# Strategy for wellbeing and mental health in Georgia by 2030

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## Acronyms and abbreviations

| | |
|---|---|
| **AFD** | French Development Agency |
| **ASD** | Autistic Spectrum Disorder |
| **EU** | European Union |
| **GEL** | Georgian Laris |
| **General Practitioner (GP)** | A general practitioner working in primary care or a rural doctor |
| **GDP** | Gross National Product |
| **IDP** | Internally Displaced Persons |
| **HIV/AIDS** | Human immunodeficiency virus infection and acquired immune deficiency syndrome |
| **Ministry in charge of health** | Ministry of IDPs from the occupied territories, labour, health and social affairs of Georgia |
| **NCDC** | National Center for Disease Control and Public Health |
| **SRAMA** | State Regulation Agency for Medical Activities |
| **SSA** | Social Services Agency |
| **UHCP** | Universal Health Coverage Programme in Georgia |
| **USA** | United States of America |
| **WHO** | World Health Organization |

## Foreword

This document presents the second National Mental Health Strategy for Georgia 2021-2030, based on the State Concept of Mental Health Care which was approved by the Parliament of Georgia in December 2013 and on WHO recommendations. It takes into account the results of the first National Mental Health Plan for Georgia 2015-2020 adopted by the Government of Georgia on the 31st of December 2014. It has been prepared by the Ministry of IDPs from the Occupied Territories, Labour, Health and Social Affairs of Georgia (the Ministry in charge of health in this document) with the support of French and Georgian experts from Expertise France with the financial support from the French Development Agency.

The National Mental Health Strategy 2020 - 2030 outlines the development of mental health in the country for the next 10 years, defines the values and principles underlying the arrangement of mental health and the basic needs necessary for the realization of the vision for the future. The document shall also be used as a guide for developing relevant action plans and state programs.

The Ministry of Justice of Georgia has prepared a specific strategy for mental health in the penitentiary system[1], so mental health in prison is not addressed in the present strategy. This strategy will be based on the main principles established in "*the State Concept for Mental Health Care of Georgia*" and "*WHO, The European Mental Health Action Plan 2013–2020*", which would guarantee the coherence in the mental health approach in Georgia.

Ensuring the well-being of the Georgian population and addressing mental health disorders through a mental health strategy is key to Georgia's sustainability. According to the European Office of the World Health Organization[2], in many Western countries, mental disorders are the leading cause of disability, responsible for 30-40% of chronic sick leave and costing some 3% of GDP, which shows that mental disorders are one of the top public health challenges in the WHO European Region, affecting about 25% of the population every year. By comparison, the state budget for the mental health program cost 27,5 million GEL in 2020, which represents less than 0,05 % of Georgian GDP and less than 0,2 % of the state budget for 2020.

In the European Union, with whom Georgia has signed an Association Agreement on 27 June 2014 which entered into force since 1st July 2016[3], the European Framework for Action on Mental Health and Wellbeing states that "*the need to include mental health among the first priorities of the public health agenda has been increasingly recognized in Europe over the past decades. […] Mental disorders are highly prevalent in Europe and impose a major burden on individuals, society and the economy. They represent 22% of the EU's burden of disability, as measured in Years Lived with Disability (YLD). Mental health problems are a key reason for losses of productive human capital. […] The overall financial costs of mental disorders, including direct medical as well as indirect costs through care and lost productivity, amount to more than 450 billion Euro per year*". It represents more than 3 % of the EU Gross National Product (GNP).



[1] Described in the document "Interim response of the Georgian Government to the report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) on its visit to Georgia from 10 to 21 September 2018"

[2] WHO, *The European Mental Health Action Plan 2013–2020,* https://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/publications/2013/the-european-mental-health-action-plan-20132020

[3] https://eeas.europa.eu/headquarters/headquarters-homepage_en/49070/Georgia%20and%20the%20EU

That is why it has been agreed[4] among all countries from the European WHO Region, including Georgia, that the promotion of mental health and the prevention and treatment of mental disorders is fundamental to safeguarding and enhancing the quality of life, well-being and productivity of individuals, families, workers and communities, thus increasing the strength and resilience of society as a whole. All the 52 countries members, including Georgia, have agreed on the following objectives:

**Objective 1. Everyone has an equal opportunity to realize mental well-being throughout their lifespan, particularly those who are most vulnerable or at risk**

**Objective 2. People with mental health problems are citizens whose human rights are fully valued, respected and promoted**

**Objective 3. Mental health services are accessible, competent, and affordable, available in the community according to needs**

**Objective 4. People are entitled to respectful, safe and effective treatment**

**Objective 5. Health systems provide good physical and mental health care for all**

**Objective 6: Mental health systems work in well-coordinated partnership with other sectors**

**Objective 7. Mental health governance and delivery are driven by good information and knowledge**

In addition to these objectives, the present strategy takes into account the Georgian legislation affecting mental health, and the following basic principles adopted by the Georgian Parliament in the State Concept for Mental Health Care[5] on the 11th of December 2011:

- Geographic accessibility and affordability
- Development of a balanced care model with both hospital and community-based care/services, which entails maintaining a balance between pharmaceutical and non-pharmaceutical treatments, between individual, family, and community interests, as well as between methods of prevention, treatment, and rehabilitation.
- Inclusiveness, which implies a consistent (evolutionary and harmonious) development of mental health services in Georgia which gradually encompasses the management of the full spectrum of mental disorders, taking into consideration the improvement of the country's economic condition and the growth of professional capacity in the sector.
- Provision of uninterrupted care and integration which implies the creation of a coordinated, consistent, and continuous system of various forms and methods of mental health care, which focuses on the achievement of maximum sustainable results, the integration of service recipients/patients into health and social services, as well as community involvement and participation, rather than isolation.
- Respect for human rights and dignity and participation which implies a strict adherence to the internationally recognized rights of persons with mental disorders, as well as respect for



[4] WHO, *The European Mental Health Action Plan 2013–2020*, https://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/publications/2013/the-european-mental-health-action-plan-20132020

[5] https://www.mindbank.info/item/4800

their dignity and autonomy, and maintenance of a balance between the rights of service recipients/patients and community interests, promotion of mental health in penal system and provision of equal standards.

- Monitoring and evidence-based approach which implies:
  a) on the one hand, the continuous monitoring of mental health and establishment of appropriate institutional mechanisms (the data available on distribution and prevalence of mental health disorders and other key indicators, as well as response system (service, professional staff, etc.) should be subject to monitoring) and
  b) on the other hand, piloting innovative approaches to mental health care and adapting to reality, the efficiency of which is scientifically proven in other countries.
- Scientific studies to be able to pilot the system by improving the gathering of local evidence and approaches is also required.
- It is necessary to carry out research in the field of mental health care and develop appropriate institutional mechanisms.

Besides, this strategy is in line with the principles defined by the United Nations Convention on the Rights of Persons with Disabilities and the content of the European Union Framework for the United Nations Convention on the Rights of Persons with Disabilities[6].



[6] https://fra.europa.eu/en/cooperation/eu-partners/eu-crpd-framework

# Mental Health in Georgia: Analysis of the situation

## The mental status of the Georgian population

As there has been recently no national general survey on the mental health status of the Georgian population, even if some information on specific groups (such as the internally displaced persons) is available, a mental health survey has been conducted between October 2019 and February 2020 providing an analysis of the needs of the population by the French Development Agency- Expertise France with the support of a Georgian organization, Health Research Union, to get the information necessary to set up the strategy.

This survey is in line with other surveys such as those performed under the World Mental Health Survey Initiative[7], which means that it has used internationally validated tools, with additional questions concerning the access to care, including in particular access to professionals and psychotropic drugs, and barriers to that access. This survey has not included people in mental health institutions and services at the time of the interview.. The results of this survey are detailed in a specific report made available to the Ministry in charge of health and can be summarized as follows.

At least 5% of the Georgian population is facing at any time a mental health problem severe enough to be noticed by family members, close friends and colleagues and having an impact on his or her activities. The rate of major depressive episodes is 3,03% for 12 months, (6% if using a less stringent definition), a rate that could be compared to rates reported in the World Mental Health Survey initiative for countries such as Germany or Spain (4.9%), and below France, USA or Ukraine. 2.01 % of the Georgian population face symptoms of general anxiety disorder on a 12 months' period, which is comparable to those of high-income countries of the World Mental Health Survey initiative. Also, 3 % of the population reported recent symptoms from a recent trauma, but it does not correspond to a full Post Traumatic Stress Disorders (PTSD) criterion that has been evaluated at 6.40 % among the IDP, an at-risk population.

The frequency of psychotic experiences is 4.83% in the long term. 4.5 % of the population declared having had hallucinations, 1.5% delusions, 1.61% at least a psychotic experience during the last year. These rates are close to the World Mental Health Survey Initiative's countries average but lower than France (5.7%), Spain (6.7%) or USA (8.6%).

In the field of suicide, there is an apparent contradiction. Lifetime suicide thoughts rate is relatively high and quite similar for men and women (14.0 %), with 2,7 % who refused to answer or declared that they did not know. This rate is comparable to the highest rate of suicidal rates thoughts in Europe such as in France (14.9 % for women, and 9.6 % for men) or in Germany (11.3 % for women, 8.1 % for men).

But only 1 % of the population declared a suicidal attempt (1.3 % of men and 0.8% of women), which is low compared to other countries. However, the people not answering to this question were almost 1.7%, probably due to stigmatization, which means that the real rate of suicidal attempts could reach 2.7 % for women, a rate lower than in all Europe, for example in France (6.1 %) or in Germany (2.8 %), and 3 % for men, which would be higher than in European countries.

In contrast, the suicide prevalence rate, in Georgia, is estimated at 4.5 for 100 000 people by WHO (standardized) which is close to Greece and much lower than in many European countries (France 12.1, Hungary 14.7, Germany 9.7, or Lithuania 25.3) and lower than the neighbouring countries (Russia 18.3, Ukraine 15.8, Belarus 16.6). There is a possibility that this rate may not be accurate and may underestimate the true rate.

Concerning addictions, which are frequently associated with another mental health disorder[8], the prevalence of at-risk usage of drugs (pooling moderate and high) is almost 11 % in the Georgian population, as evaluated on a 3-month period, and may be higher since addictions could be denied; if

[7] https://www.hcp.med.harvard.edu/wmh/

[8] https://jamanetwork.com/journals/jamapsychiatry/fullarticle/482045

one considers only the use of highest risk drugs only, the rate is slightly over 1 %, which is moderate compared with some other countries, such as USA (3.8%) or Lebanon (1.7%). But the gender difference is huge, and men are at much higher risk than women. The WHO ASSIST project[9] has confirmed that there is a serious problem in the field of men's addiction, with alcohol (11% of the men require brief medical intervention and 1.1 % an intensive treatment), cannabis (used by at least 8,4 % of men) sedatives for non-medical usage (8.3% of the population), amphetamine (2% of men), opioids (2% of men) and narcotics (2 % of men).

The survey shows also that there are increased mental health risks for other categories of the population:

- Ageing people are more at risk for anxiety disorder.
- To be divorced or separated is a risk factor for anxiety disorders and to be married is protective against the risk for addiction.
- To be unemployed is a risk factor for almost all mental health problems measured, including severe addiction.
- Self-employed have an increased risk for moderate addiction.
- To live in Tbilisi is a risk for depressive problems, suicidal thoughts, psychotic experiences as compared to other regions, such as Adjara region for example.
- People coming from small towns have an increased risk of depression and a smaller risk of anxiety.
- People with higher education level have a lower risk of depressive episode, suicidal thoughts, and psychotic experiences.

This analysis supports the idea of programs better focused on the most fragile taking in account the type of problem, for example, anxiety for the 60 and over, suicidal thoughts and depression among the unemployed or people with a disability.

As a conclusion, the survey confirms that the burden of mental health is at least as high in Georgia as it is in other countries surveyed with the methodologies of World Mental Health Survey Initiative, with several specificities which have been stressed here.

## Implementation of the previous Strategic Document on Mental Health Development and Action Plan for 2015-2020 (2015-2020)

The first Mental Health Development and Action Plan [10] has been implemented with the following principles/priorities, in line with the objectives defined by WHO:

- Protection of human rights and respect for human dignity
- Equality and accessibility
- Tolerance and social inclusion



[9] The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

[10] Government of Georgia, Resolution #762, Approval of the Strategic Document on Mental Health Development and Action Plan for 2015-2020, December 31, 2014

- Priority for Community-based service/care in the community
- Care coordination and integration
- Comprehensiveness
- Community Involvement
- Meeting the needs of particularly vulnerable groups
- Creation of conditions that will facilitate the self-determination of a person with mental health problems

These priorities have been translated into strategic directions and tasks which were mainly to be handled by the Ministry in charge of health, with, in some cases, support from donors' organization.

It is not easy to assess all the tasks detailed in the National Mental Health Plan, as there has been no official or even informal review during the 5 years of its implementation. This should be corrected in the next strategy.

On the administrative side, there is a ***lack of resources***: a special unit for coordination and supervision of state policy was supposed to be created, but it has not been possible, which may have contributed to the lack of implementation of the Plan.

***The legislation*** has been regularly redrafted by way of amendments, but these patches have created contradictions within the law, and it ***is not yet at international standards***. Besides, in its present version, the definitions and articles are conflicting with those of the Law of Georgia on health care and with the Law of Georgia on Patient's rights, and the patients' rights are disseminated in different parts of the law, sometimes with conflicting drafting. The law still mentions practices which are not practically authorized in Georgia, such as shock therapy or convulsive therapy. Some important topics are missing: worldwide, children mental health is a priority, but it is absent from the law except for the mention of children when it describes the procedure of consent; the priority in the world and Georgia is on a balance between community health care and institutional care, but the law is still generally hospital-centered. A total redrafting based on WHO standards was considered necessary by the Ministry in charge of health and a proposal for a new law has been prepared in June 2020 with international support from Expertise France- French Development Agency and Georgian experts at the request of the Ministry and could be rapidly presented to the Parliament.

***The epidemiological surveillance system is not at international standards***, as it will be detailed later, and the preparation of the new plan has only been possible because Pr. Kovess (Expertise France - French Development Agency) has performed a specific epidemiological survey. The information available consists in a far too limited set of data on outpatients received by the National Center for Disease Control and Public Health (NCDC), and administrative and financial data from hospital and services used to pay for the services by the Social Service Agency (SSA) are not used that way and at any rate, would not be sufficient to analyze the mental health situation in Georgia and the performance of the mental health care. The Ministry got from the Expertise France - French Development Agency a proposal for such a surveillance system which could be implemented rapidly. ***The reforms of public funding and the development of a comprehensive e-health system are ongoing***, and support is given by international donors. However, these are long-term projects, and it should be linked to an improvement of the health information system, which is a long-term project for the whole health system.

A special effort is ongoing for the **development of protocols and quality guidelines** based on the latest scientific evidence and best practice, but even if they are all adopted there is still no mechanism to check that they are implemented in the mental health system.

The strategic priorities included a strong emphasis on **human resources**, which was needed, but it seems that it has been difficult to develop the planned human resources strategy, and even clear baseline figures are still not available.

The development of a regular, dynamic **cooperation model between the outpatient community centers and community-based mental health centers**, which was one priority has been partly achieved

through the strong and successful development of mobile teams managed generally by the same structures as existing outpatient community centers. But the involvement of Primary Health Care in mental health services has not been realized as planned in the strategy, due to the financing system[11], to the weaknesses of the primary health care and to the lack of mental health training in primary health care settings.

During the last 5 years, there has been a strong push for **deinstitutionalization**, in line with the strategy. In 2014, 28% of the budget of the State program for mental health was devoted to community centers and services, it has reached 42 % in 2020).

5 institutional structures (shelters) have been created, for patients needing less care, as new departments in mental health hospitals.

However, the analyses performed in 2020 (see below) shows that this policy has not diminished the number of patients staying for a long time (more than one year) in the institutions, among them some patients not requiring psychiatric care and it is still a challenge. There are several reasons to explain that: the weakness of community mental health services, including those able to provide home visits and reactive interventions for the most seriously disturbed and severe patients; and more importantly the lack of a sufficient range of solutions to support patients who could not and should not leave hospitals without adequate support.

The development of a ***concept of employment support service*** for people with disability has been created, mainly with a financial incentive for employers, but it has not been used. This topic should be addressed in a specific social strategy for people with disabilities including ex-patients from the mental health services.

The action plan 2015-2020 included as a strategic objective "*Improving and strengthening **human rights protection in psychiatric institutions***" and aimed at a reduction of the human rights violation reported by the Public Defender of Georgia and the Committee for the Prevention of Torture in Europe. The existing mechanism to improve the situation is the following: the public defender detects human rights violations when he or she visits the institutions, and the Ministry in charge of health implements corrective measures, thus improving the situation in the mental health institutions and services. This does not function as expected, as indicated by the Public Defender of Georgia in the summary concerning mental health in its last report (report 2019 published in 2020): the reports notes that "*Similar to the previous years, in 2019, the situation in large institutions remains to be a serious problem. There are ten large psychiatric institutions in Georgia. The Public Defender believes that conditions and therapeutic environment existing in these institutions cannot ensure patients' dignified life or protection of their rights. Treatment with antipsychotic medicines needs to be reviewed, updated and changed*".

The Public defender has also expressed concerns with the fact that the treatment is predominantly pharmacological, with almost no psychosocial interventions, and that the lack of adequate somatic healthcare in the psychiatric institutions is a big issue.

Since there is not a systematic and quantified evaluation of these violations, it is difficult to follow the results of the previous mental health strategy but the persistence of such problems is documented. From a systemic point of view, the public authorities, and in particular the Ministry in charge of health is today more sensitive to human rights issues, especially with international reports on the situation in Georgia. But such long-lasting problems are hard to change in a short schedule: the ministry is under a strong pressure to devote resources to avoid to treat patients in the remaining two big hospitals and to allocate funds to community services, whose budgets are thus restricted, and at the same time it is supposed to intervene on a case-by-case basis in these big institutions, especially one of them, to solve the problems linked to a lack of qualified staff and to the inadequate, unsafe and dilapidated buildings.

[11] For example, a patient with mild anxiety or sleep problems will have to pay for his or her treatments if he is treated in primary care, but it will be paid by the mental health program. That explains why people are referred to psychiatrists instead.

Besides, it seemed difficult to immediately close the more problematic psychiatric institution, which gathers patients from all parts of the country, because small psychiatric wards in towns with general hospitals are mostly lacking, day hospitals are absent and community services are not able to manage such demanding patients. Moreover, international experience shows that closing the big institutions is a heavy project, needing a qualified project team with project management experience, qualified social and nursing staff to assure sustainability and the Ministry of health does not have yet this type of resources.

The standards for the different types of structures are not clearly defined, and the Ministry and, even if they existed, public authorities would not be able to control themselves that the laws, regulations, and standards are respected in mental health structure, as there is no specialized independent inspectorate. The Ministry and the Social Service Agency may receive some complaints from the patients, but as noted by the Public Defender in its 2019 report, "*The existing external control mechanisms are based on patients' complaints. They do not ensure the required degree of state control considering the shortcomings of psychiatric care and the absence of adequate and accessible procedure allowing patients to complain about human rights violations. In particular, the work of control mechanisms is not comprehensive or coordinated and it tends to fail to follow up rigorously on the identified violations*". And these are mainly investigated by the colleagues of the person who is accused of these violations, as there is a lack of independent experts on such situations which are complex to analyze.

Even if they wanted to address human rights violations, psychiatric institutions are facing major challenges in terms of human resources compared to most other countries. For undefined reasons, Georgia is one of the few countries in the world almost without nurses in psychiatric care, when, in other countries, nursing occupies a pivotal role in all mental health care settings. They generally handle the entry process, and when needed the crisis, under psychiatrist supervision. They work closely with treatment teams (psychiatrists, psychologists) to develop individualized patient plans, aiming to maximize care and, when they work in outpatient community centers and other community teams, they help patients to live productive lives together with occupational therapists. In hospitals, patients are continuously under psychiatric nurses' supervision. Nurses are a central element of the treatment, as they organize the patients' activities, closely interact with them and provide the medications. They also play a central role in the assessment and maintenance of patient's safety to avoid putting the patient or others in a position where their physical safety is threatened.

In the absence of qualified psychiatric nurses in Georgian psychiatric hospitals or wards, it appears that this important work is partly done by psychiatrists[12] and occasionally psychologists, which is a clearly insufficient and somewhat a misuse of their role, and mostly by non-qualified staff with evident risks concerning the health, the safety and the human rights of patients. This leads to potential overmedication.

The last priority of the previous strategy was "***Raising public awareness, changing attitudes / reducing stigma***", and consisted in actions aiming at having elements of a mental health promotion program, with a strong case for fighting stigmatization. Even if there is among Georgian specialists an understanding that the present level of stigmatization, inherited from the Soviet times, is a handicap for the Georgian health system, et even if there was a will from international donors to support an action in this domain, the program envisaged and built by the Ministry, international experts and NCDC was implemented with limited resources by the specialized team from the NCDC.



[12] According to the Georgian statistics they are 375 psychiatrists and narcologists (10.1/100 000 inhabitants) and 1178 neurologists (31.8/100 000 inhabitants) for neurologists. Compared to many European countries the rate of psychiatrists is high.

## Mental health care survey

After studying the mental health status of the Georgian population and analyzing the impact and challenges of the previous mental health strategy, it seemed important to get some elements of mental health care provision.

The National Center for Disease Control and Public Health (NCDC), which oversees the surveillance of communicable and non-communicable diseases publishes in its annual report, an "administrative" lifetime prevalence and yearly incidence of mental diseases in Georgia by using outpatient data. Both indicators underestimate the importance of such problems, since many of them are not in contact with such community services, although having been hospitalized, could be in contact with private practitioners or not being in contact with any type of care[13]. Also, NCDC did not provide one-year prevalence which could usefully reflect and monitor the situation.

The Social Service agency which administers state social and health protection programs, including the mental health program, finances mental health institutions and services and thus gets precise and detailed information about their activities and their customers, either for inpatients' or outpatients' structures and services. This information could potentially be an extensive source of information for monitoring and research on the mental health situation in Georgia, even if it does not provide information on those who are not in contact with such structures (in particular on the patients suffering from the most common disorders such a mild and moderate depressive, anxiety and addictive disorders).

That is why, in the population survey performed by Expertise France - French Development Agency for the Ministry in charge of health, there were questions concerning the access to mental health care. The results show that the needs in Georgia for mental health care are similar to those of other countries and gives a useful indication of the challenges Georgian people face when they have a mental health problem.

6.45 % of the people surveyed have declared that they have looked for help for a mental, drug or alcohol problem at least once in their life, which is very low if compared with the results of the surveys performed in other countries such as The Netherlands (29.9 %), France (27.8 %), Spain (15.4 %), Germany (22.3 %), Italy (9.7 %), Bulgaria (14.7 % for women and 8% for men) or even Romania which is more similar (8.1% for women and 6.8% for men). Rates for seeking help for depressive and anxious disorders and suicide attempts are quite low. The stigmatization of mental health problems and difficulties to access to specialized mental health care may explain these figures.

The survey shows that among those who have looked for support, 17.24 % have met a psychiatrist and 38.31 a neurologist, 40% a psychologist, 10.5 % a general practitioner.

The fact that people are not meeting first a general practitioner when they have a mental health problem seems to be a Georgian specificity, as, in most of the countries surveyed, people begin by meeting a general practitioner. The surveys made in the World Mental Health Survey Initiatives show that, in such a situation, 78 % of people in France, 71 % in The Netherlands, 52 % in the USA, 50 % in Japan meet first a general practitioner to discuss their mental health problems. Until now, the lowest rate in the world was in Mexico with 33 %. It may be attributed to the stigmatization, to the absence of training of general practitioners in mental health or to the fact that mental health consultations and pharmaceuticals are free in the mental health system and paid by the patients when they consult their general practitioner, as they are not part of the Universal Health care package. Trained general practitioners in other countries practice a triage, deal with some simple cases of anxiety and depression, which prevents the congestion of mental health institutions and services.

Another Georgian specificity is that Georgians use more frequently neurologists than psychiatrists when they have a mental health problem, which is surprising as "*neurologists focus on those brain disorders*

[13] Prevalence refers to proportion of persons who have a condition at or during a particular period, whereas incidence refers to the proportion or rate of persons who develop a condition during a particular time period

*with cognitive and behavioral abnormalities that also presented with somatic signs—stroke, multiple sclerosis, Parkinson's, and so forth—while psychiatrists focused on those disorders of mood and thought associated with no, or minor, physical signs found in the neurological examination of the motor and sensory systems—schizophrenia, depression, anxiety disorders, and so on*[14]". One reason for this Georgian specificity is that it may be a way to avoid psychiatrist since psychiatry is very much feared and discriminated. But as neurologists which are much more numerous than psychiatrists are not well trained in psychiatry in Georgia, this is a potential threat to the adequacy of treatment.

Visiting a religious adviser is also relatively less frequent in Georgia (4.2 %) than in other countries when the average is 12.3 % in the countries surveyed by the World Mental Health Survey Initiatives and 16.7 % in middle-income countries such as Georgia.

The financial side of the decision to seek help cannot be ignored. The survey shows that in the absence of private insurance, 93 % of the people seeking mental health support were paying themselves, and 7 % only were getting free support from the mental health program. This is a barrier for access to treatment and could explain why people are not treated before showing major symptoms and needing hospitalization.

The treatments provided are mainly psychotropic drugs (61 %), psychotherapy or counselling (32%) and psychosocial support (7%). Addictions are the most important reason to consult a mental health specialist, which questions the separation between the Mental Health program and the State Program of Drug Addiction.

## The Georgian mental health care system

This mental health care system is managed by the Ministry in charge of health, who supports the preparation of the legislation on the government's side and prepares the strategies and action plans to be adopted by the government and the Parliament. The Ministry defines specific regulations for the mental health system, with the advice of a mental health policy-making council which includes representatives of both governmental and non-governmental organizations and heads of psychiatric institutions and services[15]. It is assisted by the Social Service Agency which administers the state social and health protection programs, including the mental health program, finances mental health structures and services, and oversees mental health promotion.

At the basic level, the legislation and the financing system do not include general primary health care professionals in the mental health care system. The mental health program created in 1995 does not finance consultations with general practitioners (GPs) working in primary care centers in towns or as rural doctors in other areas. These practitioners are not trained to detect or handle even light mental health problems, which is unusual and may contribute to stigmatization.

The mental health system financed by the mental health state programme includes diverse services:

1) Outpatient community (OP) centers.
2) Psycho-social rehabilitation services.
3) Day hospital for patients under 18 years.
4) Crisis intervention for patients 16-65yy.
5) Mobile outreach team (MOT) services.
6) Hospital care for adult patients.

[14] Mary G Baker, Rajendra Kale, British Medical Journal, 2002 Jun 22; 324(7352): 1468–1469.

[15] http://moh.flash.ge/ka/news/606/

7) Hospital care for children with mental health problems

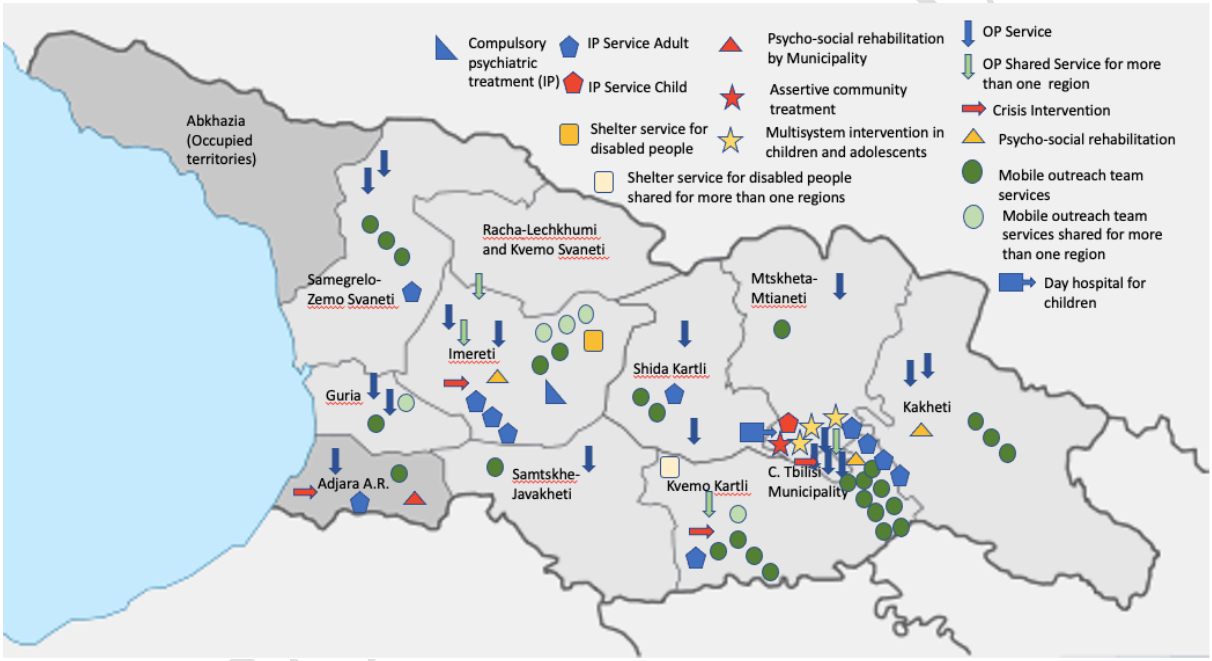
8) Shelter service for disabled people with mental health problems

9) Compulsory psychiatric treatment.

These services are financed by a global budgeting payment model excluding day hospital service, financed by a Fee-for-Service model[16]. Besides, there are multisystem intervention provisions for children and adolescents and assertive community treatment in Tbilisi, financed by the municipal budget, and psycho-social rehabilitation in Batumi municipality, financed also by the municipal budget. Most mental health services are provided by specialized institutions/facilities. However, some services are integrated into general hospitals.

The geographical distribution of service providers is presented below.

*Picture 1 Cartography of Mental health service provision in Georgia*




## 1. Inpatient facilities

There are 11 inpatient facilities for adult, and 1 inpatient facility for children (in Tbilisi)

According to the Ministry in charge of Health's website in December 2020, the impatient facilities had the following capacities in October 2020:

[16] Fee-for-service (FFS) is a payment model where services are unbundled and paid for separately.

*Table 1 Psychiatric hospitals - Number of beds*

| | Hospital location | Name of facilities | Bed Capacity |
|---|---|---|---|
| 1 | C. Tbilisi Municipality | Center For Mental Health And Prevention Of Addiction | 100 |
| 2 | C. Tbilisi Municipality | №5 Clinical Hospital | 30 |
| 3 | C. Tbilisi Municipality | Tbilisi Mental Health Center | 210 |
| 4 | C. Tbilisi Municipality | Evex Hospitals | 18 |
| 5 | Kvemo Kartli, C. Rustavi Municipality | Rustavi Mental Health Center | 22 |
| 6 | Imereti, C. Kutaisi Municipality | Kutaisi Mental Health Center | 29 |
| 7 | Adjara A.R., C. Batumi Municipality | Batumi Medical Center | 150 |
| 8 | Imereti, Khoni Municipality | Academician B.Naneishili National Centre Of Mental Health | 540<br>(includes approximately 250 forensic beds with variations in time) |
| 9 | Samegrelo-Zemo Svaneti, Senaki Municipality | Senaki Mental Health Center | 15 |
| 10 | Shida Kartli, Surami | Mental Health Center Of Eastern Georgia (Surami Psychiatric Hospital) | 65 |
| 11 | Imereti, Terjola Municipality | Imermedi-Imereti Regional Medical Center (Terjolamedi) | 18 |
| Total | | | 1197 |

The density of inpatient beds by region is the following:

| Region | Population[17] (thousands of inhabitants) | Number of beds | Density (beds by 100 000 inhabitants) |
|---|---|---|---|
| C. Tbilisi Municipality | 1 184,8 | 358 | 30,2 |
| Adjara A.R. | 351,9 | 150 | 42,6 |
| Guria | 108,1 | 0 | 0 |
| Imereti | 487,0 | 587 (337 without forensic beds) | 69,2 without forensic beds |
| Kakheti | 310,1 | 0 | 0 |
| Mtskheta-Mtianeti | 93,3 | 0 | 0 |
| Racha-Lechkhumi And Kvemo Svaneti | 29,1 | 0 | 0 |
| Samegrelo-Zemo Svaneti | 311,1 | 15 | 4,8 |
| Samtskhe-Javakheti | 152,1 | 0 | 0 |
| Kvemo Kartli | 434,2 | 22 | 5,07 |
| Shida Kartli | 255,1 | 65 | 25,5 |
| Total | 3729,6 | 1197 | 32,1 (or 35,5 when including 125 beds in smaller institutions called shelters) |

These figures show that there are inequalities between regions, which means that in some parts of Georgia people must be treated far from their communities. Besides, it should be noted that the ratio of beds per 100 000 inhabitants is low compared to most EU countries and more than two times lower than the EU average:

| Country | Mental health beds/100 000 inhabitants[18] |
|---|---|
| Germany | 128,5 |
| France | 82,6 |
| Spain | 36,1 |

[17] National Statistics office, January 2020

[18] https://ec.europa.eu/eurostat/databrowser/view/tps00047/default/table?lang=en

| Country | Mental health beds/100 000 inhabitants[18] |
|---|---|
| Sweden | 41,3 |
| Portugal | 63,6 |
| Austria | 58,3 |
| Bulgaria | 56,8 |
| Denmark | 47,0 |
| Finland | 56,8 |
| Slovenia | 65,6 |
| Ireland | 33,6 |
| Lithuania | 97,6 |
| Estonia | 52,3 |
| Latvia | 122,5 |
| Average EU | 72,6 |

A rapid study of the population in mental health institutions and services performed by experts from Expertise France - French Development Agency, prepared with the data available in the Ministry in charge of health, shows that a part of these mental health beds is occupied by people who are not benefiting from mental health care: in 2018, there were 60 persons in psychiatric hospitals suffering from dementia and 42 persons suffering from intellectual disabilities, when their place should be in specialized social structures.

The same study shows that, according to statistical data provided by the Ministry and which should be confirmed, long-term hospitalization is not globally decreasing despite some regional variations. Also, the number of persons who have been hospitalized in Georgia at least one night seems to have remained stable from 2018 (11 248) to 2019 at 11 149. However, the trend of the number of hospitalized patients is difficult to follow due to a number of changes across years in the information system and a lack of standardization of data collection.

There is a limited number of mental health services in general hospitals, which is not in line with the WHO recommended model[19], and an absence of community residential settings for mental health patients.

The study performed by Expertise France shows also that hospitalization for children is rare and for short duration periods, between one week and one year, except for some children suffering from intellectual disabilities. Half of the hospitalizations concern adolescents who are 17 or 18 years old. A third of hospitalization concerns children with intellectual disabilities who should not be in child psychiatry, as they do not require such type of care. The small number of autistic children as compared to children with intellectual disabilities brings questions about diagnostic criteria and child psychotic disorders treatment adequacy, as some children labelled as suffering from intellectual disabilities may suffer from psychotic or developmental mental health diseases which require specific treatment

### 2. Community services

The mental health program for 2020 defines as follows the different community services:

[19] WHO Mental Health Gap Action Programme Intervention Guide

- Outpatient community centers using the bio-psycho-social model and a multidisciplinary approach, provide diagnosis, in their offices, at home or in the community. Each center serves a population of 70 000 to 100 000 inhabitants, and has a staff of 1 psychiatrist, 1.5 nurses and 1.5 Psychologists (working in reality part-time). They cannot exceed 4 home visits or community visits for each patient every 2 months. They check also the disability status of people.
- Community-based mobile team for people with severe mental disorders who are frequently or hospitalized for a long time and have not been to an outpatient facility for at least the last three months after discharge or have a history of poor tolerance for treatment or have social problems that they are unable to resolve independently due to illness. Their teams consist of 3 staff members, including a psychiatrist, and 2 other members who can be social workers, psychologists, nurses, or junior doctor. Their tasks consist in the development and the implementation of an individual situation management plan in home services with regular visits, in telephone consultations, in providing medications prescribed by a psychiatrist, in the training of the patient's social skills, in assistance in solving social problems together with medical services, in psychoeducation and supportive psychotherapy of the patient, the patient's family members and supporters, in organizing the hospitalization of the patient in case of criteria for hospitalization in a psychiatric hospital, in supporting the patients in accessing to somatic care. The community-based mobile teams function 8 hours a day.
- Psychiatric Crisis Intervention Services for Adults (16-65 years) is a specialized service, which provides services to individuals living in a certain geographical area (population 150,000 on average) to reduce the difficulties of psychiatric hospitalization. The service is provided before the hospitalization and in the post-hospitalization period and provides the following support: it intervenes within 1 hour for people suffering from severe psychotic symptoms or behavioral and affective symptoms that may affect the life or the health of the patient or those around him. Their teams consist of one team leader (psychiatrist), one psychiatrist, one psychologist, one social worker for every 20 cases (all part-time). These teams can provide urgent and scheduled outpatient consultations, a psychiatric evaluation of patients, medical treatment in day hospital; clinical-laboratory monitoring of different as needed; individual, family and group psychotherapeutic services; telephone counseling available to beneficiaries 24 hours a day. These services can be provided at the patient's place of residence (two daily visits possible) and, if necessary, after transfer to the crisis intervention center or by referring to another appropriate psychosocial/psychiatric service provider. After the crisis is over and the patient's clinical condition improves, when daily visits are no longer needed, the patient is referred to the appropriate community service, and if the patient's condition does not improve, despite two daily visits, the patient is hospitalized. The Psychiatric Crisis Intervention Services function 8 hours a day.
- Psychosocial rehabilitation teams are taking measures following the standards for the Georgian psychosocial rehabilitation, to allow the patient to get basic skills necessary for independent living.

*Table 2 - Mental Health services and regional/ municipality coverage funded under the State program Budget (2020)*

| Region | Population[20] (thousands of inhabitants) | Outpatients community centers | Mobile outreach teams | Crisis intervention teams | Psychosocial rehabilitation team |
|---|---|---|---|---|---|
| C. Tbilisi Municipality | 1 184,8 | 5 | 9 | 1 | 1 |
| Adjara A.R. | 351,9 | 1 | 1 | 1 | 0 |
| Guria | 108,1 | 2 | 2 | 0 | 0 |
| Imereti | 487,0 | 4 | 5 | 1 | 1 |
| Kakheti | 310,1 | 2** | 3** | 0 | 1 |
| Mtskheta-Mtianeti | 93,3 | 1 | 1 | 0 | 0 |
| Racha-Lechkhumi And Kvemo Svaneti | 29,1 | 0* | 0* | 0 | 0 |
| Samegrelo-Zemo Svaneti | 311,1 | 2** | 3 | 0 | 0 |
| Samtskhe-Javakheti | 152,1 | 1** | 1** | 0 | 0 |
| Kvemo Kartli | 434,2 | 1 | 5*** | 1 | 0 |
| Shida Kartli | 255,1 | 2 | 2 | 0 | 0 |
| **Total** | **3729,6** | **21** | **32** | **4** | **3** |
| * Population receives service only at a facility located in the neighboring region ** Part of the population receives service at the facility located in neighboring region *** One of these facilities provides service for only other neighboring region | | | | | |

Table 1 above indicates the population covered and the type of services funded by the state Mental Health program in 2020.

Also, there is a day hospital for adults in Tbilisi, and municipalities finance some services such as 3 multisystem intervention services for children and adolescents and one assertive community team for adults in Tbilisi, and one psychosocial rehabilitation service in Batumi.

The role of municipalities in the system is unequal, as it seems that some may invest in health (in the assertive community team in Tbilisi for example) and other more in social support for people with mental health problems. Considering the role of municipalities defined in the law on Self Government, an evolution of their role, could be for example to provide adequate shelters for people suffering from dementia or intellectual disability, or assisted-living facilities for people suffering from mental health problems people and leaving mental institutions. Also, as it is the case in other countries, cities could provide adequate premises for children's mental support structures, such as day hospitals and consultation places.

As the map shows, the geographical coverage of the Georgian territory does not seem to be optimal, but the situation has been improving in the last years at least for mobile teams which seem to play an important role in recent mental health planning and are relatively easier to set up.

However, the community services suffer from the size of the teams, which are small as the psychiatrists, psychologists, nurses and social workers are generally working at the same time in 2 or 3 services, so in

[20] National Statistics office, January 2020

full-time equivalent, mobile teams and outpatient community centers are understaffed, even if the government has obliged the providers to devote 35 % of the budget to staffing the service for outpatient community services.

Besides, there are some unusual limitations for some of these services: for example, according to the mental health programme, it is legally impossible for an outpatient community center to provide for free more than 4 home visits from the outpatient multidisciplinary team. If the patient needs more support, he or she is referred to the local mobile team (which luckily is often delivered by the same professionals and generally managed by the same provider). If a patient of an outpatient community center or followed by a mobile team is in crisis, he or she is referred to a crisis team, which may or may not be the same professionals.

As a consequence, the same patient may be in contact with all the three types of community services: he or she can be the customer of an outpatient community center, can come home for consultations and support, have to deal with a crisis mobile team, spend some days in an inpatient structure, and after this hospitalization be supported by a mobile team as well. Each separated team may lack the relevant information about the patient known by the others. To be more efficient, the system would benefit from more coordination through a unified secure record system to monitor and quantify these overlaps, as well as between in and outpatients services whereas managed or not by the same organization.

It is difficult to draw firm general conclusions from these elements and it would be useful to perform an in-depth territorial analysis of the need for extension of this coverage, especially for the need to develop psychiatric wards in general hospital and community services which will convey less stigmatization and chronicity. It is already planned by the Ministry in charge of health.

However, the review of the existing, although limited, data by experts from Expertise France could provide some information concerning the case-mix[21] for community services and the needs to be completed.

Globally, with the figures provided by the Ministry in charge of health, it seems that young people (14%) and people over 65 (12,6%) represent a relatively important part of the patients. For the children, the main problems are intellectual disorders (30,5%), autistic disorders (6,4%); child behavior and emotional problems (35,7%). For the people over 65, the reason for using community services are dementia (one third) and stress and anxiety (41%). For people aged 34 to 65, psychotic disorders represent a third of the problems treated, and anxiety and stress 40%.

The proportion of cases and the composition of the case-mix is very different across the regions: in some regions, there are few people using community services; in some region (Guria) children disorders are an important part of the clientele whereas in others this is rare; anxiety and stress disorders are the main clientele is quite a few regions whereas it reaches only 10% in Kakheti and 27% in Guria. It may be linked to the different density of services depending on the region.

But the main lesson comes from the comparison between the needs identified by the mental health survey performed by Expertise France, and the visits to community services: 6,45% of the population has declared to have looked for help for a mental health problem, and among them, 85% sought help from a mental health provider. But only 0,45% of the population visited at least one-time an outpatient community center or were supported by a mobile team. Community services cover only one-tenth of the needs.



[21] A case mix is the groups of patients requiring similar tests, procedures, and resources that are treated at a particular hospital or service. Case mix is a way to define a hospital's or a service's production and has been identified as a major factor in differing costs among hospitals and among individual patients (The medical dictionary, US)

# Challenges to address in the new strategy

## The incomplete architecture of the services and structures

The previous strategy has led to a situation mainly in line with international standards for the architecture of services. In 2020, the budget for inpatient services represents 57,5 % of the state budget for mental health, and the budget for community services represents 42,5 %, which represents a positive change compared to 2014.

In principle, the first contact with patients happens with the outpatient community center either as a consultation or by a call, if the patient could or do not want to attend a consultation, who should handle them and if necessary, organize their transfer in inpatient institutions. Even if data about entry modes into the system are lacking, it seems that in many cases, the family bring the patient directly to an inpatient resource without any passage through an outpatient resource.

Another issue is the hospital discharge and the capacity to maintain patient outside full-time hospitalization and reduce rehospitalization. A key issue is a panel of outpatient resource able to avoid chronicity and to treat patients as close as possible from their family and social network to avoid marginalization. On this respect, the absence of mental health day hospitals and places where part-time care could be provided for severe mental health patients is absent in Georgia. Indeed, since the 1960s, psychiatric day hospitals have become in the world increasingly common for different types of cases: as an alternative to full inpatient treatment, as a follow-up treatment after an inpatient stay, as an extension of outpatient treatment, and as a rehabilitation facility, and sometimes as a structure able to handle a crisis, thus avoiding the use of inpatient structures. The advantages of day hospitals are the following: the individual patient may benefit from remaining in his or her familiar social environment despite comprehensive therapy; day hospital treatment facilitates the use and development of the resources available in the social environment; it offers the advantage that existing problems and conflicts in the personal environment can be integrated into the treatment, and the costs of day hospitals may be lower than those of inpatient structures.

As in Georgia, the outpatient community centers already play a part in this role, an evolution of the architecture of the services must be considered. Noteworthy day hospitals could be adapted to the patient's needs: they could attend daily, or a few days in the week, part-time or full time for participating in different treatments and activities. Also, day hospitals are the main and often unique resource for child psychiatry since children need to remain in their family during their care episodes.

Another main difference with international practice and recommendations is the fact that the Primary Health Care is not involved, which is extremely unusual and not in line with WHO recommendations[22]. WHO indicates that "*Most countries report that general practitioners deal with common mental health problems: identifying and referring people with problems (95% of countries); diagnosing problems (86%); regularly treating people with common disorders (86%)*". It is not the case in Georgia, and it leads to a damaging situation, where the resources necessary to treat severe mental health problems are partly used to treat patients with mild anxiety or depression who could be handled by general practitioners with basic training in mental health to assess the mental health status of the patient and treat the mild cases. It causes delays in the access to mental health care when patients arrive with severer pathologies and it is an expensive choice, as it uses costly specialized services when a simple general practitioner could diagnose and treat mild common mental disorders (e.g., mild depressions or mild anxiety and addictive behaviors).

[22] Integrating mental health into primary care: a global perspective, published by WHO, https://www.who.int/mental_health/policy/services/integratingmhintoprimarycare/en/

The rest of the organization of the mental health system is quite standard. After a stay in an inpatient institution, where patients stay in general for a relatively brief period[23] (37 % stay less than 8 days, 44% less than a month), the outpatient community centers and the mobile teams are potentially available, and for those who need them, psychosocial services can support them, in some cities.

For mental health promotion, the NCDC division of health promotion has overseen a component in its 2015-2020 strategy called "*Health Promotion Strengthening and Popularization, Including Mental Health Promotion*". In the field of mental health, several initiatives were taken to prepare actions and campaign to support mental health promotion with specific activities aiming at overcoming the stereotypes, stigma and discrimination, an action which could be better supported.

The Ministry of education is using a team of psychologists to support mental health in schools and the Ministry of Justice is training prison staff on mental health problems.

## The absence of an adequate children's mental health component

According to WHO, "Worldwide 10-20% of children and adolescents experience some sort of mental disorders. Half of all mental illnesses begin by the age of 14 and three-quarters by mid-20s. Neuropsychiatric conditions are the leading cause of disability in young people in all regions. If untreated, these conditions severely influence children's development, their educational attainments, and their potential to live fulfilling and productive lives. Children with mental disorders face major challenges with stigma, isolation, and discrimination, as well as lack of access to health care and education facilities, in violation of their fundamental human rights".

Of course, this sort of statement is pooling together severe and disabling mental health disorders such as Autistic Spectrum Disorder (ASD) which are relatively rare: depending on studies and population 1 to 2% of the 3 to 17 years old, intellectual disabilities 1% whereas anxiety disorders or Attention Deficit Hyperactivity Disorder (ADHD) could be more frequent, depending on the definition and the populations surveyed, and did not require such intensive treatment.

In the field of autism, there has been in Georgia some evolution recently, as several municipalities have their own program for children with autism, so this must be taken into account. For example, in Tbilisi, the "*Rehabilitation of Children with Autism Spectrum Disorder*" sub-program, children with a diagnosis of General Development Disorders are eligible to 20 complex therapy sessions for beneficiaries under 7 years of age, and 15 sessions for beneficiaries aged 7 and over. The voucher costs 420 GEL for users under 7 years old, and 315 GEL for users aged 7 and over. Another program has been implemented in the Adjara region. However, these programs have still to be assessed in line with international standards and on the adequacy of the targeted population.

At any rates, these initiatives are in no way sufficient to compensate for the huge gap in addressing child and adolescent needs, especially with mental health problems and a lack of paradigm of prevention, early identification, and intervention.

The main challenges are:

- There is an absence of knowledge of the mental health and well-being status of children and adolescent.
- There is no medical specialty competence for child and adolescent psychiatry, which is unusual worldwide as no psychiatric nurses and no educators trained in that field.

[23] But there are no data about the rate of rehospitalization

- Except for a specialized ward with 10 beds for children in Tbilisi, partly occupied by children with intellectual disabilities in the absence of other structures adapted for such problems, there are no specific mental health services for children such as day hospitals, intensive home visits to support parents, adapted teaching for severely ill children, outpatient facilities for diagnosing and treating the less severe disorders.
- There are no support and guidance for parents of children and adolescents with mental health problems

## The worrying human rights situation in the mental health care system despite a political will to overcome it

The Public Defender of Georgia[24] "*believes that conditions and therapeutic environment existing in these institutions cannot ensure patients' dignified life or protection of their rights*". That is certainly a challenge, but it needs to be detailed.

From the publications of the Public Defender[25][26], interviews with specialists and with patient representatives, it can be concluded that the problems identified are in particular the following:

- Absence of involvement of patients in their treatment
- Absence of privacy
- Lack of psychosocial treatments
- Lack of attention from staff to conflicts between patients
- Absence of attention for reproductive health
- Conflicts between patients with lack of attention from staff
- Extreme non-compliance with sanitary standards in certain buildings
- Problematic practices for physical and chemical restriction of patients,
- Absence of respect of the person, and possibilities of personal hygiene
- Lack of access to adequate medical care in case of physical illnesses, with delayed medical care for months and premature death,
- Patients lack access to maternal health care and experience significant issues with reproductive rights,
- Labour exploitation of patients by the staff or the management



[24] Public Defender of Georgia, Human Rights Situation in closed institutions, National Preventive Mechanism 2017

[25] Public Defender of Georgia, Protection of Women's Sexual and Reproductive Health and Rights in Psychiatric and State Care Institutions, Special Report, 2020

[26] Special Report of the Public Defender of Georgia, Thematic report on the monitoring carried out at Acad. B. Naneishvili National Centre of Mental Health Ltd (April 22-25, 2019)

These problems originate mainly from more general challenges:

- a lack of rules defined by the law and by regulations, and an absence of inspections to control the implementation of the rules
- the absence of easy access to institutions for patients' lawyers, as NGOs provide lawyers but they have no access to institutions
- the absence of a sufficient number of trained staff, as, except for the deliverance of pharmaceutical treatments and occasional consultations with overloaded psychiatrists, the patient may be abandoned to himself or herself with uncontrolled non-qualified staff
- with the pressure to direct the resources to community services in line with international regulations, the public authorities have no sufficient resources to invest in the buildings and the staff of the remaining psychiatric institutions. Besides, the buildings used by public institutions are owned by the Ministry of Economy and Sustainable Development, which charges rent without overseeing their maintenance.

## The challenges of deinstitutionalization and the development of community services

Deinstitutionalization is a movement that advocates the transfer of mentally disabled people from public or private institutions, such as psychiatric hospitals, back to their families or into community-based homes. The political push for deinstitutionalization in Georgia has been strong in the recent years, but it has had a limited effect until now, mainly in the absence of strong community services which could prevent hospitalizations and handle patients stabilized after treatment in mental health hospitals.

Georgia has also tried to create a few smaller structures (shelters) to offer accommodation and services for people who do not need heavy mental health treatments. But these structures should not be considered as a move towards deinstitutionalization as they are themselves institutions, where people have no more autonomy than in mental health hospitals, no more privacy (there are no individual rooms), have less space for activities, and, for the ones visited by the Public Defender, suffer from the same flaws as the hospitals. Shelters could be considered as a possible solution for deinstitutionalization, but it appears that the present concept in terms of case mix, staff, activities, premises, functions, and localization is not adequate and should be entirely reviewed.

There has also been a more successful effort to develop community services and in particular mobile teams to support people who have been for long periods in institutions

More recently there has been an attempt to develop assisted housing facilities in the community to support the return to a normal life. An NGO, Kheli Khels (meaning Hand in Hand in Georgian) have got support from the state program for people with disabilities to develop assisted-living facilities. The Ministry in charge of health plans to develop such community structure to support the deinstitutionalization for patients who do not need any more health care or only light treatments and could live in the community.

This is a step in the right direction, but the shortcomings are still important and can threaten the quality of community mental health care. But serious challenges are threatening the evolution towards community care.

**The first challenge is linked to human resources.** For example, according to the annual program voted by the Parliament for 2020, each mobile team should consist of 3 staff members, including a mandatory psychiatrist, and the other members may be social workers, psychologists, nurses, or junior doctors. The main difficulty is that they are not working full time, as the budgets are not sufficient (7000 GEL for one year for one mobile team, when according to statistics Georgia the average monthly salary at the end of 2019 in the country was 1 100 GEL per month). All the professionals involved are then working

in other service or structure as well: for example, a psychiatrist, or a nurse, or a psychologist has often to work at the same time in an inpatient service, in an outpatient community center and in a mobile team to get a decent salary. This is not a problem per se, on the contrary, as it allows the staff to follow patients, but this has been done through an organized rotation of tasks without depriving the mobile team of the needed resources. Ultimately, due to the lack to staff availability, the mobile teams, the outpatient community centers, and the inpatient institutions cannot function according to the objectives of the program as defined by the Ministry in charge of health.

Also, **the training of the people visiting patients at home is not adequate.** Nurses, who are very few in the mental health system, have seldom a training in mental health, as there is no official training, and limit themselves to checking that the persons are taking their medications and are in good physical health. The social workers are also not trained, which means that they are often not able to deal with mental health customers. Psychiatrists and psychologists have no sufficient time to perform home visits.

Having not established a continuous control of the organization and the functioning of the services and structures, the Ministry in charge of health has tried to improve this situation by obliging the providers of certain service to spend at least 35% of the budget on salaries (for example 2 450 GEL for mobile teams), which is more than extremely low when compared to other countries. Besides, as there are no rules for the definition of salaries, this 35% can represent quite different levels of services.

Outpatient community centers also have problems with the premises where their activities take place. Most of the time, it has been reported that they are not adapted for mental health activities and that they often do not allow for the necessary privacy or activities such as group therapies or workshops.

The crisis teams are quite few (4 for the country), and their roles and case mix are not well defined as compared to mobile teams; they seem to have the same problems as the other services in terms of staffing and lack of adequate training of the staff.

Ultimately, the outpatient community centers and services' difficulties hamper the possibility to reach the objective defined in the program to "to *reduce the burden of psychiatric hospitalization*". Solutions must be found, to fulfill these missions more efficiently, in line with international practice.

## The difficulties linked to exclusive vertical programs

An important instrument for the public health care in Georgia is a horizontal program, the Universal Health Coverage Programme (UHCP), which provides a package of benefits for the majority of the Georgian population, with better coverage for pensioners, children aged 0–5 years and households registered as living below the poverty line. It includes basic primary care and some diagnostic services, as well as urgent outpatient and inpatient care (with a cost ceiling), elective surgery (with 10–30% co-payments), oncological services and obstetric care, but nothing in the field of mental health. Alongside cover provided under the UHCP, the health budget also finances vertical health programmes for priority diseases and conditions, including mental health, diabetes management, HIV/AIDS, drug addiction, child leukemia services, dialysis and kidney transplantation, palliative care, and public health programs programmes including tuberculosis control, vaccination programmes and the hepatitis C programme. But there are strict barriers between the programs.

The Public defender has detected a serious issue during its visits to mental health institutions: monitoring and managing somatic (physical) health problems and access to medical care remain problematic in the mental health hospitals and shelters, which should legally treat them. The official position is that in case of a somatic problem, the person must be transferred to a general hospital, which is done only in an emergency case, and not for common problems which are not treated and lead to more serious situations. Also, the Public defender indicates that there is a problem for long-term treatments which are not delivered for people in mental health hospitals.

The separation between the vertical programs means that people benefiting from mental health care cannot for example get at the same time tuberculosis treatment or even be treated for an addiction. This leads to a situation where, for example, a mental health patient should stop all psychiatric treatments to be treated for cancer, tuberculosis or for an addiction, or a person who has an addiction problem or

cancer cannot be treated at the same time for his or her mental health problems, which does not make sense from a medical point of view. This situation has been corrected by establishing bridges between programs, and the Ministry of health plans to find solutions.

The complete separation between mental health and substance abuse (restricted to drug addiction in Georgia) programs, is challenging since substance abuse is a mental health disorder. It should be reminded that if WHO's department in charge of mental health is called the Department Mental Health and Substance Abuse and manages a Mental Health and Substance Abuse program, it is because it is difficult to address separately substance abuse and mental health problems. It should be an inspiration for Georgia. Besides, many persons will present a substance abuse disorder and other types of mental disorders and require treatment for both. But on the other hand, mixing in the same structures psychiatric patients with drug addicts may create serious problems: solutions have to be found to enable psychiatric patients to have access to addiction care when needed, and drug addicts should access to mental health treatments without mixing the two populations.

Also, this separation of the programs leads to other problems, as the legislation is separated too, people with drug addiction cannot be treated against their will, while people with mental disorders can be treated, creating confusion for people suffering from both mental health and addiction problems who do not comply to care. It is therefore suggested to review the legislation for drug addiction.

## The lack of financial resources

In 2010, the Georgian GDP was 20,75 billion GEL, the state budget 6.97 billion GEL, and the public budget for mental health was 9.95 million GEL. When the 2020 budget was prepared, the expected GDP was 50.9 billion GEL (+ 245 %), the state budget 14.2 billion GEL (+ 204 %) and the public budget for mental health 27.5 million GEL (+276 %) which is a sign of the Georgian commitment in this domain.

As already indicated, this effort in favor of community services which grew from 26,8 % to 42,6 % of the public expenses for mental health, themselves sharply increasing, is not yet sufficient as there is a need for more staff and specially qualified psychiatric nurses. The effort needs to be continued, as community services are spread over the country, but are still too weak.

The international team supporting the preparation of this strategy has been surprised that pharmaceuticals seem to cost more than 35 % of the budget of institutions and services when they generally represent between 5 % and in extreme cases 15 % of the budget of the same type of structures in all types of all other countries. It seems that this discrepancy could come from different elements:

- A tendency to use pharmaceuticals in all cases, even in cases where psychological and social support would be a solution (but there are no resources)
- In Georgia the unexpensive first-generation antipsychotic drugs seems to be systematically replaced by new generation's ones, which are at least two times more expensive but have not proven to have greater effectiveness in studies financed by public funds, in particular in the US[27] and the UK[28] , a result that has pushed the vast majority of countries in the world to only prescribe last generation antipsychotic to children and some adult patients for whom the first-generation antipsychotics were not effective or entailed side effects.

[27] CATIE (Clinical Antipsychotic Trials in Intervention Effectiveness) study, sponsored by the US National Institute of Mental Health (NIMH), found that the first-generation antipsychotics (FGAs) performed very well against the third-generation antipsychotics (TGAs) risperidone, olanzapine, quetiapine and ziprasidone

[28] The CUtLASS (Cost Utility of the Latest Antipsychotic Drugs in Schizophrenia Study) study, sponsored by the UK National Health Services (NHS), refuted hypothesis that the use of modern antipsychotics is superior to the use of FGAs in terms of quality of life

- There may be a problem of pricing of pharmaceutical, which is general in Georgia and has been discussed in December 2019 in meetings organized by the Curatio foundation[29] with representatives from the Parliament of Georgia, of the Ministries and public agencies in charge, of the State Audit agency of Georgia, of the Public Defender, of pharmaceutical companies, of medical and family associations, and with experts.

This is a question to be studied, as any decrease in the price or the use of pharmaceuticals would be useful if it does not impact the quality of care. The other question to study is the quality of some generic products used, which do not seem to be at the level of the original product according to several specialists.

## The lack of resources for administrative governance

The Georgian mental health system's governing structure is organized around the Ministry in charge of health, which "is formally accountable for the health of the population, oversights the health system, the quality of health services and equity concerning access to health care throughout the country. Its responsibilities have been substantially reduced since Soviet times, especially concerning direct service provision, direct purchasing, and regulation. Different waves of decentralization by deconcentration and privatization over several years mean that the ministry now controls only a handful of specialized hospitals[30]".

The Social Services Agency (SSA) is an agency under the administration of the Ministry in charge of health which, among other roles, which purchases services according to the national programmes, including mental health. The State Regulation Agency for Medical Activities[31] (SRAMA) is another agency formally responsible for issuing the licenses for medical activities and permits for health care facilities and pharmacies, as well as regulating medical professionals, pharmaceuticals, and medical devices. The National Centre for Disease Control and Public Health (NCDC) oversees mental health surveillance and mental health promotion. The Public Defender[32] visits one or two mental health institutions yearly and provides reports for the government, the Parliament, and the public, but it is not checking the community services, or the quality of care, the focus being on the violation of rights. It means that there is a need for another mechanism for checking the quality of mental health care in institutions and services.

It is a modern administrative structure which is similar to those of European countries, but it lacks the usual tools for governing a decentralized system:

- The Ministry in charge of health and/or the Social Services Agency would need a team with qualified specialists able to continuously help to define a policy, support and control its implementation, and propose the necessary adaptation
- The mental health surveillance by the NCDC[33] is limited due to a lack of resources. It is based on a few data sent by some mental health providers and treated automatically without a sufficient quality check



[29] Pharmaceutical pricing policies to improve the population's access to pharmaceuticals in Georgia, Dialogue Summary, December 2019

[30] WHO, European Observatory of Health Systems and Policies, *Georgia - Health system review, 2017*

[31] http://www.rama.moh.gov.ge/geo

[32] http://www.ombudsman.ge/eng

[33] https://www.ncdc.ge/default.aspx?language=en-US

- There is a need of a system for delivering licenses to mental health professionals and structures, with a follow up to renew these licenses after a certain time based on certain requirements (for example to an obligation of regular training for health professionals)
- There would be a need for standards for the functioning of the different mental health services and wards which are operated mainly by private operators, and a need for checks of these standards, in addition to the annual visit from the Social Service Agency aimed at checking the use of the budget, and to the occasional visits of the Public Defender for checking the human rights situation

There has been in Georgia debates concerning the consequences of privatization for the mental health system. As a free market does not function without clear rules and a strict application of these rules, the new strategy should find a solution to better define rules and standards, and to control that they are implemented.

# Strategic priorities

These strategic priorities aim at addressing the main challenges for mental health in Georgia, taking into account the State Concept of Mental Health Care approved by the Parliament of Georgia in December 2013, the results of the first National Mental Health Plan for Georgia 2015-2020 adopted by the Government in December 2014, and Georgia's international commitments, such as the European Convention on Human Rights and the United Nation Convention on the Rights of Persons with Disabilities. They also aim at promoting a patient-centered care approach.

It takes also into account Georgia's commitment to the 4 core objectives and the 3 cross-cutting objectives of the WHO mental health strategy:

**Core objectives**

1. Everyone has an equal opportunity to experience mental wellbeing throughout their lifespan, particularly those who are most vulnerable or at risk.

2. Persons with mental health problems are full citizens whose human rights are respected and promoted.

3. Mental health services are accessible and affordable, available fairly.

4. People receive effective and respectful treatment–offered the way people want it.

**Cross-cutting objectives**

1. Physical health and mental health depend on each other

2. Mental health care needs partnerships and accountability

3. Good and transparent knowledge and information is available about activities for mental health and mental disorders

The following strategic priorities have been identified and are detailed in the following chapter:

- Create comprehensive mental health services for children
- Develop the role of primary health care in the prevention and the treatment of mental health pathologies
- Treat as much as possible mental health problems in the community
- Prioritize deinstitutionalization
- Support isolated communities by developing services, including e-health
- Ensure patients' rights with an assertive action
- Combat stigmatization
- Create solid governance of the mental health project and the mental health system
- Facilitate the treatment of addictions for people in the mental health system
- Provide adequate human resources
- Funding the strategy

## Priority 1: Create comprehensive mental health services for children

With the implementation of the present strategy, Georgian children shall benefit from few dedicated children hospitals beds, numbers of day hospitals, community centers providing consultations, treatments, and other activities, with adapted teaching where needed. At the same time, a survey shall be made to determine the mental health status of Georgian children, which will allow determining the needs in terms of structures and services.

The first action for this priority is the training of professionals, as it will be impossible to develop the necessary structures for children without them. These professionals shall be psychiatrists, specialized nurses, clinical psychologists, and special educators[34]. Specific training programs have already been tested in Georgia or are available from international partners.

Once they are trained, the first type of structures to be created in the main towns in Georgia shall be day hospitals which are presently lacking and are a tool of the utmost importance for treating children and adolescents, as medication should not be generally used and children should not be in inpatient care. These day hospitals should be easily accessible for the population in and around towns, in schools or near them. They should be able to receive children at least 3 days per week to provide psychotherapies, group therapies, specific workshops, and special education. They should also provide family therapies and visit families when necessary.

Hospitalization of children and adolescents shall be avoided and used only for very short periods, for evaluation or brief separation from family. Travelling to Tbilisi is not acceptable for parents and children who are living in other provinces. Therefore, a small hospitalization unit for children (3-5 beds) shall be created at least in Batumi and one or two other places, preferably in or around a general hospital with pediatric services together with day hospitals and other outpatient resources.

Children and adolescents actually labelled as suffering from intellectual disabilities and presently hospitalized or staying in institutions shall be individually reassessed to determine if they can benefit from mental health treatment, as their condition can be caused by mental health ailments and may be improved. Those with intellectual disabilities due to organic causes shall preferably stay in their families, and when it is impossible, stay in assisted living homes financed on social programs. Children shall go during the day when possible to normal classes with or without the assistance of specialized educators, or to special classes with a teacher and a specialized educator in normal schools, or to special schools to be developed with teachers and specialized educators. These solutions will be developed by the ministry in charge of education, and for the specialized educators with the participation of the programs of the ministry in charge of social affairs.

Adolescents treated for mental health problems and having addiction problems as well, which is very frequent, shall benefit from consultations by addictologists (financed by the mental health program) at the request of psychiatrists treating them in a mental health structure, and the cost of the treatments necessary to fight their addiction shall be financed by the State Program on Drug Addiction after prescription by a narcologist. Whenever possible adolescents suffering from mental health disorder and addictions should be treated in specific units, separated from adults and young children.



[34] Special education (also known as special-needs education, aided education, exceptional education) is the practice of educating students in a way that addresses their individual differences and special needs.

| Objectives | Target 2030 |
|---|---|
| **1. Perform an analysis of the mental health status of Georgian children and adolescents to determine the needs for structures and services** | To be performed in 2021 |
| **2. Train a sufficient number of psychiatrists, psychiatric nurses for children mental health services** | At least 10 psychiatrists 15 nurses trained each year. |
| **3. Create a children mental health certification for psychiatrist and psychiatric nurses working in children mental health services** | To be done in 2021-2022 |
| **4. Create training and diploma for special educators of children in mental health structures** | Creation in 2021<br>The first group of 15 trained in 2022 |
| **5. Create children and adolescents' day hospitals together with consultation services around the country** | 2/3 day-hospitals created per year from 2022 |
| **6. Analyze the need to create 3-5 children hospital beds once the day hospitals have been created and once the children suffering from intellectual disabilities have been reoriented to other services** | A study presented in 2024 |
| **7. Assess the case-mix, the relevance and the results of programs and other initiatives for autistic children developed by municipalities, and other actors, and decide on a specific action plan for autistic children** | Assessment in 2022 |
| **8. Create assisted living facilities for children when their families cannot keep them at home even with professional support** | 2023 after assessment of the need |
| **9. Facilitate the treatment of addictions for children and adolescent treated in mental health centers and services** | Authorize in 2021 the psychiatrists in children' community centers and mobile teams to prescribe consultations with narcologists<br>Finance the pharmaceuticals prescribed by narcologists consultants with the State Program on Drug Addiction in 2022 |

## Priority 2: Develop the role of primary health care in the treatment of mental health pathologies

This priority aims to align Georgia with WHO guidelines and international practice, as according to WHO[35], "modern mental health services are no longer the exclusive responsibility of psychiatry. On the contrary, more collaborative and coordinated partnerships should be established and actions should be taken to favor community care that guarantees people with mental disorders receive the respect, safety, trust and effective care they deserve". The decision has been already taken when Georgia supported the WHO's European Mental Health Action Plan (2013) which encourages the Member States to establish primary care as the first point of access for people with mental health problems and provide the capacity to deliver treatment for common mental disorders.

With this evolution, it is expected that people in Georgia can access mental health services closer to their homes. This keeps families together, maintaining their daily activities, and prevents the indirect costs of seeking specialist care in distant locations. Besides, mental health care delivered in primary care minimizes stigma and discrimination and removes the risk of human rights violations that occur in psychiatric hospitals. Georgia should expect good health outcomes at a reasonable cost, provided that general primary care systems are prepared for this evolution.

The general practitioners in Georgia have already received guidelines for the ministry on the treatment of depression and dementia, and this could be extended to anxiety disorders, at-risk substance consumption, first psychotic episode, and suicide risks. The primary healthcare services must be considered as a normal point of access for mental health problems, which means that it should be clearly stated in their instructions, and that their staff should be properly trained to be able to play this role and treat some mental health pathologies. This has been done for the 6 months' project launched by WHO and the Georgian Ministry in Tbilisi and Batumi in 2020 for managing mental health problems linked with the COVID epidemic. This experiment must be assessed, and an improved model for involving primary health care centers in mental health, with the relevant training sessions, shall be developed as a key part of the present strategy.

The health authorities and primary care managers shall encourage patients with mental health problems to visit primary care services, by informing them and withdrawing the financial obstacles existing until now: the system where the first visit to a psychiatrist is free, and a visit to primary care for mental health problems is fully charged to the patient should be abolished.

All the professionals working in primary care shall be trained as soon as possible to be able to receive, treat when possible or refer patients with mental health problems to the adequate mental health professional or structure. The additional workload shall be assessed after some months to decide on additional funding for the primary care sector.



[35] https://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/priority-areas/mental-health-in-primary-care

| Objectives | Target 2030 |
|---|---|
| **10. Train all professionals in primary care services for their role in mental health** | 100 % of people working in primary care services, including rural doctors, trained (2022) |
| **11. Develop the compulsory mental health component in the initial and continued training of general practitioners in primary care centers and rural doctors to allow them to detect efficiently mental health conditions and treat mild ones** | • Content of the training defined in 2021<br>• 100 % have followed the training defined by the Ministry of Education and the Ministry in charge of health (2022) |
| **12. Remove the financial obstacles for people visiting primary care services and rural doctors for mental health problems** | All packages of the Universal Health Care (UHC) Program include a free initial consultation for mental health problems (2022)<br><br>The prescription of pharmaceuticals or of 6 consultations with psychologists for treating minor depression and anxiety by a general practitioner is paid by either the mental health program or included in the packages of the Universal Health Care (UHC) Program (2022) |

## Priority 3: Treat as much as possible mental health problems in the community

This priority aims to give the right to Georgian people suffering from mental health problems to be treated in the community. To reach this goal, the process shall be the following.

An initial assessment shall be performed by a general practitioner or rural doctor, or by a psychiatrist if the person wishes to do it when referred by the general practitioner or rural doctor.

In case of a light disorder, the person shall be able to be treated in the primary care system by a trained general practitioner or rural doctor, with the necessary consultations and prescriptions, such as pharmaceuticals and a maximum of 6 consultations with a certified psychologist (see priority 2).

In case of a more serious disorder, the person shall preferably be referred to a psychiatrist in an outpatient community service where an assessment shall be performed. Depending on the result of this assessment:

- These patients shall normally be treated by an outpatient community center with a combination of consultations with professionals, medications, therapies and different kinds of day-time activities whose purpose is to improve the quality of mental health patients' lives and to maintain their independent initiative and activity. It may include for example workshops, training, cooking opportunities, physical exercise, or cultural activities. Each outpatient community center must offer at least the activities of a basket of services defined by the Ministry in charge of health. This will offer an alternative to the hospitalization or to the systematic use of pharmaceuticals to treat mental health problems
- For people who cannot or do not need to visit the outpatient community center to participate in the activities, there will be a sufficient number of mobile teams in charge of visiting the patients at their home, providing consultation with professionals, checking the compliance with the prescriptions, and supporting the social integration of the person. Contrary to the present rules, these mobile teams shall deal with all types of patients, having or not having been hospitalized[36]. There shall be a coordination mechanism with common patients files shared between the outpatient community center and mobile teams working on a geographical area, to avoid duplicating the work with the same patient and they shall for this purpose be managed by the same provider, and, if possible, share a coordinating psychiatrist as their medical manager.
- In other cases where the patient would benefit from intensive treatment, the outpatient community center will refer him or her to the nearest inpatient facility

The mobile teams and the crisis teams shall be merged rapidly to improve efficiency and ensure that in case of a crisis the team knows about the patient, mobile teams and outpatient community centers organizing themselves to handle crisis among patients in its sector night and day to avoid a direct hospitalization without an assessment in the community. They will provide assessments when patients need to be referred to an inpatient mental health care unit, in liaison with the general practitioners or the rural doctors, according to the law and implementing rules defined by the government.

[36] Until now, community-based mobile team services were for people with severe mental disorders who are frequently or for a long time hospitalized and have not been to an outpatient community center for at least the last three months after discharge, or have a history of poor tolerance for treatment

The outpatient community centers and the mobile teams shall provide, as needed, treatment and social support for patients after hospitalization in an inpatient structure.

After 5 years, the Ministry in charge of health shall analyze if it would be useful to merge mobile teams and outpatient community centers in one structure, but for the moment they should be kept separated until each of them has reached a sufficient level of resources, to avoid transfers of resources preventing the development of mobile teams.

Also, Georgia shall test, and, if proven useful, develop respite houses offering intensive, short-term support to help people prevent and manage a mental health crisis in a residential setting rather than in a hospital. This solution used in other countries shall be tested as an alternative to sending people having a mental health crisis to a hospital, for example for people with mental health problems who do not feel safe at home overnight, or when things at home are contributing to them being in crisis. They will offer overnight accommodation, a small number of beds, a home-like environment and intensive treatment[37].

New rules and standards for the functioning of the outpatient community centers, mobile teams and respite houses shall be prepared based on the new Georgian model by the Ministry in charge of health and adopted by the government. The Ministry in charge of health shall check regularly that the community centers and services function according to these rules and standards. It shall also create and support networks of professionals from outpatient community services to exchange best practices and to discuss possible improvements.

To be able to implement the next priority (deinstitutionalization), community services, which include outpatient community services and mobile teams, shall be reinforced to a level defined using the methodology defined in the relevant guides of the WHO Mental Health Policy and Service Guidance Package (and in particular "Planning and budgeting to deliver services for mental health")



[37] Information from Mind UK which provides provide mental health services in 125 local communities across England and Wales, mental health foundation Australia, Mental Health, Addictions and Intellectual Disability Service New Zealand, Community Access and Parachute NYC USA, and Regional Office for Europe of the World Health Organization

| Objectives | Target 2030 |
|---|---|
| **13. Redefine by regulation the roles of and the activity requirements of the different structures to adapt them to the model described above.** | Having clear regulations on the roles and activity requirements (2021) |
| **14. Redesign the map of Georgian outpatient community centers to have 1 for 100 000 inhabitants, and 1 mobile team for 50 000 inhabitants (these structures being organized to work together in close coordination)** | Map produced (2022) |
| **15. Reinforce existing mobile teams to allow them to reach the staff requirements above** | 100 % of mobile teams at the required staff level (2022) |
| **16. Reinforce existing outpatient community centers to allow them to reach the staff requirements above** | 100 % of mobile teams at the required staff level (2024) |
| **17. Test the respite house system** | Test in 2022 and 2023 |
| **18. Define with the municipalities their possible involvement in developing supported housing and community services for people with mental health problems** | 2021: definition of a standard agreement/contract between a municipality and the ministry of health for collaboration to develop supported housing and services for people with mental health problems<br>2022-2030: progressive implementation |

## Priority 4: Prioritize deinstitutionalization

The WHO European Mental Health Action Plan (2013) adopted by the 52 countries of the region states that "The consensus is that care and treatment should be provided in local settings since large mental hospitals often lead to neglect and institutionalization". To allow the system to move on, the present strategy shall aim at implementing as soon as possible the WHO European Mental Health Action Plan which states (Objective 3) that "large institutions, associated with neglect and abuse, are closed".

In the future, people suffering from severe mental health problem who cannot be treated in the community shall be treated in smaller psychiatric wards to get intensive mental health treatments, avoid stigmatization, neglect and abuse, to get a correct standard of general care and to be treated near their families and friends.

As soon as possible, Georgia shall close the big psychiatric hospitals and develop small hospitals or wards (20 to 30 beds including day hospitalization) managed by the public service or specialized NGOs in towns with general hospitals, to support the physical health of mental health patients. Each of these new structures shall be able to offer day hospital services. A forensic unit shall be kept for prisoners with mental health problems.

All patients suffering from dementia (60 persons in psychiatric hospitals) and suffering from intellectual disabilities (42 persons in psychiatric hospitals) shall be reallocated to relevant social structures (preferably assisted living facilities or family care) which would provide them with the necessary social support. It will be financed by other programs managed by the Social Service Agency.

As soon as they don't need inpatient care in psychiatric wards, all the other patients (except those who need forensic psychiatry services) should either be at home (for those who can) or in an assisted-living facility with the relevant educational, social and psychiatric support from community services (outpatient community center, or/and mobile team), or with treatment in day hospital.

The assisted living facilities shall offer different levels of support corresponding to the different needs of the people with mental health problems. They shall provide a homelike setting, organized on a common model (with an average of 4 to 6 persons living in a house or an apartment, with their room and shared facilities), but with different level of therapeutic intervention and remedial education, with the objective of evolution from one level to the next and moving to their own home as a general objective.

To facilitate the transition from the existing institutions to their own home or these assisted-living facilities, there should be a specific programme (transition programme) with transition workers to prepare people to go back to live in the community (in own home or family, or in family housing units), and create the link with community centers and services[38]



[38] Vigod SN, Kurdyak PA, Dennis C, Leszcz T, Taylor VH, Blumberger DM, Seitz DP. Transitional interventions to reduce early psychiatric readmissions in adults: Systematic review. British Journal of Psychiatry. 2013

| Objectives | Target 2030 |
|---|---|
| **19. Establish a plan to:**<br>- **gradually create small mental health wards preferably situated in or near general hospitals and better covering the Georgian territory, small structures for discharged patients requiring assisted-living facilities at different levels of supervision**<br>- **progressively close or reduce the size of inadequate psychiatric hospitals when creating new structures.**<br>- **reassess and transform the shelter concept to create into decent places supporting patients towards autonomy**<br>- **test and if useful develop day hospitals in main towns** | Plan established in 2021<br>(forensic beds not included in the plan, to be considered separately) |
| **20. Implement the plan** | Implementation beginning in 2022, finished in 2030 |
| **21. Develop standards defining the case-mix, the role, the staff and the activity requirements of psychiatric wards, assisted-living facilities and other psychiatric services and structures, and control that they are respected** | Regulation published (2021) |
| **22. Experiment a transition program to support long term patients who are going to leave specialized inpatient psychiatric institutions** | Experiment from 2022 |

## Priority 5: Support isolated communities by developing services, including e-health

As indicated by the American Psychiatric Association, telemedicine is the process of providing health care from a distance through technology, often using videoconferencing. Telepsychiatry is a subset of telemedicine, which can involve providing a range of services including psychiatric evaluations, therapy (individual therapy, group therapy, family therapy), patient education and medication management. It is done through direct interaction between a psychiatrist and the patient. It also encompasses psychiatrists supporting primary care providers with mental health care consultation and expertise. Mental health care can be delivered in live, interactive communication. It can also involve recording medical information (images, videos, etc.) and sending this to a distant site for later review.

With the support of the Ministry in charge of Industry, the Ministry in charge of health shall test the use of these modern and relatively inexpensive tools for supporting the mental health of isolated communities in Georgia, with the support of one or more community service which will receive an additional budget for the experiment.

| Objectives | Target 2030 |
|---|---|
| **23. Prioritize places where mental health services are absent and plan adapted resource** | Study to be produced in 2021 |
| **24. Test telepsychiatry in Georgia for isolated regions integrating local staff and/or recruiting local staff whenever necessary** | Choose the region (2021)<br>Define the content of the pilot<br>Launch the pilot (2022)<br>Assess the results (2023)<br>Generalize the pilot of successful (2024-2030) |

## Priority 6: Ensure patients' rights with an assertive action

A new law on mental health[39] shall be proposed to the Georgian Parliament, inspired by international standards and WHO recommendations.

The sanctions for violating patients' rights shall be steeply increased in the relevant legislation and shall include prison's sentences.

All staff working in mental health services and facilities shall have to study and regularly prove their knowledge of the content of the Georgian law on Patient Rights and the law on Mental Health.

The Ministry in charge of health shall establish a team independent from mental health structures and services to investigate complaints concerning violation of patients' rights.

Also, the Ministry in charge of health shall proceed to the implementation in the mental health system of the new law implementing a legal capacity reform.

| Objectives | Target 2030 |
|---|---|
| **25. Adopt a new law on mental health in line with international standards** | Adoption in 2021 |
| **26. Train and create a certification system for all staff of all levels working in mental health concerning patients' rights** | 100% of the staff trained at the end of 2021 |
| **27. Increase the sanctions for human rights infringements in the criminal code – draft provided by French Development Agency** | Adoption in 2021 |
| **28. Have a team with independent specialists and lawyer(s) in the Ministry in charge of mental health able to handle complaints** | Recruitment and training in 2021, beginning of operations in 2022 |
| **29. Modify the law to allow patients' lawyer to meet their customers at any time in mental health services and structures** | Adopted in 2021 |
| **30. Extent the competence of Georgian Public Defender to all mental health structures and services** | Adopted in 2021 |

[39] inspired by a draft provided by Expertise France - French Development Agency

## Priority 7: Combat stigmatization

In terms of prevention of mental health problems, the most efficient actions are in the field of substance abuse prevention, as preventing mental health problem is still challenging.

However, the Ministry in charge of health with the NCDC shall put a priority on fighting stigmatization, with a specific communication program aiming at allowing people in Georgia to recognize mental troubles, and at avoiding that they choose not to be cured in the mental health service.

Also, as priests may be asked for support and advice by people facing mental health problems, the Ministry in charge of health shall contact the religious authorities to discuss the possibility to implement a program to develop the knowledge of mental health among priests.

| Objectives | Target 2030 |
|---|---|
| **31. Develop a nationally and locally adapted communication program to fight stigmatization based on best practices and evaluate its effect** | Adoption in 2021 |
| **32. Organize workshops on mental health and mental health care in Georgia for volunteered priests** | 2 workshops proposed every year for 10 years |

## Priority 8: Create solid governance for the mental health project and the mental health system

As the difficulties of implementation of the previous strategy can be attributed partly to the absence of a governance system for the reforms, the government shall create as soon as 2021 a project structure in the ministry of health able to organize the transformation and follow its implementation and composed of:

- A mental health project Board, charged with regular oversight of the project, whose members shall represent all significant areas of participation in the project and have authority to make decisions on behalf of those areas. Members shall be relevant Directors from the Ministries involved.
- A high level full-time mental health project manager (with a full-time assistant project manager) in charge of taking actions to implement the project as defined, within the time frame. He or she shall be the person with day-to-day responsibility for the conduct and success of the project and have control over all project resources under the authority of the Project Board.
- A mental health scientific board advising the project manager, which could be the existing Council for determining the Mental Health Policy,

As the present system does not provide reliable information to follow the project, the Ministry in charge of health shall create a small, specialized surveillance unit (for example with a statistician, an epidemiologist and a statistical assistant) either in the NCDC or in the Social Service Agency, which will manage the data received in these two structures, and use them to provide the statistics and dashboards necessary to follow the evolution of the project. It shall be a permanent team to allow the government to monitor the mental health status in Georgia.

The government shall also create a system to control mental health structures and services with a state mental health inspectorate. The inspectors (at least 4 persons) shall be state agents with the necessary qualifications (in mental health, law, etc.) able to control that laws, regulations and standards are respected by a health care provider. They shall perform surveys with the users to measure their satisfaction, use all available information in the structure inspected to check the quality of care, and interview staff members. They shall provide their reports to the government, and when necessary propose financial and administrative sanctions and inform the authorities on possible criminal acts.

In liaison with WHO, the government shall provide every two years with an external evaluation of the project by international experts.

In the second period of the strategy, when the reform will be fully implemented, the old structures closed or modernized, the new structures opened, and rules and standards developed and tested, the Ministry in charge of health will analyze international practices to improve quality, such as certification and accreditation to determine what would be useful to implement in Georgia. A report shall be prepared for the Parliament to this effect.

Explanation:

The use of certification for a mental health structure or service would provide a formal attestation or confirmation of certain predefined characteristics of an organization, generally provided by a third party after some form of external review, education, assessment, or audit. Certification distinguishes between three main sectors: certification of systems, products, and personnel. The purpose of certification is to demonstrate that specified requirements are met. It guarantees that chosen rules and standards are respected in the processes at the moment of the audit and theorize that good processes will provide good results but this does not guarantee the quality of the final product or service although it is a necessary condition which facilitates it. It is more and more used in the health system in association with the ISO 9001 standard. Certification comes also as a cost: even if the cost of the audits is limited, it may use many days to prepare and implement a quality policy in the organization to be certified as did any type of evaluation.

Accreditation is different from certification as it is based on a thorough self-assessment and compared themselves to recognized standards of best practice. Accreditation means that the organization, agency, or program was able to demonstrate evidence of implementation to all of the relevant standards. It is a rigorous process conducted by a third party organization, made of teams of professionals (usually physician, nurse and administrative executive) whenever possible themselves still active.

In France, there is an accreditation system that professionals from the field (for example mental health) have built together, producing accreditation tool (a handbook) including the most important elements to ensure quality in a structure or a service. Then, after a self-assessment based on the handbook, each structure and service proceeds to the necessary improvements. At the final stage representatives of similar structures and services come and proceed to a control of the structure using the handbook. They write a final report, the accreditation is decided (or postponed before a new visit) and later (after 1 year, 2, 3 years or 5 years) the process is reproduced. The system itself is evolving and new methods are designed for example the “tracer patient” which allows following randomized patients in different diagnoses all along, trough the process of admission and discharge. It is a dynamic process to collectively improve quality that never ends. An abridged version of accreditation results are public and should be displayed at the hospital place.

| Objectives | Target 2030 |
|---|---|
| **33. Create a unit for mental health surveillance (2 epidemiologists, 1 statistician, 1 assistant) trained for such purpose** | Surveillance unit created in 2021 and trained internationally |
| **34. Create a mental health unit in the Ministry or in the SSA in charge of managing the project, monitoring the strategy and its operational actions plans** | Project team recruited and trained in 2021 |
| **35. Create a mental health inspectorate** | Inspectorate recruited and trained in 2022 |
| **36. Provide every year with a review of the implementation of the mental health strategy to the Parliament** | From the beginning of 2022 |

## Priority 9: Facilitate the treatment of addictions for people in the mental health system

As already mentioned, many individuals who develop substance use disorders are also diagnosed with mental disorders and vice versa. Multiple national population surveys[40][41] have found that about half of those who experience a mental illness during their lives will also experience a substance use disorder and vice versa. This ratio seems even to be higher for adolescents. But in Georgia, there is a separation between the treatment of people with addiction and people with mental health disorders, since people cannot benefit at the same time from the State Program of Drug Addiction and the Mental health state program. The result is that people treated for mental health problems cannot be treated for addictions, and people treated for addictions cannot be treated for their mental health problems, which is a serious problem.

In line with other developed countries, propositions shall be presented to merge progressively the mental health and addiction treatment in one program under one ministry.

In the short term:

- addictologists shall be recruited part-time as consultants in the mental health services, with an additional budget from the Mental health state program,
- treatments for addictions prescribed by addictologists shall be financed by the State Program of Drug Addiction

| Objectives | Target 2030 |
|---|---|
| **37. Recruitment of consultants addictologists in the mental health program** | 100 % of structures and services recruit an addictologist as a consultant (on request or part-time) |
| **38. Authorize the payment by the mental health program of medications against addiction prescribed by addictologists and psychiatrists for mental health patients** | Modification of the program in 2021 for 20222 |



[40] Ross S, Peselow E. Co-occurring psychotic and addictive disorders: neurobiology and diagnosis. Clin Neuropharmacol. 2012;35(5):235-243. doi:10.1097/WNF.0b013e318261e193.

[41] Kelly TM, Daley DC. Integrated Treatment of Substance Use and Psychiatric Disorders. Soc Work Public Health. 2013;28(0):388-406. doi:10.1080/19371918.2013.774673.

## Priority 10: Provide adequate human resources

This strategy cannot be implemented without relevant human resources, and in the present situation, the main problem is the lack of specialized mental health nurses. There have been some attempts to train mental health nurses in Georgia, such as the first 12 modules of 12 days training program prepared by the European Union (EU) and the Council of Europe (CoE) for 15 nurses working in prisons for the Ministry of Justice of Georgia in 2017. There have been other interesting attempts to train psychiatric nurses, without relevant results due to a lack of interest of candidates.

This lack of interest as certification in psychiatric nursing must be fought, and the following tools are proposed in this strategy:

- create a certification for mental health nurses, which could be obtained more easily for people with a minimum experience in mental health services and structures
- making it attractive with a salary bonus added to normal salaries for nurses
- making compulsory for mental health services and structures to hire a certain proportion of mental health nurses through national standards

Another problem to solve with the strategy is the fact that the Georgian population facing mental health problems are mainly going to visit neurologists, which are treating physical problems affecting the brain, spinal cord, and nerves, instead of a psychiatrist. It would be fine if the neurologists were trained for treating psychiatric disorders, but it does not seem to be the case. So either their training should include the knowledge and treatment of mental health problems, as it is the case in some countries, which means courses and residency for some months in a psychiatric service or structure, or they should not be authorized to treat psychiatric problems.

There is also in Georgia a problem linked to the fact that psychologist is not a regulated profession. The result is that “psychologists” working in mental health services may have only no training or limited training in clinical psychology, which is a serious worry. This shall be regulated, with minimal requirements for psychologists already working in mental health services and structures.

The training of the treatment of children has been addressed in priority 2, and the questions linked to the training of all people working in mental health services on patient’s rights are addressed in priority 10.

As part of the Mental Health Gap Action Program launched in 2008 in response to the wide gap between the resources available and the resources urgently needed to address the large burden of mental, neurological, and substance use disorders globally, WHO has developed training manuals[42] and programs which are very useful to develop the necessary training modules for the staff operating in mental health services and structures. They have already been used in Georgia and are a good basis for the training proposed here.

The last question is the determination of the quantity of staff needed in each type of service and structure to allow the strategy to be implemented.



[42] https://www.who.int/mental_health/mhgap/training_manuals/en/

| Objectives | Target 2030 |
|---|---|
| **39. Create a standard training and a certification for mental health nurses and assistant nurses** | 2021 |
| **40. Making it attractive by creating a substantive salary bonus added to nurses' salaries** | 2022 to 2030 |
| **41. Making it compulsory for mental health services and structures to hire a certain proportion of mental health nurses (staff standards to define) and nurse assistant** | 2023 |
| **42. Better regulate the scope of diagnoses that neurologists are allowed to treat excluding mental health problems** | 2021 |
| **43. Regulate a profession of "clinical psychologists" and their standard training who should be after a certain period (3 years) the only psychologists authorized in mental health services and structures** | 2022 |
| **44. Define Georgian standards for staffing, premises, and other means for the different types of services taking into account the methodology from WHO in Mental Health Policy and Service Guidance Packages "Human resources and training in mental health" and "Planning and budgeting to deliver services for mental health"** | Standards published (2021) |
| **45. Review the licensing system to ensure that continuous training is an obligation for professionals** | Licensing system discussed in 2021, decided in 2022 |

## Priority 11: Funding the strategy

The proposed strategy would bring Georgia to international standards of care in mental health, and it would certainly provoke an increase in the expenses. However, it should be considered that the share of mental health cost in the state budget reaches only 0,19. That is low, and by comparison, the budget for mental health (27.5 million GEL) is largely inferior to the 39 million GEL allocated in July 2020 to increase the salaries of ambulance and village doctors will increase by 100 GEL. Another interesting figure to take into account in the "*Vision for Developing the Healthcare System in Georgia by 2030*" published by the Georgian Parliament in 2017 which was planning an increase of more than 70 % of the share of the health budget in the state budget in 15 years (from 2015 to 2030), which means an increase of almost 9% per year before including the impact of growth (which would mean almost 15 % per year with a 5 % growth similar to the growth in the recent years).

The main elements of the costs are:

- The costs for preparing the implementation of the strategy, which will have to be financed in 2021, with the possible technical and financial support of international donors
- The costs for training, which must be separated in initial training costs (to be financed by the Ministry in charge of Education) and in continuing training for people already in the mental health system (to be financed by the mental health program) and in primary care (in the universal health program).
- The costs for creating children services, in particular, small day-hospitals with for some of them a limited number of inpatients beds after the first training pieces are delivered and the first staff members are certified
- The costs for deinstitutionalization and for developing smaller hospital wards, day hospitals, community services and assisted-living facilities for mental health patients in the community (to be financed by the mental health program)
- The costs for creating assisted-living facilities for people with intellectual disabilities and organic dementia (to be financed by social programs)
- The costs for supervising the project, regulating, monitoring, and controlling the mental health systems, which consists mainly in staff in the Ministry in charge of health and/or the NCDC and/or the Social Service Agency

More detailed planning for the first 3 years shall be prepared in 2021, with the following considerations:

- All key stakeholders must be part of the preparation of the planning, including for example municipalities, professionals, patients, and families
- The teams necessary for supervising the project, regulating, monitoring, and controlling the mental health systems shall be in place before the end of July 2021
- Actions to ensure patient's rights, the involvement of primary care and training must be prioritized, and relevant legislation shall be presented to the Parliament in 2021
- Children day hospitals shall be created in Tbilisi (2022) and Batumi (2023), with the necessary assisted-living houses

- Two of the biggest mental health hospitals should be closed by end 2023 and the relevant day hospitals assisted living facilities and community services and structures should be in place
- Standards for the different types of structures should be published by the end of 2021
- The proposed dispositions to facilitate the treatment of addiction for people in the mental health systems will be in place
- An experiment of the use of telepsychiatry for patients in isolated zones will be conducted before the end of 2022 and assessed in 2023

An analysis of the costs of and of the standards for prescribing antipsychotic medications shall be performed in 2021 to examine the reason for the present pharmaceutical costs.

The Agreement through between Georgia and China on "*Improvement of Infrastructure of Mental Clinics in Georgia in view to Support the Mental Health Reform*" will be reviewed to finance the new wards and day hospitals.

| Objectives | Target 2030 |
|---|---|
| **46. Increase the annual budget for mental health by 15% in addition to inflation** | Each year until 2030 |
| **47. Propose annually multiannual plans to implement the strategic priorities in line with this increase,** | Each year until 2030 |
| **48. Present to the Parliament an independent report prepared with international experts concerning the price and the quality of pharmaceuticals prescribed for mental health diseases, and an action plan to correct possible problems** | Presented in 2022 |
| **49. Review the existing program to build new asylums and shelters** | As soon as possible in 2021 |