Mental Healthcare in Georgia

Basic Directions of State Policy

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Introduction

The main purpose of National Policy is to provide assistance to all the stakeholders in finding their respective places in accordance with their capabilities and needs and achieving maximum results in development and functioning of mental healthcare. The Document reflects mental healthcare visions existing in the country. It also defines values and principles, upon which the mental health arrangements are based, as well as the efforts that should be undertaken in order to implement the future visions.

The Mental Health State Policy defines efforts of all the stakeholders for the period of next 10-15 years. However, some of its key points might be renewed after a certain period. It shall be considered the guideline for development of the future detailed National Action Plans and respective programmes.

As the country and its healthcare system develop, in some 3-5 years the issue of reviewing requirements comes on the agenda. This often precedes new cycle of Mental Healthcare Strategic Plan development; revision, deeper specification or addition of new principles (unless there are any unforeseen and abrupt changes in the existing environment) might become necessary in 15-20 years, and this will be an indication of starting new stage of the state policy development in the field of mental healthcare. It is extremely hard to forecast the moment, when revision of values will become necessary. Whenever it happens, it implies absolutely new vision of the mental healthcare and, respectively, development of new state policy.

The actual necessity of mental healthcare state policy development is conditioned by the several circumstances

- High burden of mental disorder – almost one third of the world population has experienced the mental disorder and it still remains the main factor causing disabilities; reduced labour productivity caused by the mental disorders results in 3-4% GDP losses in the developed countries, while in developing countries it represents one of the most serious hindering factors for economic growth.
- There is no health without the mental health. The mental health is necessary precondition for full-valued personal and public prosperity.
- The image of the society is best displayed through its attitudes towards the disabled – will it be the mentally or physically disabled, elders or any other groups.
- The approaches (medical service and care forms) towards mental health existing in the country show the general level of country’s human development.
- Necessity of fulfilling the international commitments in the field of mental health

The mental health state policy is based on the evidences collected by Georgian and foreign specialists in this field and is developed in accordance with the International experience. Situational analysis is based on the 2006 Georgian Mental Health System Assessment Report with use of WHO Assessment Instrument for Mental Health Systems (WHO-AIMS).

Chapter one of the document – Current Status – is reviewing the mental health conditions in Georgia and abroad. The emphasis is made on the aspects causing the biggest concerns of the stakeholders and requiring the optimal resolution. The international experience and the best policy practices are taken into consideration in the process of future vision elaboration.
Chapter two – Current Status – contains two sections: Baseline Principles and Values is describing conceptual basis of mental health system arrangement; section two – Arrangement of Mental Health System – describes future vision, key functions, main actors and distribution of functions between the parties, as well as the resource flows.

Chapter three – future vision – reviews the efforts, without which achieving the set targets will be impossible. The efforts are grouped by the Policy Strategies, based on which the detailed mental health action plan will be developed in the future.

Finally, the chapter contains additional information (basic notions, figures, results of analytical studies, etc.) assisting the reader in better understanding the ideas and thesis reviewed in the main part of the document.
I. Current Status

1. Mental Healthcare in Georgia

There is no reliable information on spread of mental disorders in Georgia. In 2007, according to the official data:

- 72,588 mental patients were registered (indicator of mental disorder incidence made 1.651 per 100,000) and 2,677 new cases were diagnosed (60.9 cases per 100,000)
- In the structure of mental disorders schizophrenia, schizoid and delusional disorders (30.5%) and mental retardation (28.5%) prevailed.

According to the expert data, the spread of number of mental disorders exceeds the official data minimum twice (this indicates towards the deficiencies of epidemiological surveillance): “in the majority of the countries the schizophrenia incidence varies within 24-50 per 100,000, while the same indicator in Georgia makes 9.5”.

According to 2007 data: a) 1,235 psychiatric beds were for 327 days per year; b) the mental health services were provided by 221 psychiatrists (out of certified 309). In Georgia, where the community based mental health services are not developed, the ratio of beds to the population (28.1 beds per 100,000) is quite low (in compare to the other European countries).

The professionals are mainly represented by psychiatrists and nurses; there are practically no specialized social workers, occupational therapists, community workers, family doctors trained in diagnostics/treatment of mental disorders, etc.

According to the results of 2005 Needs Evaluation Research, the persons having mental disorders in Georgia are mainly poor, have low access to medical and other auxiliary services, almost unavoidably are subject to institutionalization and have low access to education and employment.

“The existing mental health services can satisfy only 40% of requirements and needs of the persons having mental disorders. There are no services oriented towards their integration, reduction of unemployment and poverty; only 2% is involved in rehabilitation programmes… currently existing out-patient mental health service is extremely ineffective in satisfying the basic needs of persons with mental disorders and their families”. The details of evaluation of needs of persons having mental disorders are described in the Annex.
The legal basis for mental health system in Georgia is represented by the Law on Mental Care (2006), which “envisages modern mental health requirements and development of the tools necessary for the proper enforcement of the Law. The amendments on forced mental treatment introduced in 2007 Criminal Code and Criminal Procedural Code were not reflected in the Law on Mental Care, and this created the number of procedural problems with regard to the forced mental treatment. The detailed analysis of the legal framework in the field of mental health is given in the Annex.

2 International Experience

- What are principles upon which the mental healthcare is founded?
- In consideration of the status, which mental health models shall be taken into account?

In Georgia the state expenditures in mental health make 4% of the total state health expenditures and, with this regard, Georgia is ahead of only three European countries (Czech Republic, Poland, Bulgaria). The same indicator in the developed European countries varies within the range of 8-12%. In 2004 in Georgia the per capita expenditures made USD 1.1 (PPP), while in neighbouring Armenia the same indicator made USD 5, in Bulgaria – USD 6, in Kazakhstan – USD 9, in Lithuania – USD 14 (~USD 100 in the developed countries). According to the experts’ estimations, the per capita cost of the basic mental healthcare package in the low income countries varies within the range of USD 1.8–2.6, and for the medium income countries – USD 3.2–6.3.

Mental healthcare is mainly financed through the taxes or social insurance. The role of the private insurance is strictly limited in the most of, and especially the low income countries. The world average of the private mental health expenses (amounts paid from the pocket of patient) makes 17.8%, For the low and medium income countries (the group to which Georgia actually belongs) the same indicator makes 11%, while in Georgia, it reaches (by the rough esteem) 40%.

European and mainly the former socialist countries today are facing the need of resolving principle issue: to reject the unjustified institutionalised mental services. In these countries, existence of the large mental institutions (conditions in which are really unfavourable – they resemble rather the detention places, then the medical institutions and provide for very few possibilities of human rights protection) significantly influences the existing situation.

Unlike Georgia, the clear trend of planned reduction of the numbers of psychiatric beds can be observed in Europe (five-fold reduction of the psychiatric beds in Georgia was caused by the limited financing)– the persons with mental disorders are being transferred from the mental in-patient institutions to the general profile hospitals, the shelters near their places of residences or even discharged home under the supervision of out-patient services.

Nowadays, European countries are inclining to the idea of creating a unified network of need-based units, which would be providing the differentiated services to the persons having mental disorders and their family members. The conceptual basis of such a reform is the new approach – Balanced Mental Healthcare, which, in consideration of the country needs and capacities, implies the mix of quality, sustainable and efficient services necessary for retaining-improving mental health. This approach does not deny any approach (in-patient treatment, for instance) for the sake of other (community based healthcare, for example). Quite on the contrary, it implies combining all possible and necessary treatment forms for achievement of the maximum possible outcomes.
The detailed description of balanced model variants for the country groups by their income levels, as well as some parameters of developments in this field are given in the Annex.
II. Future Vision

1 Baseline Principles and Values

1.1 Values

Humanity and Respect of Human Dignity
In any link of the mental health care chain, the person’s interests are of a primary importance, respect to his/her dignity and provision of services in maximally human environment for care are ensured.

Equality and Accessibility
Any person having mental disorder, notwithstanding his/her age, sex, ethnic origin or religious beliefs, equally deserves decent treatment and shall have an equal access to all the necessary services.

Tolerance
That the people having mental disorders are different is very usual and is not considered the source of any emotional discomfort and all the more of any discrimination.

1.2 Approaches and Principles

The principles of mental health development, arrangement and service provision can be grouped around several key approaches:

1.2.1 Balanced Care

Keeping balance between hospital and community based care
Coexistence of such services and care within and outside in-patient institutions that:

- are able to maximally satisfy mental health needs of the population
- comply with the modern international standards
- are directed towards ensuring services in the minimally limiting environment, and
- comply with the capacities of the country (financial and professional-technical resources, public approaches and attitudes)

Keeping balance between medicinal and non-medicinal treatment
Such coexistence of medicinal and non-medicinal methods (psychotherapy, social rehabilitation, etc.) that:

- is directed towards social integration and maximal promotion of conditions for adaptation of persons having mental disorders
- provide for the best possible and sustainable outcomes with the minimal use of medicines
Keeping balance between interests of person, family and society

Protecting person’s interests, taking into account interests of family and society:

- limiting person’s rights (in selecting the treatment methods, for instance) only in cases, when there is reasonable justified chance of causing harm (physical, social, financial) to the family (or society) or himself
- limiting person’s or family’s rights, in order to reduce reasonably justified risks (hazards) to the society

Keeping balance between prevention, treatment and rehabilitation methods

Such ratio of prevention, treatment and rehabilitation measures, which attaches priority to the prevention and rehabilitation measures and, hence, reduces necessity of treatment.

1.2.2 Integration

Integration and continuity of services

The majority of mental disorders, for the achievement of maximally beneficial, sustainable effect, require coordinated and consistent application of various care forms and methods. The preference shall be given to management method, by which the various specialists (or providers of independent services) timely detect the changes in the condition, respectively refer the patient and make the optimum use the existing range of treatment and rehabilitation services with maximum cost-effectiveness and for the benefit of the patient.

Integration into healthcare and social security

To the extent possible, in consideration of readiness of the healthcare and social security authorities, the functions in mental healthcare (services) are distributed among these authorities, provided that:

- the healthcare and social security authorities possess sufficient qualification, experience and resources (technical, financial) for providing such services
- the healthcare and social security authorities are able to provide these services in more cost-effective manner and can ensure broader coverage by the adequate services (then the separate mental health institutions)
- the rules of timely referring patients to the respective profile mental health specialists (service providers) in accordance with the clinical and social indications are observed

Integration into the society instead of isolation

In consideration of the society approaches and safety, the maximum integration of the individual into the society and providing healthcare-social services without separating from the society (family) is ensured

1.2.3 Consistency

Evolutionary development

The mental health sphere develops gradually, in line with the improvement of country’s economic indicators and pace of professional capacity building in the system. The new forms and methods of services are complementing or partially replacing the existing forms. No form is rejected if there is a threat of creating disbalances between the demand and supply, and unless the new alternative for has been introduced.
Harmonious development

The mental health sphere is developing along with the general healthcare and social security systems, in the unified context. Accordingly, the harmony from the institutional arrangement standpoint is retained and there are no conceptual discordances.

1.3 Requirements

Flexibility

The mental health system will be able to timely and effectively respond to the changes in the environment; in particular, in case of increasing or decreasing financial flows, the issues of providing services will be resolved in the manner, which will ensure outcome maximisation (in case of increased resources) or hazard minimisation (in case of decreased resources).

Sustainability

The relations between all links of the mental health system are built on the principles of mutual practicability and justice, and require less compulsory (administrative or practical) mechanisms. They are formalised by the strictly determined rules that are not fit to the specific persons; the prime costs of services and prices are matching each other and are sufficient for respective functioning and development of each economic unit.

Need-focused

The capacities and diversity of mental health services (care) fully satisfy the needs and not only demands of the population. The needs of the population are identified to the maximum possible extent and, along with the development of capacities of respective services, the demand is formed.

Reducing stigma

The attitudes of various strata of the society towards persons with mental disorder and members of their families are changed: mental disorder does not represent the cause for mockery or all the more of alienation of persons having mental disorder or their families anymore. The society provides maximum support to such persons in arranging the normal life; the persons with mental disorders and their families themselves feel no embarrassment, do not try to avoid communication with the society and are not alienated.

Result-oriented

The mental health services – as a whole and each of them – are oriented towards achievement of the results, and this is manifested in the medical outcomes (health conditions) and subjective appreciation of service qualities by the patients/relatives. The quality of the services is measured by the results (medical outcomes) rather than by process characteristics (number of visits, number of bed-days or average occupation of bed, for instance).

High standards of care and treatment

Clinical or non-clinical aspects of the mental health services (for instance the care conditions) are approximated to the international standards as much as the financial resources allow. The clinical practice (methodological) guidelines are adapted and introduced.
Fair distribution of financial burden

The financial burden in the mental health sphere is distributed in the manner, which does not limit vulnerable (relatively poor strata of the population) in using necessary and high quality services, with full respect of their dignity.

2 Arrangement of Mental Healthcare

• What purposes are served by the mental health policy?
• What determines the success of state mental health policy?

2.1 Goals of the State Policy

The goals of state policy in mental healthcare, just like the goals in general healthcare, are defined in three dimensions:

• Improvement of mental health status of the population
• Improvement of mental health system compatibility with the expectations of the population
• Strengthening financial safety in the field of mental health

2.2 Functions (Functional Arrangement)

• What functions (activities) are necessary to satisfy the above requirements set for the (mental) health system?
• What are the functions, by which the activities in the field of mental health shall be grouped (for instance, service, care, etc.)?

The functions in the field of mental health are divided into three groups, thus, ensuring the proper performance and satisfaction of the above requirements:

• The governance functions:
  o Policy development
  o Development of legislation (defining norms in the legal space)
  o Evaluation of public policy
  o Financing

• Public activities:
  o Social mobilisation
  o Advocacy

• Medical and social services:
  o Service provision
  o Development and introduction of service standards
  o Training professionals

Service provision covers the wide range of professional activities, from services of in-patient mental hospitals to activities of self-assistance/club-type services.
2.3 Main Actors and Distribution of Functions

- Who are the main actors (agents)?
- What are the functions assigned to the actors?
- How the actors are regulated in fulfilling their functions?

The parties involved into the mental healthcare activities can be divided into three institutional groups:

- State
- Market (service providers, insurance companies, etc.)
- Society (relatives, family, person)

The distribution of functions among the main actors is schematically shown in the Annex.

**State**

The exclusive competence of state is development of the mental health public policy; with the support of state, maximal involvement of all the respective stakeholders, including persons having mental disorders or their representatives, into policy development process shall be ensured.

The state plays decisive role in targeted financing of the mental health services, in the first place to ensure the access to the respective quality services for the vulnerable population.

The state authorities, with participation of the other stakeholders, shall develop laws and regulate the field of mental health within the limits set by such laws.

The state is interested in the assessment of outcomes of the mental health policy and monitoring the policy implementation. For these purposes, it carries out monitoring and evaluation of policy implementation and assess an impact on mental health status and introduces amendments into the policy, as necessary.

**Market**

The market institutions play the key role in providing specific services. In particular, this can be specialised NGOs or social institutions.

Besides, NGOs actively participate in policy making processes, like law development, evaluation of state policies and fundraising for financing the services. The main actors in social mobilisation, advocacy and professional training sphere are the NGOs.

The main function of professional associations is development and introduction of clinical (service) standards, as well as training of the staff, advocacy and participation in development of the laws.

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**Distribution of Functions and Inter-sectorial Coordination between the State Authorities**

- **Ministry of Labour, Health and Social Security**
  - Development of mental health policy, legislation, as well as of regulation, evaluation, prevention and treatment programmes
  - Development of rehabilitation programmes, mechanisms for support of special needs, pension regulations
  - Development of special employment programmes, support and prevention activities at the working places

- **Ministry of Science and Education**
  - Providing the respectively educated professionals to mental health system; development of mental health support and prevention programmes for the public schools

- **Ministry of Justice**
  - Treatment/rehabilitation of persons having mental disorder in the penitentiary institutions

- **Ombudsman**
  - Protection of rights of the persons having mental disorders, primarily in the treatment institutions
The main function of educational institutions is providing the respectively trained professionals to the system.

Insurance companies participate in financing of medical services for certain types of mental disorders.

**Society**

Media plays the key role in social mobilisation and advocacy.

Religious organisations are mainly involved in social mobilisation, providing services and charities (financing certain types of services).

Family institute (including relatives) play the biggest role in providing social services and financing (direct and indirect).

### 2.4 Resources

- **What kind of resources (financial, professional, technical) is necessary to ensure the smooth functioning of mental health system?**
- **What sources of resource mobilisation are available?**

The following resources are necessary for development of the mental health system:

- **Technical**
  - Methodologies (technology)
  - Professional (staff)
- **Financial:**
  - Investment
  - Recurrent (expenses)

The methodologies shall be developed and introduced by the professional associations, NGOs and, partially, by the medical services providers with private and state financing.

Training of professionals shall be carried out partially by state and mainly by private financing. The indicators of the professionals’ mobilisation in the field will come closer to the average European values (for instance, the number of psychiatrists will reach 500, psychotherapists – 900, social workers specialised in the mental health – 2,600, and the nurses specialised in the mental health – 2,000).

The investments into professional capacity building will be attracted from the private sources; the only exemption will be made for limited number of specialised mental in-patient clinics, renovation/re-equipment of which will be financed from the state budget.

Minimum 8% of total healthcare budget of Georgia will be allocated to mental health system for financing the basic mental package, with the view of reaching USD 6 per capita.

The share of private expenses in the mental health sphere will reduce twice (20-25%); the share of medicines’ costs in the total expenses will also reduce (on the account of growing share of professional reimbursement).
III. Main Directions of Development

- What shall be the direction of efforts to improve mental health in the country?

The mental health system development activities will mainly be carried out in three directions:

1. Improving outreach and quality of mental health services/care:
   1.1. Providing market with duly trained professionals
   1.2. Introducing new forms of medical and social services
2. Changing public awareness (attitudes)
3. Improving public administration in the field of mental health

1 Improving Outreach and Quality of Mental Health Services/care

1.1 Providing Market with Duly Trained Professionals
- Development and introduction of methodological guidelines on medical practices and social services
- Development of new professional standards and reviewing the existing ones
- Elaboration of long term plan for development of professional resources (staff)
- Bring the curricula in compliance with the new service requirements and professional standards

1.2 Introducing New Forms of Medical and Social Services
- Adaptation of methodological guidelines and preparing professionals for new forms of services (medical, social) for the pilot testing
- Development of pilot plans (including evaluation criteria) for new services forms
- Pilot testing and evaluation of new forms and, in case necessary, introducing respective amendments into the methodologies (technological process of services)
- Wide-scale, step-by-step introduction of the approved services (based on the availability of financing and professional staff)
- Development of restructuring plan for existing service providers or reviewing the existing structures

2 Changing Public Awareness (Attitudes)

- Studying public awareness (views, attitudes, expectations, attitudes)
- Development and implementation of long- and short-term public mobilisation (education, changing attitudes) strategies
- Training media representatives (capacity building) in key issues of mental health
3 Improving public Administration in the Field of Mental Health

- Development of unified assessment system for the mental health state policy (implementation and outcomes)
- Improving system for studying the needs of population in the field of mental health and improving epidemiological surveillance system
- Development of the evidence-based policy advices (recommendations) in the field of mental health and submitting them to the state authorities
- Development of the sustainable and efficient state financing system for the mental health
- Introducing the transparency and accountability mechanisms for budgetary expenses in the field of mental health
- Organising and involving stakeholders (professional associations, NGOs, service providers, consumers' associations, etc.) into policy evaluation and development
Annex 1. Justification of the Need for State Mental Health Policy

High prevalence
The WHO Report 2001 states the high frequency of mental and behavior disorders that are found in more than 25% of people in a certain period of their life. One in every four adults has a mental problem at least once in his/her lifetime. One out of every five children has a mental health problem.

Economic Burden
According to ILO, economic losses associated with mental disorders in EU countries are estimated as 3-4% of GDP.

Losses of Social and Human Capital
Mental disorders mainly cause erosion of social capital because of marginalization, isolation, separation, and other reasons. Losses of human capital mainly result from suicides, violence, drug use and disabilities. Mental disorders cause 12-15% of the burden of disability worldwide, which exceeds the disability burden associated with cardiovascular diseases and is twice as high as the burden caused by oncological diseases. About 30% of disability-adjusted life years are associated with mental health problems.

Mental Health Specifics in Georgia
The prevalence of mental diseases in Georgia is similar to that in other countries of the world and represents a significant factor limiting the population’s ability to work, promoting mortality, economic lagging, and poverty. Mental disabilities lay a heavy burden both on the family and the country. Mental health problems in parents have an impact on their children’s emotional and intellectual development. In the same time, mental and behavior disorders affect the efficiency of prevention and treatment of different infectious diseases in Georgia, such as AIDS, TB, and Hepatitis C.

Similar to other Eastern European countries, socioeconomic crises and armed conflicts of the recent years have had a strong negative impact on the physical and mental health of the population in Georgia.

Annex 2. Conditions of People with Mental Health Problems and Mental Deficiencies in Georgia (2005)

Issues Related to Data Collection
Caution is necessary when dealing with statistics shown in this survey. Though the authors have used information obtained from the most reliable official sources, such as the State Department for Statistics, the Ministry of Health and the Ministry of Education, the data fail to precisely describe the reality as the data collection system in the country is very underdeveloped, with the data gathering being especially difficult in rural areas.

One should be also careful when handling official statistics provided by the Ministry of Health. Experts believe that official data on mental disorders fail to accurately reflect the real situation, especially with regard to new cases (compare: according to DSM criteria, the morbidity rate of schizophrenia in most countries of the world ranges within 20-54 per 100000 population, whereas in Georgia the rate is 9.5). In addition to the underdeveloped patient registration system, the existing situation with data is due to several important reasons:
• **The official statistics** is based on patient data registered by mental health institutions and thus reflects the use of mental health services and not the factual disease data (incidence and prevalence) obtained from an epidemiologic survey.

• **Changes in legislation**: in the Soviet period, registration of mental disorders was mandatory and was subject to rigorous control; according to the Law On Psychiatric Care adopted by Georgia in 1995, patients now have the freedom and the right for refusing to be officially registered.

• **Very low number of people seeking assistance from mental health specialists**: Because of scarce economic means of the population and lack of trust to state mental services that fail to provide adequate care and treatment, the overall use health care services is very low. In case of mental disorders, the situation is aggravated by stigma: people with mental health problems try to avoid addressing medical specialists and frequently self-treat.

• **Misdiagnosing**: As mentioned above, rather than going to psychiatrists, because of stigma people with mental health problems go to see general practitioners, neuropathologists and psychologists, who are less competent in diagnosing mental diseases and in some cases fail to timely refer the patient to a mental health specialist. Even if coming to a psychiatrist, people with mental health problems try to make their problems look less serious than they are, thus increasing the possibility of misdiagnosing.

• **Inaccurate patient registration data**: Again, stigma makes people with mental health problems who have a comparatively better economic status seek assistance of private physicians. Of course, these cases are not registered. Even if using public medical services, patients frequently demand that their case would not be registered in the official registry of patients with mental diseases. Thus, as the official health statistics are based exactly on official registration data, it fails to provide accurate data because of the above-discussed reasons.

• **Incorrect diagnosis classification (coding)**: Since the State Mental Health Program covers the costs of certain mental disorders only, there is a practice similar to a ‘DRG shift’ that becomes a reason for inaccurate statistics. Mental health specialists deliberately misdiagnose patients who are unable to pay so that they would get the main package of services paid for by the state. For example, a mild depression can be deliberately misdiagnosed for a severe depressive disorder as the latter is funded by the state program; and a severe stress reaction can be substituted with a chronic post-traumatic stress disorder.

• **No mass screening system**: The public health care system in Georgia does not envisage any mass screening programs for any mental disorder.

**Statistics and Demography**

There have been major changes in the official statistics of mental disease cases in Georgia since 1990s. Despite the socioeconomic crisis that followed after re-gaining independence, the incidence of mental disorders continuously decreased then, being the lowest in 1990-1992, and started to increase in 1992, with the upward trend continuing to date. According to the official statistics, the mental disease incidence rate has tripled, and the prevalence has doubled since 1992.

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1 DRG Shift means a deliberately documented incorrect diagnosis that does not reflect the patient’s actual status, i.e. the status is deliberately misinterpreted for the purpose of getting a larger compensation from a health insurance company.
The low statistics in early 1990s were due to the collapse of the disease registration system in that period and the significant decrease of state funding for the health sector. The state cut down the funding for the public health care in general and the mental service in particular. As the patients then had to cover the costs of mental services out of their pockets, only a smaller part of the population could use public medical services whereas a larger number of people with mental disorders were untreated and unregistered because of their hard financial condition.

The increase in mental disease incidence rates in later years can be accounted for by two factors: rather improved system of disease registration and the state mental health care program adopted in 1995 as part of the healthcare reform under the State Programs of Mandatory Health Insurance for the population. Yet even these two factors cannot fully explain the upward trend in the incidence of mental and behavior disorders, as the increase also reflects the difficult situation with mental health in the country. In the same time, despite the improved registration system, a significant number of people with mental health problems still remain undiagnosed, untreated, and officially unregistered because of the insufficient and inadequate psychiatric care.

The official mental disorder prevalence data include the number of people registered in so-called Mental Disorder Registration Sheets filled out by psycho-neurological and drug addiction institutions as well as GP policlincs countrywide.\(^2\)

In 2004, 106,921 of **people with mental disorders** were registered (the prevalence rate was 2,445.8 per 100000), including 68,993 people registered by psycho-neurological dispensaries, 31,417 – by addiction treatment dispensaries, and 6,511 by GP facilities. Out of those, 7,637 people were diagnosed for the first time in 2004 (an incidence rate of 174.7 per 100000 population), including 1,290 children (an incidence rate of 140.8 per 100000 population).

The official number of mentally ill people registered with psycho-neurological dispensaries in 2004 was 68,993 (a prevalence rate of 1,578.2 per 100 000), including 3,206 people diagnosed for the first time (an incidence rate of 73.3 per 100000 population).

According to the data from psycho-neurological dispensaries, 20.236 out of 68,993 cases of mental disorders (i.e. 30%) were people with mental retardations (a prevalence rate of 469.8 per 100000 population), including 1039 people diagnosed for the first time (an incidence rate of 23.8 per 100000 population). The of the total number of 20,536 mental disorder cases, mild mental retardation was found in 8,732 people (a prevalence rate of 199.7 per 100000), including 365 first diagnosed people in 2004 (an incidence rate of 8.3).

The number of people discharged from psychiatric clinics in 2004 was 3,782; 3,598 of people were hospitalized, including 18 people at the age of under 18.

In 2004, 84 patients died in psychiatric hospitals (the mortality rate in hospitals was 2.3 per 100 hospitalized cases). The number of people who died outside hospitals was unknown. Judging from the mortality rate among those hospitalized, the mortality rate was 1.95 per 100000 population in 2004.

\(^2\) Health Care, Statistical Guide, Georgia 2003-04, National Center for Disease Control and Health Statistics, Ministry of Health
Out the total number of people with mental disorders in 2003, 14,904 people were given the limited working ability status (those were people officially recognized as ‘people with limited abilities’), including 4,258 people with schizophrenia and 3,583 cases of mental retardation. Out of the total number of mental retardation cases (3,583), 544 were people under the age of 15.\(^3\)

\(^3\) Data available from the State Social Insurance Fund.
Annex 3. Needs Assessment of People with Mental Disorders in Georgia, 2008

The survey confirmed that people with mental disorders belong to one of the most vulnerable groups of population
- Despite labor age and education, their absolute majority (90%) is unemployed, the sole source of their income is disability pension, more than third experience poor housing. They are not settled - 18% of people with mental disorders are divorced, 40% have never been married, in comparison to the control group, they live alone by 2.4 times more;
- Income and housing of people with mental disorders and their families are 9-10 times less in comparison with control group.

The most common diagnosis in psycho neurological dispensaries is schizophrenia and schizoaffective disorder, as expected
- Schizophrenia is one of the heaviest diseases in psychiatry with a far-reaching negative impact on person’s skills and family’s welfare generally. Despite different length of disease, people with mental disorders get similar aid in dispensary (only difference is in medication dozes) that fails to meet individual requirements of the person with mental disorder;
- 85% of interviewed people receive disability pension, and despite their young years, remain incapable till the end of their lives. Almost half of registered disabled persons in Georgia are people with mental disorders.

Dispensaries serve large number of population that is affected on efficiency of contacts between a person with mental disorder and dispensary
- Psycho neurological dispensary work in same old style, waiting to be addressed by the person with mental disorder, and is limited mainly by giving out medication. Majority of people with mental disorders are not visited by dispensary staff at all, more than third of people with mental disorders do not address dispensary – part of them due to health state, another part due to absence of money for transport. Only 2% of interviewed people with mental disorders attend art therapy.
- Individual visits are expensive for dispensary considering transportation, fuel and time costs;
- Half of people with mental disorders think health and social institutions are difficult to access economically and geographically;
- Dispensary staff paid home visits to only 8% of registered people with mental disorders in 2007, while about one third of the latter had experienced 1 to 3 cases of relapse during a year and 14% experienced more than 3 cases; only 2% of people with mental disorders, committed suicide attempts were provided adequate psychiatric assistance.

According to the people with mental disorders and their family members, present mental health care services meet 40-50% of their needs. Increased financing in outpatient mental health care was reflected at expanded supplies of medication to dispensaries.
- Dispensaries are sufficiently supplied with narcoleptics; medicines mainly are of old generation, although there are some new generation ones as well. Psychiatrists mainly prescribe haloperidol, triflazine, chlorpromazine, carbamazepine, cyclodol, diazepam and amitrptyline. Different dispensaries prescribe haloperidol, cyclodol and diazepam with different frequency. Sometimes a number of narcoleptics are prescribed simultaneously and also, quite often patient takes diazepam for years that runs counter to the international standards. Given that

treatment instructions in mental health have not been officially approved, it’s difficult to assess correspondence of dozes and combinations of medication with diagnoses.5

- The survey confirms that people with mental disorders, who take medicines in large quantities from dispensary, also buy extra quantities of diazepam and cyclodol monthly. It can be suggested that these people with mental disorders have the problem of medication dependence.

43% of people with mental disorders pay 80% of the total monthly expenses on medication out of pocket.

- Dispensary spent on medication for people with mental disorders hospitalized twice in 2007 two times more than average expenses

- Side-effects of psychotropic medication are obvious. Patients protest against the treatment thinking that medicines make them flaccid and they do not want to stay in a sleepy mood for long. For the family though, the medication is the sole mean “to calm” the person with mental disorder; as it was discovered, family members often change prescription, increasing dozes voluntarily.

- 10% of interviewed people had been hospitalized during the year, with the average length of hospitalization amounting to 54 days. Whereas the survey did not cover the people on inpatient care, discussing the hospitalization index and its average length is difficult. It can be suggested though that these indicators will be bigger, since the monitoring of psychiatric hospitals showed that one third of interviewed people stay in hospital for years, while more than half have been on inpatient care at least for 2-3 months.6 The survey did not cover as well the people with so-called chronic mental disorder, who spent 2 years (2006-2007) in the hospital without a break.

By rough estimates, the sum that the family pays on the hospitalization of the person with mental disorder out of pocket amounts to 40% of the whole expenses spent on this person.

- Outpatient services make a considerable focus on pharmacotherapy, which calls for annual increase of expenses spent on medication. In terms of acute deficit of financing in previous years, supplying medication was inadequate, that at the end, has positively affected the continuity of treatment of people with mental disorder and reduced partially family’s expenses. Although its should be mentioned that medication, twice as much, fail anyway to safeguard the person with mental disorder from repeated hospitalization and 43% of people with mental disorder spend monthly on medication extra money out of pocket. Moreover, while being under permanent effect of medicines and experiencing a “hyper”-care from family, people with mental disorders are passive, lose independent living skills, do nothing to change anything in their lives and just fit to the role of person with mental disorder. They gradually experience the state of “learned helplessness”.7 This problem won't be resolved only by increasing expenses further on medication, if the specific proportion of pharmacotherapy is not reduced, with parallel increase of psychosocial rehabilitation portion.

Non-governmental sector plays an important role in psychosocial rehabilitation

- 4.3% of people with mental disorders enjoy the rehabilitation service, 8% have already undergone this service offered by non-governmental organizations. It’s noteworthy that in all three districts (Tbilisi city, Gldani district of Tbilisi and Telavi [Kakheti region]) where the survey had been implemented, different non-governmental organizations carry out these activities in the framework of the State Program. Supposedly, involvement of people with mental disorders into the rehabilitation process in other regions, due to absence of relevant services, will be more difficult.

5 Guidelines for treatment of main mental disorders are developed but the Healthcare Ministry by different reasons delays their approval
7 Learned helplessness – is a psychological condition in which a human being or an animal has learned to act or behave helpless in a particular situation, even when it has the power to change its unpleasant or even harmful circumstance. (Seligman, 1975).
In the state package of outpatient care psychosocial rehabilitation is not a priority. Whilst the overall financing of psychiatric programs increased by 34%, the psychosocial rehabilitation portion remained unchanged and amounts to 0.8% of total budget for mental health. Under such conditions, non-governmental organizations actively participate in state tender and have been implementing the social integration program for 155 beneficiaries with restricted capabilities in Tbilisi and Telavi for 2 years by now. For years, the non-governmental organizations have been carrying out the pilot projects financed by foreign donors. Using their theoretical and practical experience in terms of shortage of professional human resources and practical experience is vitally important. The practice of providing certain (mainly community care) services to users by non-governmental organizations is a worldwide practice. Experience shows that non-governmental sector accepts reformist ideas more easily and in comparison with state structures, is more flexible.

**Healthcare issue of people with mental disorders remains problematic**
- One third of interviewed people pointed out the healthcare issue (both the mental and somatic health) as the most pressing problem, urgently needed addressing;
- State social programs more or less solved the problems related to electricity and heating for people with mental health problems; partially they also addressed the food problem; however, only 6% mentioned improvements in healthcare.
- The survey confirmed that healthcare is one of the most acute problems for people with mental disorders and the State Program does not cover this group. Data of monitoring of psychiatric hospitals showed the same results, confirming that 45% of people with mental disorders do not receive the healthcare service other than mental health care. It’s a fact that mental health patients do not have access to the healthcare services.

**When receiving social aid, majority of people with mental disorders said that bureaucratic barriers do not create problems**
Majority of people with mental disorders said they were served adequately when getting social aid. 3-4% mentioned certain difficulties (queues, request for additional documents, problems with finding adequate job, rude attitude) forcing them to pay from pocket.

**Permanent conflict with family members is co-relation with asocial and criminal behavior of the person with mental disorder**
- Half of people with mental disorders think they have problems with their families and do not get psychosocial assistance from mental health services;
- People with mental disorders have had disputes with their families or neighbors over the apartment or private property 25 times more in comparison with control group;
- People with mental disorders have conflicts with relatives and neighbors 5 times more in comparison with control group;
- 88% of people with mental disorders have problems within families where caregivers spend some time or the whole day providing care for them.
- More than half of people with mental disorders live in expanded families in Georgia. This can be attributed to the warm and caring relations within families that traditionally constitute a valuable resource in the country, thus being a positive factor. On the other hand, without relevant assistance from outside, existence of the person with mental disorder within family can cause a considerable distress for all family members. Consequently, relations worsen and, instead of providing support, family is transformed into the permanent seat of tension and conflict that was well confirmed by survey results. The conflict oversteps the family boundaries and aggression and asocial behavior of the person with mental disorder are manifested publicly. The problem has another angle as well – relatives are not interested in active involvement of the person with mental disorder into public life,
partially because they are ashamed, and partially because they are hyper-caring and have an increased anxiety. Family members protest against autonomy and independent life of the person with mental disorder for they fear they will lose control on him/her believing that the latter cannot lead an independent life, he/she “may be lost in street, something bad can happen, he/she won’t be able to protect him/herself, etc.”

- The survey confirmed that the present mental health services hardly offer anything to the people with mental disorder and their family for addressing psychosocial problems. The above-mentioned would be possible in case a multidisciplinary professional group (composed of a psychiatrist, nurse, social worker and desirably, psychologist, occupational therapist) will work with person with mental disorder and his/her family. For this purpose different services should exist: crisis intervention, suicide prevention, homecare mobile group with different techniques: behavior correction, problem-solving strategy, reducing aggression, symptoms management modules and others. The privilege of work of such groups is being in contact with the person with mental disorder, crisis intervention, prevention of hospitalization, control on treatment regime, psycho education, early detection, homecare, working with families.8

**People with mental disorders have poor social contacts in comparison with control group**

- The survey showed that people with mental disorders have twice as little social contacts as the control group
- 74% of people with mental disorder have not gone out for years; they have rare contacts with relatives. More than 80% of people with mental disorders usually are isolated at homes;
- Unemployment, social isolation and incomplete treatment are the main problems for people with mental health problems.

**Providing care to people with mental disorders is a heavy burden**

- Caregivers mentioned economic and psychological problems;
- 68% of caregivers are unemployed since they spend the main course of the day taking care of person with mental disorder; 70% have not been on vacation for years, conflict in families is a common case; one third of income is spent on providing care for people with mental disorder;
- In caregivers’ words, day care centers would reduce their burden.
- The deficit existing in the mental health system lay on caregivers’ shoulders. Interviews showed that like persons with mental disorders, caregivers also do experience social and economic problems. In comparison with control group, they suffer from unemployment, serious health problems and emotional disorders more. Need of daycare centers for people with mental health problems (“they won’t be sitting all day long at home doing nothing”) and the need for psychological help for caregivers were identified as the main requests of those interviewed. We think this request is well justified considering social problems and psychological stress caregivers have experienced for years.

8 Thornicroft G, Tansella M (2003) What Are the Arguments for Community-based Mental Health Care?
Annex 4. Mental Health Policy Choices in Georgia

Similar to all other countries of the former Soviet Union, Georgia’s healthcare system was rather well-developed, even despite the weaknesses of the ‘Semashko’s system’. It is also true about mental health care, though the adverse impact of the political system affected it stronger than other components of the public healthcare system. After the political, economic and social crisis of 1990s, the development of the social sphere in Georgia did not start from zero, as there was some legacy, both positive and negative, left behind after the soviet period. The processes are shown on the diagram below (see Figure 1).

Today Georgia has reached point 3 and is faced with a choice. The first part of the U-shaped curve corresponds to the period between well-functioning ‘Semashko’s model’ (before 1990) and the time when Georgia started to overcome the crisis in all spheres in 1995 (Point 2 on the diagram).

Mass inpatient care was typical for the mental health care system at point 1, whereas outpatient treatment (primarily drug therapy) was mainly provided by specialized institutions (dispensaries).

The period between points 2 and 3 (i.e. up to date) can be described as follows:

- Mini-rehabilitation of what was still remaining of the ‘Semashko’s model’ (with increased allocation of funds) and small-scale piloted alternative mental health services without any single State mental health policy.
- In other words, the State started to spend more for mental health care (compared to 1995) yet made no institutional change, and the level of public funding failed to reach even the one recommended for low-income countries.

Figure 1: Mental Health Care Evolution Curve in Georgia

The country is now faced with a choice between with two major options (i.e. is in the G point):
Without any institutional change, allocate more resources for mental health, ending up with partial rehabilitation of Semashko’s model: at point S the renovated system would be structurally similar to Semashko’s model, yet less sustainable and less efficient functionally; Simultaneously start step-by-step institutional changes and increase resources allocated for mental health care. Then… the country would have a chance to develop towards A-B-C depending on the spending for mental health care, i.e. towards implementing a balanced-care model.

There is also the third ‘way’: not increase the funds spent for mental health care and continue to dismantle/reconstruct the system…. According to the development model, it would actually mean dawdling around point 3.

**Figure 2: Matrix of Mental Health Policy Option**

<table>
<thead>
<tr>
<th>Policy Option</th>
<th>Policy Approach Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semashko’s Model Rehabilitation</td>
<td>No</td>
</tr>
<tr>
<td>Balanced stage A</td>
<td>Minor</td>
</tr>
<tr>
<td>Balanced stage B</td>
<td>Moderate</td>
</tr>
<tr>
<td>Balanced stage C</td>
<td>Serious</td>
</tr>
<tr>
<td>Dawdling around point 3</td>
<td>Minor</td>
</tr>
</tbody>
</table>