly severe and moderate (48.3% severe, 33.6% moderate) summing up 81.9%, less than one fifth being mild (18.1%).

The sum of severe and moderate cases was similar for substance use disorders (almost 59.8%, resulted from 42.7% severe and 17.1% moderate) and anxiety disorders (63.4% resulted from 30.3% severe and 33.1% moderate).

Within the impulse-control category, the mild cases particularly (77%) and the moderate ones in lesser extent (16.7%) dominated, accounting for 93.7% of cases.

Comparing the disorders categories, it appeared that mood disorders had the highest percent of severe classifications, almost fifty of cases (48.3%); followed in descendent order, the substance use disorders (42.7%) and the anxiety disorders where the percent of severe cases reached one third for (30.3%), meanwhile the impulse control disorders showed the lowest one (6.3%), under 7%. (See graph 2).

The moderate cases appeared with similar percents for any mood disorder and anxiety disorders (33.6% and respectively 33.1%) and showed half value level for substance disorders and impulse disorders (17.1 and 16.7%).

The highest percent of mild cases was found within impulse disorders, reaching three fourths (77%) meanwhile was half value level for substance disorders and anxiety disorders (40.1% and respectively 36.6%) and less than one fifth (18.1%) for any mood disorders.

The percent of severe cases is 20.0% of respondents with 1 diagnosis, 45.0% with 2 diagnoses, and 60.5% with 3 or more diagnoses.

### Table 1: Demographic distribution of the sample compared to the population on post-stratification variables

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### Figure 1: Structure by severity of cases stratified by mental comorbidity (% of respondents)
Severity by categories
The severity by each disorder

Among the anxiety disorders, the percent of severe cases was over 50% as follows: for generalized anxiety disorder 59.4%, agoraphobia without panic 57.9, panic disorder 57.9% (graph 3).

It was little less than 50% for posttraumatic stress disorders (46.7%) and around one third for social phobia (36%) and any anxiety disorder (30.3%).

For specific phobia the proportion of severe cases was a little bit over one fourth (27.1%), decreased to less than one fifth (17.2%) for obsessive compulsive disorders and resulted very low (5.4%) for adult separation anxiety disorder.

The highest percent of mild cases was found for obsessive compulsive disorder (82.8%).

The percent of mild cases decreased at less than 50% for posttraumatic stress disorders (44.7%), around one third for any anxiety disorder (36.6%) and specific phobia (33.6%) and much more, at fourth value (23.2%) for social phobia.

Panic disorder and generalized anxiety disorder showed low values, under 15%, for mild cases percent (14.1% and 11.6% respectively).

Almost all cases of adult separation anxiety disorder and agoraphobia without panic met the criteria for severe or moderate, as the percent of mild cases was 3.9% and respectively zero.

If for agoraphobia without panic there is a certain balance between severe and moderate cases, with a slight predominance of severe (57.9% and 42.1%), for adult separation anxiety disorder can be noticed an obvious predominance of the moderate cases over the severe ones (90.6% versus 5.4%).

For generalized anxiety disorder, agoraphobia without panic, obsessive compulsive disorders, adult separation anxiety disorders, the number of cases is low and the results should be considered carefully.

Compared to anxiety disorders (where the severe percent varied largely from 5.4% for adult separation anxiety disorder till 59.4% for generalized anxiety disorder), the percent of severe cases varied for mood disorders within a narrower range from 39.6% for dystymia till 61.9% for bipolar disorder (broad) (graph 4).

The highest percent of severe cases was found for bipolar disorders (broad) (61.9%) but for the others was placed between 48.3% (for any mood disorders) and 39-41% (39.6% for dystymia and 41% for major depressive disorder).

Regarding the percent of mild cases, the same narrow amplitude was found: the percent varied from 16.5% for major depressive disorder till 18-20%, being around 18% for bipolar disorder (18.8%) and any mood disorder (18.1%) and reaching 20% for dystymia.

Among impulse control disorders prevailed the percent of mild cases, being 100% for oppositional defiant disorder and attention deficit disorder but around 75% for intermittent explosive disorder (74.7%) and any impulse-control disorders (77%). (graph 5).

The percent of severe cases was around 7% for intermittent explosive disorder (6.9%) and any impulse-control disorders (6.3%) and the percent of moderate cases reached about one fifth for intermittent explosive disorder (18.4%) and any impulse-control disorder (16.7%).
All cases of alcohol dependence met the criteria for severe classification, all cases of drug dependence for moderate; from alcohol abuse and any substance use disorders, around two fifths of cases were severe (49.1% and 42.7%) meanwhile other two fifths were mild (46.9% for alcohol abuse and respectively 40.1% for any substance use disorders).

The anxiety disorders with the highest percentage of severe classifications were generalized anxiety disorder (59.4%), agoraphobia without panic and panic disorder (each one with 57.9%) while bipolar disorder (broad) had the highest percentage of severe classification among mood disorders (61.9%). Alcohol dependence showed the highest percent of severe classification (100%) among substance disorders, meanwhile impulse-control disorders had very low percents of severe cases (6.9% or 6.3% for intermittent explosive disorder and any impulse-control disorders) and zero for oppositional defiant disorder and attention deficit disorder.

Were predominantly severe (having more than 50% of cases meeting the criteria for severe) alcohol dependence (100%), bipolar disorder-broad (61.9%), the cases with 3 or more disorders (60.5%), generalized anxiety disorder (59.4%), agoraphobia without panic and panic disorder (each one with 57.9%).

The highest percent of moderate was found in drug dependence cases (100%) and adult separation anxiety disorder (90.6%).

The percent of mild cases was predominant (over 50%) for oppositional defiant and attention deficit disorders (100% each), obsessive compulsive disorder (82.8%), any impulse-control disorder (77%), and 54.7% for those with one disorder.

**Twelve-Month Use of Mental Health Services**

All respondents were asked whether they ever received treatment for “problems with emotions or nerves or use of alcohol or drugs”. In the respondent booklet was displayed a list of types of treatment providers for visual recall purpose.

The list of professionals included: a psychiatrist, a general practitioner or family physician, any other physician (eg, cardiologist, gynecologist, or urologist), a social worker, a counselor, any other mental health professional (eg, a psychotherapist or a mental health nurse), a religious or spiritual advisor (eg, a minister, priest, or rabbi), or any other healer (eg, a chiropractor, herbalist, or spiritualist).
Reports of 12-month service use were classified into the following categories: psychiatrist, non psychiatrist mental health specialist (psychologist or other non psychiatrist mental health professional in any setting, social worker or counselor in a mental health specialty [MHS] setting, or use of a mental health hotline), general medical (GM) provider (primary care physician, other general physician, nurse, or any other health care professional not previously mentioned), human services (HS) professional (religious or spiritual advisor or social worker or counselor in any setting other than a specialty mental health setting), and Complementary and alternative AM professional (any other type of healer, such as a chiropractor, participation in an Internet support group, or participation in a self-help group).

Psychiatrist and non psychiatrist specialist categories were combined into a broader Mental Health Services category; Mental Health Services category was also combined with general medical into an even broader Health Care category. Human services and CAM were also combined into a non-Health care category.

Separate assessments were made for different types of professionals, support groups, self-help groups, mental health crisis hotlines (assumed to be visits with no psychiatrist mental health specialists), CAM therapies, and use of other treatment settings, including admissions to hospitals and other facilities (each day of admission was assumed to include a visit with a psychiatrist).

Follow-up questions asked about age at first and most recent contacts and number and duration of visits in the past 12 months.

**Probability of 12-month service use**

Were examined the proportions of respondents with 12-month disorders who obtain any treatment in the 12 months before interview, by disorder and service sector.

In order to analyze the intensity and quality of treatment, was examined the median numbers of visits and proportions receiving minimally adequate treatment concordant with evidence based guidelines.

Regarding the service use for any disorder, from the 176 cases, one fourth (23.6%) received any treatment, mostly (22.8%) health care and only 0.8% non health care (diagram 1).

Non health care consisted entirely in human services (0.8%). Those with any mental disorder receiving any health care, actually accessed mainly general medical services (13.5%) and a little bit less mental health care (11.5%). 1.2% is using both mental health and medical general care.

From those with any disorder, treated, only one tenth (9.3%) used psychiatrist services but 4% other mental health care. About 1.8% were using both psychiatrist and other mental health care.

**Any anxiety disorder (126 cases)**

From those with anxiety disorders, 29% received some treatment, mainly health care (27.8%) and very few non health care (1.2%). Non health care is provided entirely as human services. (Diagram 2).

In anxiety disorders, the percents of those receiving mental health care and medical general care, are very close (14.8% and 15.1%). 2.1% are using both type of services mental health care and general medical.

**Specific phobia (82 cases)**

From 82 cases of specific phobia, one fourth is receiving some treatment (25.9%), mainly as health care (25.4%) and only 0.5% as non health care (diagram 3).

Less than half of those treated, are using mental health care (10.4%) and 15.8% general medical care. Only 0.8% is using both mental health care and general medical care.

Regarding the mental health care we can notice that none is using both psychiatrist and other mental health care.

**Diagram 1. Diagram of health care for mental disorders**

![Diagram of health care for mental disorders](image-url)

- **Any treatment**: 23.6%
  - **Any Health Care**: 22.8%
    - **Any mental health care**: 11.5%
      - **Psychiatrist**: 9.3%
      - **Other mental health care**: 4.0%
  - **General Medical**: 13.5%
  - **Human services**: 0.8%
  - **CAM**: 0.0%
  - **Any non health care**: 0.8%
Any mood disorder (59 cases)

From the 59 cases with mood disorders, again one fourth are receiving any treatment (24.7%), mainly as health care (24.2%) and very few as non health care (0.6%) (diagram 4).

The health care is delivered as mental health care (12.1%) and slightly more by general medical providers (15.5%).

3.4% are receiving both types of services mental health care and general medical care. A percent of 12.1% are going to psychiatrist and 2.2 to other mental health care providers.

The percent of those using both types of providers, psychiatrist and other mental health care is 2.2%.

Major depressive episode (46 cases)

From the 46 cases of major depressive episode, more than one fourth (27.3%) received any treatment, mainly as health care (26.5%) (diagram 5).

Within the health care, 17.2% of those with major depressive episode in treatment used general medical services and 13.8% mental health care.
Conclusions

A percent of 8.2% of the adult population in Romania meets criteria for any 12-month DSM mental disorder. The most prevalent 12 months disorder was anxiety, 4.9%, followed by mood disorders, 2.3%.

Of 12-months cases, 28.1% were classified as severe. From 12 months disorders almost three fourths (71.7%) carried only a single diagnosis. As number of disorders is increasing, the percent of severity among the cases having certain degree of co-morbidity, tend to be higher.

The structure by severity is similar for any substance disorder and any anxiety disorder but is oppositely balanced for any mood disorders and any impulse-control disorders, the mood disorders cases appearing mostly severe-moderate and the impulse control disorders mostly mild-moderate.

Within anxiety disorders, for some, the sum between severe and moderate cases was over two thirds, reaching the majority for agoraphobia without panic 100%, adult separation anxiety disorder (96%), generalized anxiety disorder (88.4%), panic disorder (85.9%), being around three fourth for social phobia (76.8%) and two thirds for specific phobia (66.4%).

The same percent of severe and moderate cases was around fifty for post-traumatic stress disorder (55.2%) but decreased to less than one fifth for obsessive-compulsive disorder (17.1%).

For adult separation anxiety disorder, within the summative percent, the biggest contribution came from moderate cases (90.6%), only 5.4% being severe.

The disorders within mood disorders appeared as equally severe as the sum between moderate and severe was around of four fifthths (80% for dysthymia, 81.2% for bipolar disorder broad, 81.9% for any mood disorder and 83.4% for major depressive disorder).

Within mood disorders the proportion of severe cases was between 1/3 (39.6% for dysthymia) and 2/3 (61.9% for bipolar disorder broad). The percent of severe cases was close, around of two fifths for dysthymia (39.6%) and major depressive disorder (41%).

Within the impulse-control, the cases for oppositional-defiant disorders and attention deficit disorders were exclusively mild (100% each one).

The sum between moderate and severe accounted for around one fourth of cases for intermittent explosive disorder (25.3%) respectively any impulse-control disorders (23.0%).

Within substance use disorder the cases of alcohol dependence and drug dependence were entirely either severe or respectively moderate.

The matter of severity of cases was approached from proportionality point of view: many of cases could be mild or self limiting but always the severe cases will need treatment; that why, it was found interesting to know how many from the cases, belong to severe classification and how many received treatment.

From a strictly planning perspective, we should keep in mind the 12 prevalence too. For some disorders, in our sample the number cases was over 100 cases as for anxiety disorder, for others ranged from 40 to 82 cases (major depressive episode, any mood disorder, specific phobia), but for many was found less than 25, more than 15 cases as for any impulse-control disorder, social phobia, intermittent explosive disorder, any substance use disorder, bipolar disorder, alcohol abuse, post-traumatic stress disorder.

For some disorders, the number of cases was extremely low, under 10, and in such situations, the results should be considered extremely cautiously.

In such situation are: panic disorder, dysthymia, alcohol dependence, adult separation anxiety disorder, generalized anxiety disorder, agoraphobia without panic, obsessive compulsive disorder, oppositional defiant disorder, attention deficit disorder, drug dependence.

Of 12-month cases, almost one fourth (23.6%) received some treatment in the past 12 months.

The proportion of cases in treatment ranged tightly from 29% till 24.7%: any anxiety disorder (29%), major depressive episode (27.3%), specific phobia (25.7%), any mood disorder (24.7%).

Most treatments occurred in the Health Care sectors (22.8% of respondents), and, within the Health Care sectors, the General Medical provider answered 13.5% of cases with an disorder.

From those with any disorder, received any mental health care only one tenth (11.5%) and Psychiatrist care 9.3%.

Almost anybody was treated by complementary and alternative medicine.

For those with any disorder, the median number of visits in any 1.7, meanwhile the mean number of visits health care was for health care and any treatment 6.

The percent of those addressing to the psychiatrist provider for any mental disorder is twice higher than the percent of those using other mental health care (9.3% compared to 4.0%).

The percent of those using any treatment is highest for anxiety disorder.

Even the percent of those without disorder treated with mental health care, psychiatrist care is low (around of 1%), given the huge number of those without disorder from the general population, it appears that many people are receiving inadequate care.

Of all respondents, 3.4% used services in the prior year and of the respondents without any disorder, 1.8% used any treatment.

Most likely many people with mental disorders in Romania remain either untreated or insufficiently treated, monitored. A better diagnosis and interventions meant to increase awareness about the significance of certain symptoms and signs, to improve addressability and access as well could enhance not only treatment initiation but the treatment quality too.

At statement level, any country recognize the importance of improving mental health diagnostic and treatment but effective interventions need a comprehensive policy planning and the best way to
accomplish this has to start with gathering accurate general population data on current mental health needs and treatment patterns. Certainly in the last years some changes have occurred in the mental health services delivery system. Advances in treatments were incorporated in daily practice and the number of patients increased as the providers got familiar with the new approaches [10,12] similar with other areas of medical sciences, pharmacological treatments have been promoted through direct-to consumer advertising [13]. Some debate about solitude, lack of communication, stress consequences and the relationship between a balanced life and mental health called awareness about mental disorders and discrimination issues. In primary care appeared the delivery of mental health services.

As in other fields of medical practice in psychiatry too it was a constant movement in the direction of the elaboration, adaptation and use of evidence based guidelines and of care quality improvement. 20-29 But needs assessment and evaluation of the new directions in treatment were not actually accurately assessed [14,23]. The mental health delivery system is organized mainly according with the opinion experts and the new tendencies already spread all over the world but both these orientations did not rely on the knowledge of specific situation or particular assessments but on assumptions that never were checked.

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