## Title: Mental health reforms in post communist countries within the context of western experiences: the case of Georgia

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1. **Key words** – Balanced mental health care, Institutionalization, Deinstitutionalization, Mental health, Public health, Social work, Georgia, Mental health reforms

**Abstract** – This paper discusses the history of reforms and best practices in mental health care in western countires and their application to the former Soviet Union Country - Georgia. Mental health reforms face unique challenges in former Soviet Union countries because of the history of high rates of institutionalization, almost no community-based alternatives for persons with physical and mental disabilities, and their segregation and stigmatization from society and the nonexistence of social work institutions. Georgia began its mental health reforms in 2011. The National Health Care Strategy of Georgia highlights the importance of balancing between community-based and hospital-based mental health services. The process of deinstitutionalisation resulted in the closure of long-stay beds in the larger psychiatric institutions and the appearance of new structural units such as psychiatric units and child mental health divisions in general hospitals as well as introduction of modern mental health services such as an acute ward, a long-term treatment department, and an outpatient service, including a crisis intervention center with a mobile team. The lack of community treatment options for patients, an unequal distribution of mental health services across the country as well as inadequate numbers of social workers among mental health professionals are the main challenges in establishing a social model approach in the mental health settings in Georgia.

## The History of Mental Health Care: the Western Experience

The history of mental health care over the last century in more economically developed nations can be described in relation to three historical periods. Period 1 describes the rise of the asylum, between 1880 and 1950; Period 2 is the decline of the asylum, from around 1950 to 1980 and Period 3 refers to the development of decentralized, community based mental health care since 1980. Thus, the development of community-based services is in fact a very recent historical phenomenon. It is important to note that although the three historical periods usually occur consecutively, the times at which they began and finished in different countries varied considerably (Thornicroft and Tansella, 2009).

Period 1 was characterized by the construction and enlargement of asylums, remote from their populations, offering mainly custodial containment and the provision of the basic necessities for survival, to people with a wide range of clinical disorders and social abnormalities. The consequences of this choice of remote locations were segregation of patients as well as the subsequent professional segregation of psychiatrists and nurses from the main body of clinical practice, and from the centres of professional status in the metropolitan, university teaching hospitals. There is now strong evidence that the asylum model has produced very poor standards of treatment and care (Leff, 1997). Despite this, in some countries, especially those which are less economically developed, almost all mental health service expenditure continues to pay for asylum care.

Period 2 has taken place in many economically developed countries when system shortcomings were repeatedly demonstrated. These recurring themes, associated with the failures of asylums, are: a) repeated cases of ill treatment to patients; b) the geographical and professional isolation of the institutions and their staff; c) poor reporting and accounting procedures; d) failures of management, leadership, and ineffective administration; e) poorly targeted financial resources; f) poor staff training; g) inadequate inspection and quality assurance procedures (Thornicroft and Tansella, 2009).

The accumulating evidence of these failures of the asylum led to the deinstitutionalisation movement, supported by strong evidence of 'institutionalism', which is the development of disabilities as a consequence of social isolation and institutional care in remote asylums. Deinstitutionalisation can be defined as including three essential components: a) the prevention of inappropriate mental hospital admissions through the provision of community facilities; b) the discharge to the community of long-term institutional patients who have received adequate preparation (Reid, Johnson, Bebbington, et al., 2001); c) the establishment and maintenance of community support systems for non-institutionalised patients. Deinstitunalisation had contradictory effect in the case of USA and UK. In the USA the reduction in the numbers of long-stay hospital beds in many states is considered to be ineffective. This is due in part to the fact that community mental health centres, organised to provide for discharged long-term patients, instead came to serve a new population of patients, previously either receiving no care, or treated in nonspecialist settings, while patients discharged en masse from psychiatric hospitals were either abandoned or transferred to smaller institutions, often private, which frequently provided a poor quality of care. By comparison, In UK deinstitutionalisation was more carefully planned and managed and consequently, the outcomes are favorable for almost all the discharged patients (Thornicroft and Tansella, 2009). A five-year study on over 95% of 670 long-stay non-demented patients discharged from Friern and Claybury hospitals found: a) at the end of five years, two thirds of the patients were still living in their original residence; b) reprovision did not increase the death rate or the suicide rate; c) fewer than 1 in 100 patients became homeless; d) over one third were readmitted during the follow-up period; at the time of follow- up 10% of the sample were in hospital; e) overall, the patients' quality of life was greatly improved by the move to the community, but disabilities remained due to the nature of severe psychotic illnesses; f) there was little difference overall between hospital and community costs: coupled with the outcome findings, the economic evaluation suggests that community- based care is more cost-effective than long-stay hospital care.

Period 3 refers to the stage in which the main goal is to develop a range of *balanced care* within local settings. In this process, which has not yet begun in some regions and countries, it is important to ensure that all the positive functions of the asylum are fully provided, and the negative aspects of the institutions are not perpetuated. This period is characterized by decreasing number of adult long-stay beds in health service facilities, remaining regional level facilities focus on forensic services, increasing number of community mental health teams and centers, creation of local non-hospital residential facilities, including hostels, group homes, nursing homes, sheltered apartments, and supported housing schemes, decreasing emphasis upon separate rehabilitation facilities, less separation between treatment and rehabilitation, stress on secondary prevention of relapse, and also, on improving quality of life, more evidence based psychotherapies and “evidence- based” psychiatry in relation to pharmacological, social and psychological treatments. It should be highlighted that this period is focused on the importance of families in terms of care giving, therapeutic potential and political lobbying group, also, the emergence of concern about the balance between the control of patients and patients’ independence (Thornicroft and Tansella, 2009).

The balanced care approach aims to provide services which offer treatment and care with the following characteristics: a) services which are close to home, including modern hospital care for acute admissions, and long-term residential facilities in the community (Mueser, Bond, Drake, et al., 1998); b) interventions related to disabilities as well as symptoms; c) treatment and care specific to the diagnosis and needs of each individual; d) services which reflect the priorities of the service users themselves; e) services which are coordinated between mental health professions and agencies; f) mobile rather than static services, including those which can offer home treatment (Thornicroft and Tansella, 2009).

The historical development of mental health services is, however, not a consistent trend from traditional hospital care to balanced care. Many contradictions occur and every country shows examples of phases of evolution and regression.

**A New model of Public Health**

The focus of public health intervention is to improve health and quality of life through the prevention and treatment of [disease](http://en.wikipedia.org/wiki/Disease) and other physical and mental health conditions, through examination of cases and [health indicators](http://en.wikipedia.org/wiki/Health_indicators), and through the promotion of healthy behaviors (Schneider and Lilienfeld, 2008). The public health approach in contrast to the traditional individual health approach, is concerned with population based interventions and systematic thinking that is expressed by seeing service components in the context of whole system, open access to services on the basis of need, teamwork, by seeing patients in context of long term/life-course perspective as well as in the socio-economic context. In addition, the public health approach allows a possibility of primary prevention and it is cost-effective (Thornicroft and Tansella, 2009). The new model of public health addressing the health of people with disabilities and mental illnesses are presented below.

Drum, Krahn, Peterson, Horner-Johnson & Newton (2009) outlined three perspectives of disability within public health. These perspectives begin with a traditional public health model of prevention of disabilities, a contemporary model that regards people with disabilities as a minority group, and finally, an emerging model based on a social determinant view that is more inclusive of disability as part of the general population that may be at increased risk for poor health outcomes. This emerging model extends beyond examining differences between people with and without disabilities (disparities) and considers disability as one of multiple social determinants of health associated with health, quality of life, and social participation. These models are presented below.

The public health approach towards mentally is based on the concept of “social medicine” and is primarily concerned with the health of populations, not individuals (Thornicroft and Tansella, 2009). It’s proposing the reform of medicine on the basis of four principals (1) the health of the people is a matter of direct social concern; (2) social and economic conditions have an important effect on health and disease, and these relations must be the subject of scientific investigation; (3) the measures taken to promote health and to control disease must be social and medical, and (4) medical statistics should be a standard of measurement. These public health principles can be applied to most disabilities, especially, to most mental disorders.

The public health impact of mental disorders can be judged according to frequency, severity and consequences, availability of interventions and acceptability of interventions. In terms of frequency, mental illnesses are common (Thornicroft and Tansella, 2009). Mental illnesses can substantially interfere with life expectancy and with normal personal and social life. Mental disorders may also have important consequences, both for individuals with mental illness and for the families. For the individuals concerned, the consequences include the suffering caused by symptoms, lower quality of life, the loss of independence and work capacity, and poorer social integration. For family members there is an increased burden from caring, and lowered economic productivity (Thornicroft and Tansella, 2009).

The public health approach implies that help should be made available and accessible, in proportion to need (Sartorius and Schulze, 2005). However, the large survey of mental illness conducted in the USA shows that this is not the case (Kessler, Demler, Frank et al., 2005). By 2003 only about half the people who received treatment had conditions that met diagnostic criteria, and so ran the risks of harm from unnecessary treatments with no prospect of benefit. In other words, even in the best resourced countries there is low coverage (the proportion of people that could benefit from treatment who actually receive it) and poor focusing (how much of those people actually receiving treatment in fact need it).

In relation to acceptability of mental health services, three key issues such as public knowledge about mental illness, public attitudes towards people with mental illnesses and public behavior towards both mentally ill people and mental health services are highlighted (Thornicroft and Tansella, 2009). The extent of stigmatization and discriminatory reactions show some cross-cultural differences, but their presence appears to be universal. At the same time, there is accumulating evidence of successful interventions to reduce stigma (Thornicroft and Tansella, 2009). Several intervention studies have shown the benefits of targeted educational interventions, for example, for police officers and for school students, to reduce stigma (Sartorius and Schulze, 2005). Interestingly, the strongest evidence for what reduces stigma is the direct personal contact with mentally ill people (Thornicroft and Tansella, 2009).

The public health approach offers a further distinct advantage in that it considers the prevention of disorders, not only their treatment. Although there is relatively little evidence that primary prevention (traditionally, it refers to measures which stop the onset of the condition) of mental disorders has been effective on a widespread basis, the association between poverty (economic deprivation, low education, unemployment) and poor health is significant and may be either direct or indirect. In fact, the cumulative impact of poverty may produce sustained effects upon physical, cognitive, psychological and social functioning. On the secondary prevention level people with a particular condition are detected as early as possible and treatment intends to improve the course and outcome of disorder. Tertiary prevention level includes reducing the disabling consequences of an early established condition. According to the different categorization of prevention stages (Rose, 1992), treatment and rehabilitation is seen as a continuum, and prevention is defined in three ways universal (directed at the entire population), selected (targeted to individuals at risk), indicated (directed to individuals at high risk or those with early features of illness). In effect, the universal prevention approach is a population-based strategy that leads to decrease population exposure to psycho-social-biological risk factors, not only for high-risk individuals, but for all members of the community (Thornicroft and Tansella, 2009).

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## A Framework for Planning Balanced Mental Health Care

Thornicroft and Tansella (2009) indicate the evidence on the advantages and limitations of two perspectives, exclusively hospital based or community based mental health care, and conclude that this false dichotomy should be replaced by a model, in which balanced care includes both modern community based and modern hospital-based care. This new balanced care is the combination of a) services in a wide range of local sites and settings outside hospital, including non-hospital long-term residential care (*modern community care*), and b) services providing acute inpatient treatment, often in general hospital units (*modern hospital-based care*). In balanced care the focus is upon services provided in normal community settings, as close to the population served as possible, and in which admissions to hospital can be arranged promptly, but *only* when necessary.

Traditional hospital care often provided interventions in many of the following six areas: mental health, social life, physical health, accommodation, occupation and money. However, they were provided in an undifferentiated form as block treatment, not specific to individual patients, and sometimes in excessive 'dose'. For example, by being provided with meals who could cook for themselves if given the opportunity, patients were disabled from exercising autonomy. In addition, patients within asylums were isolated from their natural communities, were restricted in many aspects of their basic autonomy, had weakened social networks, and so were offered a poorer quality of life. In modern mental health care mental health personnel consider a wide range of biological, psychological and social needs of service users. In fact, service user rated needs are much better predictors of quality of life than staff- rated needs. Thus, agreement between staff and service user ratings of need is a predictor of better long-term outcome of care. The family members and carers of a person with mental illness are often a valuable resource to work with mental health staff. To realize the potential for family members to play a full role in planning and providing care, their own concerns need to be understood, and their direct needs addressed. This requires all individuals who provide regular and substantial care for a person with severe mental illness to have their own care plan to assist them in their care giving role. To conclude, in the balanced mental health care, service users are seen as “partners in care” so that treatment plans are negotiated, and family members are fully involved in care (Thornicroft and Tansella, 2009).

The balanced care orientation creates a number of new challenges to planners and providers of services. The relationship between economics and mental health needs to be taken into account during the planning process and the mixture of hospital care and community care should be chosen for a particular local area at a particular point in time. In addition, the planning process is determined not only by the overall national economic situation, but also by ethical and political considerations (Thornicroft and Tansella, 2009). A further challenge to professionals is that service users and carers should be directly involved in defining local needs and priorities. It will influence the demand for the particular mixture of treatment and care (Thornicroft and Tansella, 2009).

The process of deinstitutionalisation has usually meant the closure of long-stay beds in the larger psychiatric institutions, and there is now strong evidence, for the large majority of such patients, that community-based residential care offers such people a higher quality of life. Such types of residential care are usually best provided when they are small in scale, linked closely to the other components of a balanced care system, and when they are developed gradually over time as the nature of local needs emerges. Further to this there is now growing evidence that some types of community-based alternative to acute hospital admission may also be cost-effective, such as crisis houses and home based treatment by community mental health teams, and such innovative services are likely to become more common in the coming years (Thornicroft and Tansella, 2009).

In countries with few resources, primary care staff will probably need to provide most if not all of the mental health services in primary health care settings, with specialist backup to provide training, consultation, inpatient assessment and treatment that cannot be provided in primary care. Countries with a medium level of resources can develop some of the more differentiated services. Community mental health care teams (CMHTs) are the basic building block of community mental health services. The simplest model for providing community care is generic, i.e. nonspecialized. CMHTs provide the full range of interventions, where adults with severe mental illness are assigned the highest priority. Evidence from the United Kingdom suggests that there are clear benefits to these nonspecialized, community-based multidisciplinary teams (Thornicroft and Tansella, 2009). Service recipients receive the multidisciplinary, round the clock staffing of a psychiatric unit within their natural environment. In order to meet a client’s multiple treatment, rehabilitation, and support needs, team members are trained in the areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation. CMHT strive to lessen the debilitating symptoms of mental illness each individual client experiences, minimize recurrent acute episodes of the illness, reduce hospital re-admissions, enhance quality of life, improve functioning in adult social and employment roles, develop an individual’s ability to live independently in his or her own community, and decrease the family’s burden of providing care (National Alliance for the Mentally Ill [NAMI], 2002). CMHTs can promote engagement with mental health services, create greater user satisfaction and increase met needs, although they do not produce significant symptomatic or social improvement. Their main advantages are increased continuity of care and flexibility (Sytema, Micciolo, Tansella, 1997).

Patients can benefit from seeing the same staff members over the long term, and in crisis situations, such relationships may prove invaluable. The ability of mobile CMHTs to contact patients at home, at work and in neutral locations such as local cafes means that early relapses are identified and treated more often, and that treatment may be better adhered to (McDonald, Garg, Haynes, 2002).

The generic CMHT is flexible, permitting the intensity of input to be varied according to a patient’s needs without necessitating transfer to another team. Some patients who benefit from frequent contact and outreach during a particular period, for example during a relapse, may require relatively low levels of attention during other periods. Specialized teams that have a remit to provide only intensive support have less scope for such flexibility (Burns, 2001).

In addition, the mental health field is one of the largest employers of social workers as transition from hospital to community services changed the ways in which mental health professionals carried out their responsibilities. For social worker, a major part of the work in mental hospitals is discharge planning – helping patients return to their communities by assisting them with housing, supervision and companionship from their families or friends, and making connections with community mental health centers that can monitor the patients once they are discharged and that can help them with a variety of treatment. On the other hand, social workers use case management to provide more individualized services to clients who are facing mental illness. These services may include education, housing, nutritional services, recreational programs, counseling sessions and many other kinds of assistance (Ginsberg, 2001).

## Mental Health Reforms in Georgia

Psychiatric services in the former Soviet Union were characterized by high rates of institutionalization, therefore, there is strong resistance to the introduction of community-based services. Georgia began a critical phase of its mental health reform program almost two years ago (Makhashvili and Van Voren, 2013).

In 2011 the number of people treated in mental health facilities approached 1812.12 per 100 000 population and number of persons treated in mental health day treatment facilities - 2.42 per 100 000 population (WHO, 2011). A survey indicates that schizophrenia, schizoaffective and paranoid personality disorders were more prevalent in Georgia. In fact, official statistics on mental illness prevalence does not capture patients who visit private doctors or who do not access formal psychiatric services; thus, only those who have severe mental disorders are registered at dispensaries.

In 1995, Georgia adopted a mental health care program in which people with mental disorders on the national psychiatric register under the Ministry of Labour, Health and Social Affairs received free-of-charge services and treatment at both hospitals and outpatient clinics (Sharashidze, Naneishvili, Silagadze, Begiashvili, Beria, 2004). Six psychiatric institutions with an average of 1,000 beds provided hospital care (30.27 beds per 100,000 population). However, these mental health care reforms were accompanied by a significant decrease in funding for hospital beds, without providing any alternative of outpatient and community-based services.

Health care expenditures have significantly increased over the past several years and in 2011 reached 10.1% of the country's gross domestic product (Ministry of Labour, Health and Social Affairs, 2011). However, only 2.11% of the total health budget is spent on mental health. Mental health care is delivered within the framework of the State Program for Mental Health Care and is administered by the MoLHSA. The budget of the program more than doubled between 2006 and 2011, reaching 12 million Georgian Lari (US $7.3 million). Until recently, the state allocated about US $8–11 per day for patients admitted to institutions (2008–2010) and US $7–8 per day for outpatient treatment. This was hardly enough to cover salaries, heating, and food, which resulted in ineffective care. The priority is given for funding of hospital care, less stress on funding for psychosocial rehabilitation, and a very small portion of finances is reserved for outpatient care. In 2008 the introduction of a new funding model for hospital care gradually led to a reduction of the number of inpatients. However, these reforms still did not go far enough. Essential treatment methods, such as psychological treatment, remained unavailable, and there was still a lack of community services. Multidisciplinary teamwork and case management were still absent, and there was widespread low motivation, apathy, and resistance of the system to innovations (Makhashvili and Van Voren, 2013).

Through the recent *National Health Care Strategy 2011–2015* developed by the Ministry of Labour, Health and Social Affairs (MoLHSA), the importance of balancing between community-based and hospital-based mental health services is underlined. This reform process is still very much in progress and it makes it difficult to assess its impact (Ministry of Labour, Health and Social Affairs, 2011). The priorities of this recent program are very much in accordance with international requirements and standards set by, for example, the World Health Organization. The MoLHSA's *National Health Care Strategy 2011–2015* aims to improve the population's health by reducing disease burden and mortality by 2015. Strategic objectives include reducing inequalities in access to care; improving quality of services; protecting patients' rights; promoting prevention, preparedness, and response; and improving management of the health sector. A special chapter identifies “increased physical and geographical access to services" as a top priority and stresses the need to develop balanced, integrated, and continuous care for persons with mental disorders. To implement the desired changes, the MoLHSA created a Consultative Council on Reform consisting mostly of psychiatrists (Makhashvili, Van Voren, 2013).

Georgia’s new Law on Psychiatric Care initiated a major reorganization and transformation of the mental health field (Law of Georgia on psychiatric care, 2006). It aims (1) to ensure availability and consistency of psychiatric assistance for people with mental disorders and protection of their rights, freedom and worth (2) to define mental health staff responsibilities and rights. This new Law on Psychiatric Care is considered to be progressive and rights based. The law entered into force in 2007 and instituted a number of new practices, such as making a court decision for any involuntary hospitalization obligatory. Several bylaws introduced practical procedures, for example, procedures related to the use of physical restraint. In 2009, Georgian psychiatric care experts analyzed the law's implementation and several further modifications were adopted, particularly related to procedures in forensic psychiatric treatment and prison mental health (Global Initiative on Psychiatry–Tbilisi, 2010).

The most important dimension of the new reform process, deinstitutionalization, took place in early summer of 2011. Accordingly, the most significant step was the closing of one of the largest psychiatric hospitals in the country Asatiani Psychiatric Hospital in the center of Tbilisi, which had 250 beds at the time of its closure. Acute beds (in units of 30 beds) were relocated to newly opened psychiatric units in general hospitals (four departments are now functioning in multi-profile hospitals); a new child mental health division with ten beds was opened in a general hospital; and a separate mental health center was established in Tbilisi, with a variety of services: an acute ward, a long-term treatment department, and an outpatient service, including a crisis intervention center with a mobile team. In addition, long-term residential facilities were opened in several towns (each with 40 beds), and crisis teams started functioning in some other cities of Georgia, for example, Batumi, Rustavi, and Kutaisi. Guidelines and codes of conduct were elaborated, and a service development policy was drafted (Makhashvili and Van Voren, 2013).

These reforms immediately resulted in a fall in the length of stay for patients with acute mental illness, from an average of two to three months before the reforms to an average of 21 days now. The length of stay for a patient with acute mental illness refers to the time from initial hospitalization to either discharge or transfer to a long-term department. For the next stage of the reform program, the MoLHSA (2011) plans to develop multifunctional community centers in three cities.

Currently, there are 9 reorganized Psychiatric Hospitals or Mental Health Centers in Georgia. Aside from psychiatric hospitals, there are 18 outpatient psychiatric clinics (“dispensaries") in the country. However, there is an unequal distribution of mental health services across the country: there is less access, and a lower quality of services, in poor, remote regions. Nearly half (48%) of all licensed psychiatrists are working in the capital city, Tbilisi.

Research done by the Georgian Association of Social Workers (2014) showed that the main mental health professionals are physicians (primarily psychiatrists, also narcologists and neurologists), nurses and psychologists/psychotherapists and the medical model of treatment is prevalent in Georgia. In particular, there were only 42 social workers employed at the mental health settings at the time of the study and out of 42 individuals employed as social workers, only four held social work degrees (Shekriladze and Chkonia, 2015). Direct social work practitioners in mental health settings are not provided with professional supervision nor is the social work profession regulated in Georgia. All of these highlights the need for quality social work services, establishing social work scope of work, identifying and promoting its role among multidisciplinary team of mental health professionals, defining areas of development and strengthening their competence (Shekriladze and Chkonia, 2015).

One of the essential elements in the reform process was active participation of the non-governmental sector. This process facilitated a movement towards rights-based and humane mental health care. For instance, the Global Initiative on Psychiatry together with the Georgian Association for Mental Health initiated several projects to introduce best practices in mental health. Many new community-based services, such as crisis intervention and home care were developed through pilot projects and then followed by a national scale-up. A recent example is the creation of crisis intervention teams that deal with emergency cases within certain catchment areas in the capital (Global Initiative on Psychiatry, 2010). Many projects were also devoted to capacity building including the translation and publication of modern mental health literature into Georgian, the opening of the Mental Health Resource Center at Ilia State University in Tbilisi, a wide range of intensive trainings, workshops, and conferences; and the organization of exchange visits and research activities.

The Georgian Association of Social Workers (GASW) provided several activities to enhance the role of social work in the field of mental health. Several round meetings were provided with the support of GASW and AGP Open Society Foundations to initiate an open dialogue about social worker’s job duties in mental health settings, the challenges and opportunities to develop an adequate social work institute in mental health settings in Georgia. The major achievement was to work out a job description of mental health social worker in collaboration with the NGO sector as well as state mental health professionals.

**Conclusion**

Georgia is facing many challenges in accomplishing mental health reforms underlined in the National Health Care Strategy approved by the Government of Georgia. The first steps for establishing balanced mental health services are in place. The larger psychiatric institutions are closed and new services such as an acute ward, a long-term treatment department, and an outpatient service, including a crisis intervention center with a mobile team are established. The non-governmental sector participates very actively in reforming the mental health system to introduce and strengthen rights-based and humane mental health care and to prioritize the role of social workers in providing community mental health services. However, the lack of community treatment options for patients, an unequal distribution of mental health services across the country as well as inadequate numbers of social workers among mental health professionals are the main challenges in establishing a social model approach in the mental health settings in Georgia.

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