Ilia State University

Tbilisi Georgia

Towards the Evidence-based Trauma-Informed Mental Health Policy in Georgia

PhD research degree student: Nino Makhashvili

Mentor/Principal Supervisor: Tengiz Verulava

Document submitted in support to upgrading to PhD in Public Health

June 2015

Healthcare Policy and Management Program

School of Business

Ilia State University

Tbilisi 2015

Abstract

Introduction

Most people in the world who have mental illnesses receive no effective treatment. This phenomenon, described as the 'treatment gap', is increasingly acknowledged worldwide, and is seen as the difference between the true prevalence rate and the proportion that receive any kind of treatment.

Prevalence of common mental disorders is particularly high among war-affected populations; war trauma can have long-term effects on their mental health.

Mental healthcare field is under reform in Georgia and needs scientific evidence to inform mental health policies to close the treatment gap by developing services that are necessary for effective and continuous care.

Objectives of the study

My research seeks to address 3 main topics:

- To identify the mental health disorders in 3 groups of war-affected populations: Older (the 90s') & Newer (2008) Internally Displaced persons (IDPs) and Returnees in Georgia;
- To collect experts' opinions on the best effective models of service delivery meeting the identified needs;
- To develop trauma-informed mental health policy recommendations.

The overall aim is to examine patterns of common mental disorders among conflict-affected populations and to elaborate explicit mental health policy recommendations.

Methodology

The research consisted of two parts:

1. The study on common mental health disorders has been conducted among both Older, Newer IDPs, and Returnees (sample size 3600 persons); issues as prevalence of mental disorders among these groups, associated factors, disability impact, co-morbidity issues, utilization of existing health and mental health services were studied;

2. The experts' survey has been conducted to explore experiences and opinions of prominent international and local mental health reformers and to capitalise on their vision

on relevant and most effective services applicable to conflict-affected big groups in Georgia.

Results

The study demonstrates that, several years after the end of military actions, prevalence rates of common mental disorders among conflict-affected populations are high. War experiences appear to be linked to PTSD, depression and anxiety disorders (23.3%, 14.0%, and 10.4% accordingly) and cause a substantial degree of disability among the survivors.

Evidence on treatment gap in regard of service utilization was collected, i.e. only one third of those with mental disorders sought any assistance from health services.

The experts survey provided the consensus-based evidence on priority services for our target groups. A set of services according to resourcefulness of regions across the country has been recognized. Five main themes have been identified and provided a foundation to policy recommendations concerning conflict-affected populations.

Key words: Mental health Policy, War-affected populations, Common Mental Disorders and Comorbidity, Trauma-informed Care

Acknowledgements

I would like to express my gratitude to my mentor and principal supervisor prof. Tengiz Verulava (Ilia State University) - I enjoyed and benefited from his meaningful and rich collegiality, patience and encouragement. I am also thankful to prof. Bayard Roberts (London School of Tropical Medicine, UK) for his generous support in many aspects of this work. I was privileged to have a wonderful possibility of sharing my ideas with prof. Benedetto Saraceno (Lisbon and Geneva Universities) and prof. Graham Thornicroft (Institute of Psychiatry, King's College, London), who provided valuable suggestions at the early stage of the research.

Special appreciations go to the research team members, especially to Dr. Ivdity Chiqovani (from Curatio International Foundation, Tbilisi), who were involved in big quantitative study lead by Bayard; to Dr. Mark van Omerren (from WHO, Geneva) and Mr. Emmanuel Streel for their comments on the experts' survey questionnaire; and Ms. Keti Pilauri (GIP-Tbilisi) for her devoted work on the experts' survey. Nato Kvavilashvili and Nino Agdgomelashvili also deserve my gratitude for their generous support in dealing with technical problems associated with the text.

I do exceptionally acknowledge all persons who took part in the study and shared their experiences with us – Internally Displaced Persons, Returnees, and also foreign and Georgian experts (who are appreciated by names in this thesis).

My gratefulness also goes to Academic Swiss Caucasian Net (ASCN) and to Mr. Denis Dafflon for giving me a chance to be engaged in the short-term visit program that truly enabled me to work on the thesis in a rich academic atmosphere of Fribourg University, Switzerland.

I do owe particular and excessive "thank you" to my family members (remarkably to my mother), colleagues and friends who supported and encouraged me to accomplish this challenging task.

By the work presented below I tried hard to bring together and link my two "love-stories" – a fascinating and heavy science of psychotraumatology and the challenging and stimulating field of mental health policy & reform. Do hope this study would contribute to further integration and synthesis of these areas in Georgia and beyond it.

Contents

List of figures

List of tables

Abbreviations

MH	Mental Health
IDPs	Internally displaced persons
LMICs	Low- and middle-income countries
PTSD	Posttraumatic stress disorder
PMD	People with Mental Disorders
MoLHSA	Ministry of Labour, Health and Social Affairs
WHO	World Health Organization
NGO	Non-Governmental Organization
PHC	Primary Health Care
NAP	National Action Plan

Terminology

Mental Health: A state of well being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO 2001).

Mental disorder/illness: “a clinically recognizable set of symptoms or behavior associated in most cases with distress and with interference with personal functions. Social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder as defined here" (WHO 1994).

"A syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above (APA 2013).

Common Mental Health Disorders: Common mental health disorders include depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder and social anxiety disorder (NICE 2014). These disorders can mostly be treated in primary care settings.

Persons with disabilities: include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others (UN 2006). Disability is an evolving concept; it results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.

Mental health policy: An organized set of values, principles, and objectives to improve mental health and reduce the burden of mental disorders in a population (WHO 2004).

(Psychological) Trauma: Trauma is the unique individual experience of an event or enduring conditions in which a person's ability to integrate his/her emotional experience is overwhelmed. The person experiences, either objectively or subjectively, a threat to his or her psychological safety, bodily integrity, life or the safety of a caregiver or family member.

Conflict-affected populations: war-affected populations of Georgia that were either displaced due to military conflicts (in the 90's and 2008) or have been living in regions where military actions were taking place. Sometimes we refer to them as traumatized big groups. There are Internally Displaced Persons and Returnees, but also "local" citizens, experiencing a war.

Trauma-informed mental health care: Trauma-informed care internationally represents the "new generation" of transformed mental health and allied human services organizations and programs, which serve people with histories of violence and trauma.

Trauma-informed services are informed about, and sensitive to, the potential for trauma-related issues to be present in patients/clients, regardless of whether the issues are directly or obviously related to the presenting complaint or condition.

Trauma-informed Policy: means that the state and community providers and those who oversee public mental health services are informed about the effects of psychological trauma, assess for the presence of symptoms and challenges related to that trauma, and develop and offer or refer to services that facilitate recovery in accordance with good or promising practices and evidence-based interventions.

I. Introduction

Mental Health Care and Mental Health Policy in Georgia

General background

Recent years have seen mental health (MH) rise significantly up the global and European mental health policy agendas (Knapp et al. 2007). This attention to and awareness from the side of the World Health Organization (WHO), international research institutions, governments and professional societies is well justified. An estimated 450 million people worldwide have a mental disorder. At any given time, approximately 10% of adults are experiencing a current mental disorder, and 25% will develop one at some point during their lifetimes (WHO 2001). Mental health problems are found in all countries, in women and men, at all stages of life, among the rich and poor, and in both rural and urban settings.

People with Mental Disorders (PMD) are vulnerable, often marginalized and isolated. WHO in its report on "Mental Health and Development" states, "the social and economic impact of mental and psychosocial disabilities is diverse and far-reaching, leading to homelessness, poor educational and health outcomes and high unemployment rates culminating in high rates of poverty"(WHO 2010).

Further research, which builds on the findings of the above mentioned report (Funk, Drew and Knapp, 2012) explores these diverse and far-reaching social impacts and proposes that

Targeted poverty alleviation programs are needed to break the cycle between mental illness and poverty. These must include measures specifically addressing the needs of people with mental health conditions, such as the provision of accessible and effective services and support, facilitation of education, employment opportunities and housing, and enforcement of human rights protection.

In developing countries (LMICS), families bear a significant proportion of both the economic and social burden of caring for a relative with a mental health issue, because of the absence of a publicly funded network of comprehensive mental health services. The

poverty increases the risk of mental disorders and having a mental disorder increases the likelihood of descending into poverty. It's a vicious circle where both poverty seems linked to greater rates of mental illness, and in some cases, certain kinds of mental illness seem linked to a greater likelihood of living in poverty (Hudson 2005).

Most studies show an association between indicators of poverty and the risk of mental disorders (Patel and Kleinman 2003). Factors such as the experience of insecurity and hopelessness, rapid social change and the risks of violence and physical ill health may explain the greater vulnerability of the poor to common mental disorders. The direct and indirect costs of mental ill health worsen the economic condition. It is obvious that common mental disorders need to be placed alongside other diseases associated with poverty by policy-makers and donors.

On the other hand, marginalized groups are at increased risk of developing mental ill health. Common mental disorders are about twice as frequent among the poor as among the rich (Patel et al. 1999); (Patel et al. 2007). Stigma is still strong in XXI century, erecting barriers and resistances at reform roads (Petersen et al.2010).

Nevertheless, a lack of political support, inadequate management, overburdened health services and, at times, resistance from policy-makers and health workers have hampered the development of coherent mental health systems in Low and Middle Income Counties (LMICS).

Psychiatric services in the former Soviet Union have been characterized by high rates of institutionalization and a strong focus on biological treatment. In the post-Soviet states, these features remain – there is strong resistance to the introduction of modern, community-based and user-oriented services (Tomov et al. 2007). In many cases, psychiatric reform programs have come to a halt or have even been reversed (Global Initiative on Psychiatry 2011). It is against this backdrop that Georgia began the critical phase of its mental health reform program a couple of years ago (Makhashvili and van Voren 2013).

Georgia, which has a population of 4.4 million and ranks 75th on the United Nations Development Program's Human Development Index, is one of the three Caucasian countries that regained independence in 1991. Its recent history has been turbulent. The country was ravaged by a bitter civil war from 1991-1993, the economy almost came to a standstill, and the health care system collapsed. It took until the end of the 1990s before basic health care services had been re-established. Progress continued during the first

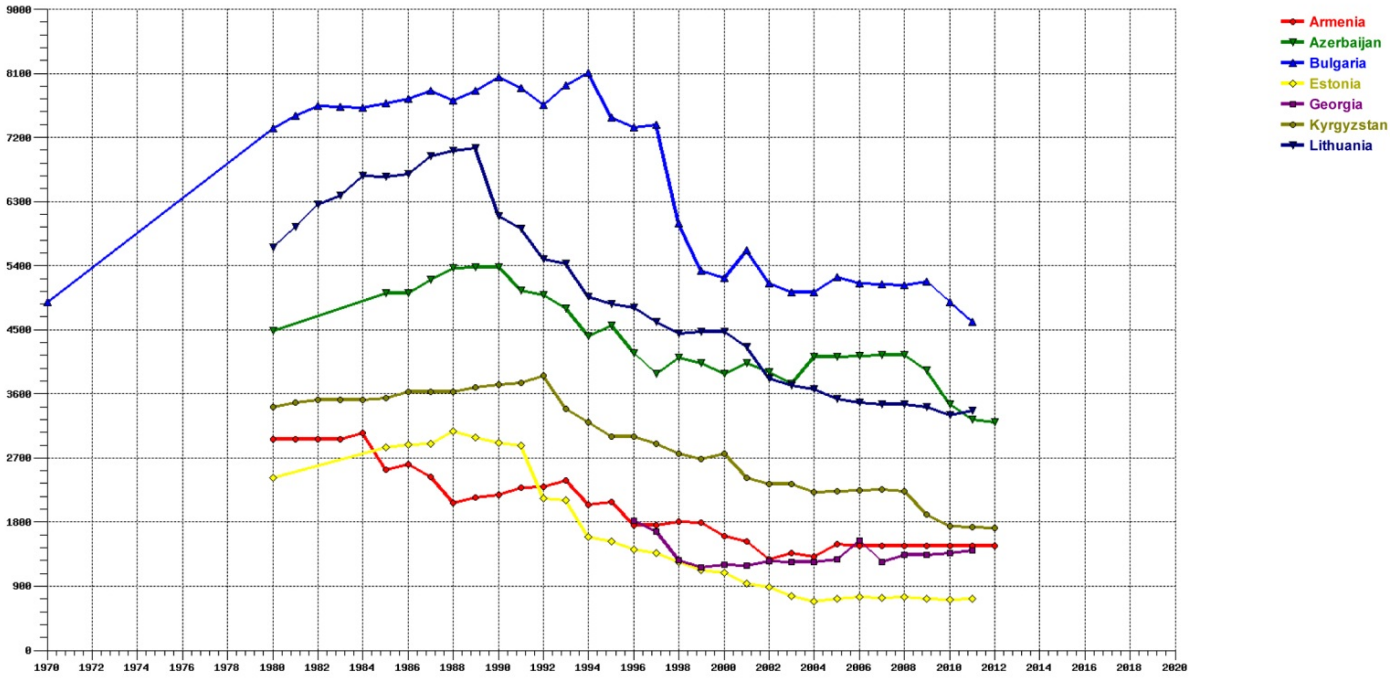
years of this century, with health systems reforms that included moving away from the "Semashko System" (a Soviet system of state-owned health facilities and state-funded health professionals); changes in healthcare financing and provision; development of private health care insurance; and the privatization of health care providers (Makhashvili and van Voren 2013).

The mental health situation in Georgia: a brief overview

The years after independence were characterized by radical decrease of the psychiatric beds. This was a general trend in post-Soviet countries as illustrated by the Figure 1, which shows that there has been an almost five-fold reduction in the number of psychiatric beds since 1995, caused by insufficient financing of mental health services (European health for all database.

Unfortunately, alongside with other countries, in Georgia this decline in hospital services was not counter-balanced by the development of outpatient and community-based services.

Figure 1. Beds in Psychiatric Hospitals (selected countries)



Source: WHO/Europe, European HFA Database, April 2014

Currently, several mental health institutions and in-patients units at general hospitals with an average of 1,200 beds provide inpatient care (28.44 beds for a population of 100,000) (WHO 2011).

Aside from psychiatric hospitals and in-patient units, there are 18 outpatient psychiatric clinics ('dispensaries') in the country. However, mental health services across the country are unequally distributed: 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 (Makhashvili, and van Voren, 2013).

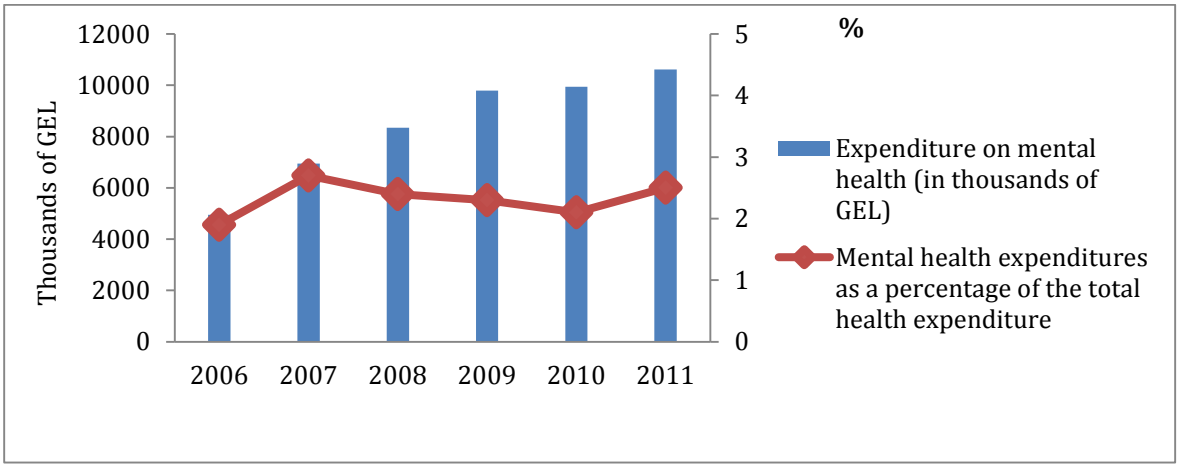
According to WHO MH Atlas (2011), the neuropsychiatric disorders are estimated to contribute to 22.8% of the global burden of disease. The total expenditure on health as a percentage of Gross Domestic Product (GDP) in 2006 was 10.14% and the per capita government expenditure on health (PPP int. $) was $73.0.

The number of officially registered people at outpatient psychiatric clinics ('dispensaries') with mental disorders in 2013 reached 68,922 (out of a total population of 4.4 million) (National Center for Disease Control and Public Health 2013). Such data is likely to be an under-estimate of the true burden of mental illness, due to the shortcomings of epidemiological surveillance and also because statistics do not capture patients who visit private doctors. It should be also noted that free care is provided to only those with severe disorders, thus many others, especially with common MH disorders, usually are not registered at dispensaries and their numbers are not reflected in the state data.

The rate of prevalence of mental disorders per 100.000 residents was 1536.o in 2013 with incidence rate of 67.3per 100.000 residents) (National Center for Disease Control and Public Health 2013).

Public Health allocations on mental health in Georgia during 2006-2011 have been characterised by a tendency of increase, but the volume (%) of spending on mental health from the total public health expenditure does not experience a substantial change and consists of about 2.5% as indicated in Figure 2 (Curatio International Foundation 2014).

Figure 2.Mental Health Expenditure in 2006-2011.



Expenditure on mental health per capita in Georgia reaches 2.8% - this significantly differs from the data of those countries that have the similar development level (Curatio International Foundation 2014).

MH services are mainly financed from the state budget. The role of private and corporate insurance in mental health services in Georgia, as well as in most of the countries in the world, is very limited.

In 1995, Georgia adopted a mental health care program (as a part of a new general healthcare program) in which people with mental disorders on the psychiatric register receive free of charge services and treatment both at hospitals and in outpatient clinics (Sharashidze et al. 2004).

Thus, MH care is delivered within the framework of this annual State Program for Mental Health Care and administered by the Ministry of Labor, Health and Social Affairs (MoLHSA); the Program is revised every year.

The budget of the program more than doubled between 2006 and 2011, reaching GEL 12 million (7.3 million US$); and continues to be increased further (GEL 14,627 ml in 2013).

Table 1shows changes in the state budget and services for psychiatric care between 2006 and 2013. The table illustrates a gradual increase in funding and diversification of the package of services that is offered to people with mental health disorders. However it also shows the priority for funding of hospital care, the stagnation of funding for psychosocial

rehabilitation, and that only a very small portion of finances is reserved for the out-patient care (Makhashvili & van Voren, 2013).

Table 1. Budget and composition of State Program on Mental Health Care 2006-2013 (in GEL)

Service components	2006	2007	2008	2009	2010	2011	2012	2013
Outpatient Services	1,200,000	2,000,000	2,397,442	2,597,232	2,597,232	2,734,000	2,855,000	2,866,000
Psychosocial Rehabilitation		50,000	70,100	70,100	70,100	47,000	70,000	70,000
Child Mental Health				100,688	151,032	75,500	151,000	151,000
Crisis Intervention and Mobile Team						14,000	520,500	662,500
Hospital Care	3,750,000	4,900,000	5,882,558	6,933,780	6,933,780	7,457,000	9,244,400	10,174,000
Hospital Care for Children						99,000		
Shelter for people with Mental Disorder								466,500
Urgent Care				45,000	45,000	45,000	97,600	-
Hospital Care of Substance Abuse Conditions				48,000	144,000	144,000	164,200	236,600
In TOTAL	4,950,000	6,950,000	8,350,100	9,794,800	9,941,144	10,615,500	13,102,700	14,626,600

Georgia spends a large proportion of the funds allocated for inpatient mental health services (71 %) and this figure has been stably high over the years. Developed European countries spend 9-31% on inpatient mental health services and much more on out-of-hospital services. Acute in- patient care commonly absorbs most of the mental health budgets (Knapp et al. 1997), therefore reducing the average length of stay may be an important system goal, especially if the resources released in this way can be used to pay for other service components (Sederer 2010); (Lelliott and Bleksley 2010).

From the perspective of universal health coverage (WHO 2010), the dominance of mental hospitals limits overall availability and accessibility of MH services.

For introducing comprehensive chain of care the country needs to develop out-of-hospital services – at present the State Program devotes up 28% to these services; among them modern community-based services take just 4.5% of the funds (Government of Georgia 2014).

The mental health system of Georgia is experiencing a severe shortage of human resources. The shortage of the psychiatrists compared to the average European index is twice less, which in absolute numbers is expressed in the deficiency of at least 250 psychiatrists (Curatio International Foundation. 2014). This concerns other specialists as well as illustrated in Table 2 below.

Table 2. MH staff per 100,000 inhabitants (2011)

	Georgia	Average European Index
Psychologist	12.8	22.2
Nurse	7.68	45.3
Social worker	2.9	60
Psychiatrist	6.87	11

(Adapted from Curatio International Foundation. 2014. Mental Health Care in Georgia: Barriers and Suggested Solutions. A Policy Brief. Tbilisi).

Social Exclusion and Human Rights

Until recently, patients with mental health problems were kept in large institutions, where people were forced to live in inhuman conditions or sometimes even left to die (Tomov et al. 2007). Georgia has yet to complete the fundamental transformation from the old-Soviet mental health care structure into a humane system that meets basic human rights standards (GIP-Tbilisi 2007).

Recent studies carried out in Georgia show the magnitude of the problem and reveal a strong link between mental ill health, social exclusion and poverty (GIP-Tbilisi 2009). Gross violations of all basic rights of in-patients are highlighted by reports from the Public

Defender's Office (Public Defender's Office 2007-2010), based on regular monitoring of closed psychiatric institutions.

Violations range from inappropriate involuntary hospitalization (which is forbidden by the Law on Psychiatric Care, introduced in 2007) to violations of a patient's right to privacy, information, and rehabilitation. The European Committee for the Prevention of Torture has repeatedly criticized the Georgian government for the poor conditions in the country's mental institutions (Council of Europe 2007; Council of Europe2010), but the tide is now changing: the evidence on human rights violations that was presented to policy-makers over the years was a strong impetus to the mental health reform process.

The push for changes

The legal framework

One of the prime outcomes of human rights lobbying was the adoption of a new Law on Psychiatric Care (CRRC 2007), which is generally considered to be progressive and rights-based (OSGF 2011). 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 by-laws introduced practical procedures, for examples procedures related to the use of physical restraint. In 2009, Georgian experts analysed the law's implementation (GIP-Tbilisi 2009) and several further modifications were adopted; in 2013-2014 the process has been continued and some other changes were made in Spring 2014 by the Parliament of Georgia, particularly related to procedures on forensic psychiatric treatment (Parliament of Georgia 2014). ; adoption time: 26.07.2014)

The crucial involvement of non-governmental organizations (NGOs)

One of the essential elements in the process was the strong voice of the non-governmental sector. The activity of civil society organizations, professional societies, user groups and family member organizations created the momentum that was essential for a movement towards a rights-based and humane mental health care. The sector often function as the conduit for international expertise and of knowledge about best practices in other countries. To provide an overview of all these NGO-originated interventions, we will

shortly describe these processes from grassroots to the national level (Makhashvili, and van Voren, 2013).

Reforms at the grassroots level

In searching for innovative, locally appropriate and implementable models, new projects and activities were developed by NGOs, according to WHO standards (WHO 2004). (WHO 2005), and other international recommendations (Thornicroft and Tansella 2004; Patel and Thornicroft 2009; Thornicroft, and Tansella 2009). State standards regarding these new initiatives were adopted (e.g. re. psychosocial rehabilitation, child and adolescent day-care service), and after they were proven to be effective and appropriate, these initiatives were replicated and integrated into the existing State healthcare system. Many new community-based services, such as crisis intervention and home care, were rolled out through this approach of small pilots followed by national scale-up. Recent examples are the crisis intervention teams that deal with emergency cases within certain catchment areas in Tbilisi and some other cities.

National level reforms

At the national level, the main strategy of the NGO community was to influence the government and other mental health policymakers to adopt legislation and to abide by the new laws; to be closely involved in developing relevant mental health policies and plans (e.g., juvenile delinquency prevention); and to help create monitoring mechanisms to ensure the protection of human rights. The efforts have been directed towards development of coherent national mental health systems. Some of these initiatives have been successful, though they required long-term advocacy and much effort; others failed, such as the attempt to introduce a psychosocial support services for war-affected populations (GIP Tbilisi 2011, 2012).

International donors

Many of the initiatives were made possible with funding from the international donor community. Whereas for many years the donor community often forgot to push for sustainability and embedding programs within the local context, this changed during recent years. In the mental health field, the European Commission, the Dutch Ministry of Foreign Affairs, the United Nations Development Program (UNDP), Council of Europe

and OSGF are among those that provide the essential financial means to carry out pilots and finance the transition until local resources could take over.

Reforms take a shape

In the process of reforming Georgian mental health care services several stages can be discerned. Increased funding as a result of doubling the state budget for mental health since 2004 allowed the MoLHSA to gradually upscale existing mental health services. This included improving the quality of treatment, the rehabilitation of some of the main psychiatric institutions, the improvement of living conditions of patients undergoing forensic treatment and the initiation of a psychosocial rehabilitation program. In 2008 the introduction of a new funding model (global budget) for hospital care gradually led to a reduction of the number of in-patients. However, these reforms still did not go far enough. Essential treatment methods, such as psychological treatments, 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. The long preparatory stage equipped the stakeholders with relevant knowledge and experience, which came handy when designing the further reforms. Acknowledging that "conditions, in which the patients of mental health care institutions live and undergo treatment, require urgent intervention", the Ministry announced a new and fundamental reform program at the end of 2010, and implementation started soon after.

The priorities of the 2010 program (MoLHSA 2010) were very much in line with the international requirements and standards set by e.g. the World Health Organization (WHO 2005; WHO 2009). To implement the desired changes, the MoLHSA created Consultative Council on Reform (consisting mostly of psychiatrists). In February 2015 the Ministry updated the Council membership and included family member of the user of MH services (Decree of the Minister 2015). It should be noted that high officials from the Ministry take active part in the discussions and consultations.

Initial steps in the new reform process

The most important dimension to the initiation of the new reform process, which took place in the early summer of 2011, was a deinstitutionalization process. Symbolically, the most significant step was probably the closing of one of the leading hospitals in the

country, the vast and dilapidated Asatiani psychiatric hospital in the center of Tbilisi, which had 250 beds at the time of its closure. The "re-structuring" of the beds took place. Acute beds (in units of 30 beds) were relocated to newly opened MH units in general hospitals (3 departments are now functioning in multi-profile hospitals); a new child mental health ward with 10 beds was opened in a general hospital; a separate mental health center was established in the capital 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 3 locations (each with 40 beds); and crisis teams started functioning in some other cities of Georgia, e.g. Batumi, Rustavi and Kutaisi. Guidelines and codes of conduct were elaborated and a new funding model for acute and longer-stay patients/client were introduced (MoLHSA 2011).

These changes immediately resulted in a fall in the length of stay of acute patients, from an average of two to three months before the reforms to an average of 14-21 days (Curatio International Foundation 201). The length of stay for an acute patient refers to the time from initial hospitalization to either discharge or transfer to a long stay department. However, lack of long-term beds, experts, carers and users of the services emphasize community-based services and inadequacy of funding.

Capacity building

The professional development of the mental health workforce has been supported. In 2011 a strategy for human resources development for Tbilisi was elaborated and basic modules for staff re-training were developed. European experts led training for local professionals and the first phase of re-training started in the summer of 2011. All mental health professionals from Tbilisi were invited to attend selected training courses and were enrolled free of charge. Pre- and post-tests proved that 67% of the trainees acquired the necessary knowledge and skills. By end of 2012, more than 300 mental health workers have been trained; the basic training lasts 160 hours and extended training lasts up to 240 hours (GIP-Tbilisi 2012). Irregular supervision of workers by the expert trainers was provided to some services to ensure proper implementation of acquired skills in the daily routine. Unfortunately, the program was stopped due to lack of further funding and MH staff from regions was not enrolled in the capacity building activities.

As in other former Soviet republics, mental health professionals in Georgia have virtually no contemporary mental health literature in own language. Western psychiatric literature was inaccessible in the Soviet Union for many decades. The publication program has resulted in new textbooks of psychiatry in Georgian (i.e. Philip Cowen, Paul Harrison, and Tom Burns (2006) Oxford Textbook of Psychiatry, Fifth Edition. Oxford Press).

In October 2011, multi-disciplinary working group initiated a revision of the Georgian national clinical treatment guidelines for schizophrenia and depression. These revised guidelines have been submitted to MoLHSA for approval and were adopted in 2013 (MoLHSA 2014). A group of Georgian experts have developed also a depression guideline for children and adolescents (that is under a review).

To facilitate further development a Resource Center on Mental Health was opened at Ilia State University (2011); it has a rich library, facilitates research, hosts conferences, workshops and trainings of both local and international experts, etc. In 2012 the pioneering 2-years long Masters program on mental health was established at the University with directions of "Social Psychiatry" and "Psychotraumatology" – 10 masters from different backgrounds have graduated in 2014.

Challenges and perspectives

Structural reform of a national mental health care system requires a long-term commitment. Such reform is likely to face repeated obstacles and setbacks that need to be overcome. In our PLoS Medicine paper (Makhashvili & van Voren, 2013) we discussed four key challenges.

1. Developing a clear mental health plan

The MoLHSA needs to prioritize and clearly plan ahead—an action plan for the coming years should be developed, which would help to link all existing and proposed mental health service components into one coherent and consecutive chain of services. This plan should have included concrete strategies and activities to overcome financial and geographic barriers to accessing care; the development of a chain of well-coordinated community-based services; the integration of mental health into primary care; and the integration into the general care mental health care program of several domains such as

prison mental health, psychotrauma care and juvenile delinquency. The WHO argues that the development and implementation of such a plan "can have a significant impact on the mental health of the population concerned" (WHO 2004).

It is worthwhile to note that NAP has been developed and adopted by end of 2014, thus this challenge has been addressed.

2. Improving research capacity

The researchers are discussing raising awareness on the needs of research capacity in mental health in LMICs (Sharan et al. 2007).

A robust research and information system should be put in place that collects and synthesizes relevant mental health data. Evidence is needed to prove that services are effective and to justify the introduction of innovative care (which is often met with strong resistance). Evidence is also crucial in helping to guide sound policy decisions and to steer the reform process in the right direction.

The 'Mental Health: Global Action Programme' (mhGAP) of the World Health Organization (WHO) envisions an active role for research in efforts to change the current mental health situation at the country level. Research-generated information is seen to be essential in determining needs, proposing new cost-effective interventions, monitoring their implementation and evaluating their effectiveness. Conceivably, such information will enable LMICs to better utilize their limited mental health resources.

Yet a comprehensive picture of mental health research production in these countries has been lacking.

3. Integrating existing services and developing care for vulnerable groups

One of the big challenges in the reform process is to integrate fragmented programs and services and to close the treatment gap by developing services that are needed for effective and continuous care.

Two major barriers to overcoming this challenge are the lack of psychosocial &rehabilitation services and insufficient empowerment of service users. Though service users' voices are increasingly being heard and incorporated into the decision-making process, support programs for users in Georgia are still scarce.

The integration of health and social services is an essential element of the new reform process, yet achieving such integration is a huge challenge. Integration calls for a careful

and diplomatic approach, since it requires overcoming vested interests and anxieties about future professional roles and positions.

Similarly, the mental health care service within the Georgian penitentiary system required major reforms (GCRT 2010). The Ministry of Corrections itself declared MH as a priority and identified a challenge of Development and Implementation of Integrated Model of Mental Healthcare (Ministry of Corrections of Georgia 2014). The ministry is introducing new programs (i.e. "Suicide Prevention Program"; rehab and re-socialization programs) to address MH needs of inmates; the ministry closely coordinates with MoLHSA and its Council as well.

Another group that needs to be targeted for care is the war-affected population. The available data indicates high levels of psychological trauma, anxiety, depression, and substance abuse, among members of these traumatized communities (GIP-Tbilisi 2010). The reform process needs to ensure that appropriate services are available to this group. The wider description of these groups is provided below in this thesis.

4. Overcoming stigma and resistance to reform

Among the main factors that contribute to the continuation of ineffective and inhuman mental health care in Georgia are the stigma and discrimination that are widespread in the media, in governmental policies, and in society at large. In order to reduce stereotyping and discrimination, and promote more positive societal attitudes towards people with mental health problems, a major anti-stigma campaign is needed.

The resistance from service providers themselves is the last, but very important, challenge to mental health care advancement in Georgia, as in many other countries in the region. In general, psychiatrists might act as a considerable obstacle to the goal of closing the treatment gap (Saraceno et al 2007). This obstacle is widespread throughout former Soviet Union countries, where anxiety about the future is a general feature and reform is often automatically seen as a challenge to one's livelihood.

Recent developments

To address the problems and challenges in a systemic way the Parliament of Georgia in December 2013 had adapted the "State Concept on Mental Health Care" (Parliament of

Georgia. 2013) - this is a main MH policy document for the country. The document states that

Georgia recognizes the significance of mental health care. This document defines the state policy on mental health issues and represents a joint vision of the Government of Georgia and Civil Society for the development of this sphere over the nearest 10 years. The major goal of the policy paper is to assist all stakeholders to contribute and achieve maximum results in the development and proper functioning of the mental health care system in accordance with their needs, capabilities and interests.

Furthermore, based on unwavering adherence to these values, Georgia undertakes the responsibility to organize provision of mental health care in the country in a way that persons with mental disorders shall receive treatment in a less restrictive environment,in as close proximity to their residence as possible or at home in accordance with their basic needs; to provide maximum protection of their rights and dignity and to ensure their full and effective participation in society on an equal basis with others.

This is an important statement that defines the strategic priorities of the reform, emphasizing service accessibility and affordability that should be ensured through the principles of so called balanced care.

The State Concept defines the Balanced Care direction:

Development of a balanced care model implies both hospital and community-based care/services and entails maintaining a balance between medicated and non-medicated treatments, between individual, family and community interests, as well as between methods of prevention, treatment and rehabilitation.

The country also declared that the effective care should be comprehensive, client-centered and continuous:

Provision of uninterrupted care and integration implies 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;

To meet the goals identified in the State Concept the MoLHSA initiated a process of drafting a National Strategy and Action Plan (NAP) for 2015-2020, that was adopted in December 2014.

Drafting of the Mental Health National Action Plan (MH NAP) has been led and coordinated by the Ministry of Labour, Health and Social Affairs (MoLHSA) and the Healthcare and Social Issues Committee of the Parliament of Georgia (HSICPG). GIP-Tbilisi, with financial support and technical guidance by UNDP, has major responsibility over the implementing of the project. Georgian Mental Health Coalition with a financial support of the Foundation "Brot fuer Welt" was a project partner funding number of working groups. The process was also closely coordinated with EU/CoE project "Human Rights and Healthcare in Prisons and Other Closed Institutions" providing MH research and technical expertise.

By June 2014 the main matrix of NAP was developed with 3 main domains: Services, Attitudes/Demands, and Governance. Each of these parts described priority directions (incl. strategy priorities, goals, major activities and sub-activities), service deliveries, outcomes, indicators and sources for verification, targets for 2014-2020, responsible agencies, funding sources, etc. On June 12, 2014, by invitation of MoLHSA, well-known international experts as prof. B. Saraceno, prof. G. Thornicroft and prof. J.M.C. de Almeida visited Tbilisi and presented their comments and recommendations for improving the NAP.

In his commentsprof. B. Saraceno identifieda neglected area of immediate intervention and recommended"Ensure that mental health care and community psychosocial supports are available during and after humanitarian emergency response and recovery". (Saraceno 2014, official letter).

Similarly, prof. G. Thornicroft indicated "there is insufficient attention in the National Action Plan to especially vulnerable populations, including internally displaced persons and people with mental illness in prisons and other places of detention"(Thornicroft 2014, official letter).

The on-going reform process needs more solid scientific data to influence the policy decisions and development of effective MH systems. As mentioned above there are several vulnerable target groups that require special attention and care.

War affected communities are among those who need to be considered by the policy makers - it is vital to develop an appropriate model for these large groups and integrate trauma-informed services into general mental health care.

2. War-affected populations and Mental Health Issues

Georgia was occupied by Soviet Russia in 1921 and remained under Soviet control until April 9, 1991. Georgia's transition after declaring independence from the Soviet Union was particularly traumatic: the economy collapsed and civil war broke out, lasting until 1994. During this time, the regions of Abkhazia and Tskinvali Region (see the map below) demanded independence from Georgia. With assistance from Russia, these regions achieved de facto independence. The conflicts resulted in a wave of internal displacement of over 300,000 ethnic Georgians from 1992-93 from Abkhazia and Tskinvali Region, of which approximately 220,000 remained displaced as of 2009. For the convenience of this thesis we call them "Older IDPs" to distinguish from those displaced in 2008 ("Newer IDPs").

A second phase of internal displacement occurred in 2008 as a result of the brief intense war between Georgia and the Russian Federation over Tskinvali Region. Consequently, at least 128,000 ethnic Georgians were displaced from Tskinvali Region and nearby areas. The majority were displaced to settlements in the district of Gori, just south of Tskinvali Region in Shida Kartli region. As a result of this conflict, the de facto authorities in so called South Ossetia and Abkhazia now have complete control over the territories, with heavy support from Russia. While Russia has recognized each territory as independent states, Georgia considers the territories Russian-occupied parts of Georgia. As of 2011, there were approximately 17,000 still displaced from the 2008 conflict - ("Newer IDPs") (United Nations High Commissioner for Refugees 2009).

Figure 3: Internal displacement in Georgia

Source: Internal Displacement Monitoring Centre (Jan 2011)

In total, at the end of 2011 there were approximately 257,000 IDPs in Georgia from all conflicts since the early 1990s, which represents at least 6% of the population (Internal Displacement Monitoring Centre 2012). The return of IDPs to their areas of origin is largely blocked, as the conflicts remain unresolved despite on-going negotiations (IDMC & NRC 2012). Almost half live in the capital Tbilisi.

IDPs are defined as persons who have been forced to flee their homes, as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State borders (Kalin 2008). There were approximately 26.4 million IDPs worldwide as of the end of 2011 (Albuja, S., et al., 2011). IDPs differ from refugees as the latter cross state borders, though they may leave their homes for the same reasons as the former. While refugees are entitled to protection and assistance from the United Nations High Commission for Refugees (UNHCR), there is no legal obligation for the extension of such rights to IDPs.

IDPs often live in precarious areas characterized by lack of access to health services, poverty, poor living conditions, uncertainty, destruction of cultural and social capital, discrimination, and marginalization (de Jong and Komproe 2002; Silove 2004).

In Georgia specifically, the provision of adequate housing remains elusive for many IDPs. The majority of current IDPs live in inadequate conditions with relatives or friends, or in multi-storey collective centres comprised of former hospitals, hotels, schools, factories, or other buildings which were initially provided as a 'temporary' housing solution when they were first displaced. Many of these centres have not been renovated for more than 20 years, and fall short of minimum shelter standards (Internal Displacement Monitoring Centre 2012). In addition to poor housing conditions, lack of access to employment and livelihoods continues to be a problem, especially for IDP women (Internal Displacement Monitoring Centre and Norwegian Refugee Council 2012).

It should be mentioned that the uprooted populations were first exposed to massive traumas as a result of political violence and war, and then re-traumatized by being, in some cases, displaced several times due to later military actions in the country. Large numbers of IDP's still live in regions bordering the conflict zones, where small and large scale violence, paramilitary attacks and continuing coercion and fear are a daily reality. Apart from other differences between developing and developed countries, it should be stressed that the issue of safety still remains a major concern in Georgia (Makhashvili, Tsiskarishvili and Drozdek 2010).

Though mental health services are available to Georgian IDPs by law, the health system has gone through an intensive and painful reform process and offers insufficient services to both the general and war-affected populations *(ibid.).*

The Government introduced targeted social assistance for persons living below the poverty line in 2007, and those who meet vulnerability criteria receive free health insurance under the program Medical Insurance for the Poor (MIP). The MIP benefit package covers urgent out-patient and in-patient treatment, planned inpatient services, outpatient care with limited diagnostics and limited outpatient drug benefit with co-payment (Zoidze et al. 2013).

"Newer" IDPs who were settled in collective centres were automatically enrolled in the MIP program (Government of Georgia resolution 2009 - It should be noted that MIP

program has been integrated into Universal Coverage Program in April, 2014) However, IDPs from 1990s conflict or IDPs from the 2008 conflict who have returned to their villages were not automatically included in MIP and they needed to qualify based on the eligibility criteria used with the rest of the population.

General mental health services are available to IDPs under the State Program for Mental Health. However, the state does not offer community-based care to these groups and not many specialists are trained in addressing specific needs of traumatised populations. This gap is filled-in, however fragmentally, with services offered by several NGOs.

A number of specialist mental health groups provide broad-spectrum and specialized psychosocial support to Georgian IDPs, including the Georgian Society of Psychotrauma (GSP) (Georgian Society of Psychotrauma 2008; GCRT 2014). In addition, NGOs such as the Global Initiative on Psychiatry - Tbilisi (GIP-T) served IPD settlements and Gori for some years (GIP-Tbilisi 2011; 2012). These services are scarce, occasionally funded by international donor agencies and are mostly alienated from a mainstream MH care system – very often there is no referral pathways established between these services and general MH care system and neither MoLHSA nor general MH service professionals are aware of the care provided.

Why is trauma-informed care and policy important?

The recognition by policy makers of the specific profile of mental disorders among conflict-affected populations is a relatively recent phenomenon (Brundtland 2000), and is still not a routine part of service planning and provision in post-conflict situations (Neuner and Elbert 2007).

A trauma-informed program, organization, system, or community is one that has undergone a transformation in awareness about the traumatic effects of violence and abuse and incorporates that understanding into every aspect of its practice or program. In such settings, understanding about trauma is reflected in the knowledge, attitudes, and skills of individuals as well as in organizational structures such as policies, procedures, language, and supports for staff. This includes attending to culturally specific experiences of trauma and providing culturally relevant and linguistically appropriate services. Any system, or setting can be trauma-informed (SAMHSA 2014).

Butler and authors argue that "a lack of awareness can result in (1) a failure to understand fully the presenting issues and their context; (2) a failure to treat or more appropriate (trauma-specific) referrals; and/or (3) retraumatization of patients with standard clinical procedures or inadvertent triggering events, which may slow progress, reduce openness to treatment or derail therapy altogether" (Butler, Critell and Rinfrette 2011). They also indicate, "Although trauma-informed care principles are widely applicable, they may also need to be tailored to the distinctive exigencies of the population being assessed or treated".

Understanding the complex interplay of trauma, dislocation, and adjustment in the migration process is an essential foundation for a trauma-informed perspective (Pumariega AJ, Rothe and Pumariega JB. 2005) and relevant national and local policies.

Inherent in this is an understanding of the relationship between trauma, mental illness, co-existing conditions and complex psychosocial difficulties, particularly important in the context of dynamic changes to the service system environment.

Addressing trauma is now the expectation, not the exception, in mental health systems. The trauma-informed care initiatives help map out and operationalize a plan for delivering trauma-informed services. Addressing trauma helps improve the quality and impact of care, increase safety for all, reduce no-shows, enhance client engagement, and avoid staff burnout and turnover.

By this study we tried to collect the scientific evidence that would influence the mental health policy and programs in Georgia for improving the MH conditions of war-affected large groups.

II. Theoretical Background

Conceptual framework – public health approach/perspective to mental health

The purpose of the conceptual framework is to aid in understanding of trauma-informed mental health service development.

To facilitate proper reforms the WHO strongly emphasizes the importance of developing community care under the umbrella of public health principles. It stresses continuity of care; a wide range of accessible services to respond to the different needs of population; partnership with families; and integration into primary care (WHO 2005).

I have chosen 2 conceptual frameworks/models for this study: to postulate an optimal mix of MH services, on the one hand (Model A) and to advise the effective set of services according to law-, middle and high-resources (Model B).

A. Optimal Mix of Services

WHO had put forward a 'pyramid of services' (Fig. 4) that provides an optimal mix of services required by people with mental disorders (WHO 2007). This model is based on the premise that no single service can meet all mental health needs. In fact, without any one of these service levels, and referrals up and down the pyramid, the 'system' breaks down, and the other parts are unable to function effectively and efficiently.

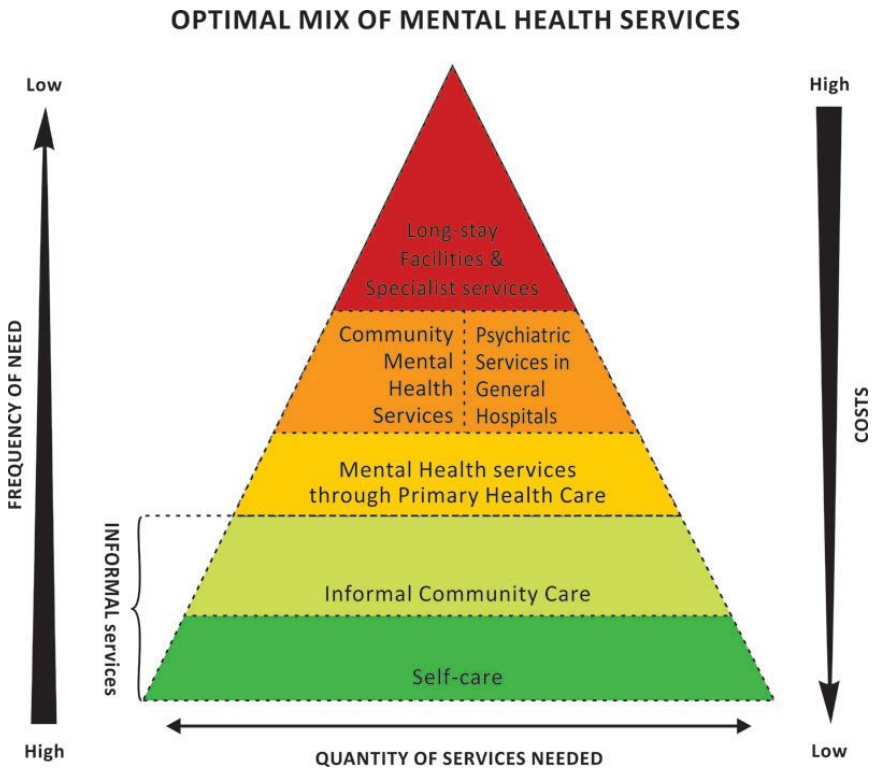


Figure 4. Optimal Mix of Services (WHO, 2007)

At the bottom of the pyramid, and where most care is provided, is self-care. Most people can manage their own mental health problems themselves or with help from family or friends. However to facilitate the autonomy and ability of people to care for themselves, the health service or non-governmental organizations need to provide information to people. This should be available and accessible to all people through, for example radio shows or pamphlets that are distributed in languages and literacy levels that people understand.

Informal community mental health services are services provided in the community but that are not part of the formal health and welfare system. Examples of this are traditional healers, professionals in other sectors such as teachers, police, village health workers, services provided by non-governmental organizations, user and family associations, laypersons, and so forth. Services at this level are important in preventing people who can effectively be cared for at this level from making demands further up the pyramid, however it is also an extremely important level for 'down referral'. People who may have been treated in a hospital, for example, and discharged, often need informal support to prevent them from relapsing or needing care at a higher level. Informal services are usually accessible and acceptable to the community as they are an integral part of the community. It can be seen then that most mental disorders are dealt with outside of the medical system.

The first 'formal' mental health service is within primary health care. The integration of mental health care into primary health services is a critical component of comprehensive mental health care. Essential services at this level include early identification of mental disorders, management of stable psychiatric patients, referral to other levels where required, as well as promotional and prevention activities. Depending on who carries out first-level health care in a particular country, activities and interventions may be carried out by general practitioners, nurses, or other staff that provide assessment, treatment, and referral services.

Mental health services at this level greatly increases physical accessibility as first-level general health care is usually relatively close to where people live. In addition, the person can be treated as a whole person who may have co-morbid physical and mental health problems. Seeking and receiving treatments part of a general health care is also often less stigmatizing for an individual, especially where having a mental disorder is regarded as shameful. Services are therefore more acceptable to service users than having to be treated in a psychiatric facility. From a clinical perspective, it has been found that most common mental disorders can be treated at primary care level. In situations where there are few trained mental health practitioners, an integrated approach substantially increases the chances of being treated for mental disorders.

Integration of mental health into primary health care requires careful training and supervision of staff. Staff needs to be equipped with knowledge and skills that enable them to provide mental health care through training provided as part of initial health worker training as well as on-going in-service training (WHO 2003). Additionally, they have to be adequately supervised and supported. Health workers often feel ill equipped and reluctant to undertake mental health in addition to other health care and so on-going assistance is essential. Critically too, where psychotropic medication is needed, this must be available at this level. This means that these drugs need to become an integral part of the supply, storage, and distribution chain and provision must be made for the prescription of necessary drugs at this level.

Where there is no integrated first-level care, addition pressures are put on the higher levels of care. People are inappropriately referred to levels of care that should be dealing with more complex problems and where there is no early identification of problems, treatment or prevention, and promotion, more people become seriously ill and need to be treated at the higher levels.

The next level of the pyramid has two complementary components, the first is formal community mental health services and the second is mental health services in general hospitals.

In addition to the informal services that are commonly provided in communities for people with mental disorder, additional formal community services such as day centres, rehabilitation services, hospital diversion programmes, mobile crisis teams, therapeutic and residential supervised services, group homes, home help, assistance to families, and other support services are needed. While not all community mental health services will be able to provide all these services, a combination of some of these, based on needs and requirements, is essential for successful mental health care. Where there are no or highly inadequate community services, it becomes very difficult to discharge patients from psychiatric hospitals, thus 'clogging up' scarce and expensive hospital beds. Others who could avoid hospitalization if community care was available are unnecessarily (though necessary in the circumstances) hospitalized.

Without a good community-level care, people often land up either in inhumane institutions or destitute and living on the streets. On the other hand, people receiving good

community care have been shown to have better health and mental health outcomes and better quality of life than those treated in institutions (Anderson, Dayson and Wills 1993).

As part of the mental health system represented by the pyramid of care, it is important that the community mental health services have strong links with other services such as the primary care and informal and general hospital services.

The development of mental health services in general hospital settings is another critical element of the organization of services. Given the nature of mental disorders, for a number of people some hospitalization at some time (or times) during acute phases of their condition will be necessary. As with integrated primary mental health care, mental health care in general hospitals are more accessible and acceptable than in dedicated psychiatric hospitals.

In any country, especially low- and middle-income countries, there are likely to be only a few dedicated psychiatric hospitals and these are usually situated in urban areas – albeit often somewhere out of town. These hospitals are very often not geographically or financially accessible to patients or families wishing to visit them. There is also often high stigma associated with these facilities that are often the butt of highly discriminatory jokes or references. While clearly the issues of stigma needs to be directly dealt with, until such time as stigma around mental disorder and particularly psychiatric hospitals does change, most people prefer to get treatment in a general hospital. Any co-morbid conditions can also more easily be treated, and special investigations can be conducted.

At the peak of the pyramid, providing services at the highest cost to the least number of people are long-stay facilities and specialist services.

A small minority of people with mental disorders require more specialist care than can be provided at general hospital level. Especially in low- and middle-income countries, where there are very few mental health professionals, and certainly not enough highly skilled people to be available in every general hospital, it is necessary to refer people with therapy-resistant or complex presentations to specialized mental health centres - or hospitals where mental health specialists are available. Moreover, a small group of people requires on-going nursing care in a residential facility due to their mental disorder. This, however, is a far cry from ‘old style’ mental institutions. Psychiatric institutions have a history of serious human rights violations, poor clinical outcomes, and inadequate rehabilitation programmes. They are also costly and consume a disproportionate

proportion of mental health expenditure. The WHO has thus recommended replacing these institutions with a network of services in the community and, for the majority, care in general hospitals where hospitalization is warranted.

The conceptual framework A that we utilize for the purpose of the study is based upon the discussed idea of a comprehensive and integrated system of mental health care. This central concept means that our research is orientated to understanding system deficiencies and treatment gaps in the study sites, and to producing evidence that directly informs the provision of services in future scaled up to a greater level of coverage, which implements task shifting.

The core conceptual challenges in the study are therefore: a fragmented services, largely based in psychiatric institutions providing poor accessibility and mostly excluding treatment of common mental disorders, primary care staff often insufficiently trained to identify and treat people with common mental disorders, a treatment culture not orientated to identifying and respecting the priorities and preferences of service users, and their participation in treatment decision making, the low policy importance attached to the mental health sector, and a largely separate NGO sector providing specific services related to unmet needs, including mental health interventions for people affected by trauma and conflict. The important aspects also are stigma and low awareness among the study populations. We therefore analysed the system requirements according to this framework, and proposed the integrated approach that can be put into practice for a benefit of war-affected groups.

Based on the study evidence, we tried to define the place and types of the trauma-informed services according to the model described above.

To complement and enhance the WHO framework of Optimal Mix of Services we used a second model - “Balanced Care Model”, the framework developed by Thornicroft and Tansella (Thornicroft and Tansella 2004).

B. Balanced Care Model (BCM)

The Balance Care Model (BCM) summarizes the evidence for distinct service components, and recommends three particular blends of the components as resource-appropriate models of care (Thornicroft and Tansella 2004; Thornicroft and Tansella 2013).

The mental health resource disparities between low and high-income settings are vast. In low income countries, for example, there are on average only 0.05 psychiatrists and 0.16 psychiatric nurses per 100,000 population, about 200 times less than in high-income settings (WHO 2005). Furthermore, training programs and facilities for mental health professionals in low-income settings are often grossly inadequate (Saxena et al. 2007: WHO 2005; Thornicroft and Tansella 2012).

The scheme developed, the Balanced Care Model (BCM), in relation to three 'levels of resources', using the World Bank classification (World Bank 2010). In this system economies are divided according to 2009 Gross National Income (GNI) per capita calculated using the World Bank Atlas method. The groups are: low income (US $995 or less); lower-middle income (US $996 - $3,945); upper-middle income (US $3,946 - $12,195); and high income (US $12,196 or more). For the purposes of the BCM the lower-middle and upper-middle income setting groups are combined (Thornicroft 2014).

1. Low-income settings

Most of the available provision in low resource settings is by staff in primary health care and community settings (Deva 2008; Ormel et al. 1994; Desjarlais and Eisenberg 1995).

The roles of these staff include: case finding and assessment; brief talking and psychosocial treatments; and pharmacological treatments (Beaglehole and Bonita 2008).

The very limited numbers of specialist mental health care staff (usually in the capital city and sometimes also in regional centres) are only able to provide: (i) training and supervision of primary care staff; (ii) consultation-liaison for complex cases; and (iii) out-patient and in-patient and assessment and treatment for cases which cannot be managed in primary care.

2. Medium income settings

G. Thornicroft in his communication to Georgian authorities (Thornicroft, 2014) states that for medium income settings, such as Georgia, it is important to appreciate that there is still a requirement for a strong primary care level of provision, so as to address the high levels of prevalence of common mental disorders in the general population (in many countries estimated at 20-30% annual period prevalence rate) (Kessler et al. 2005; Wittchen et al. 2011).

The literature from such middle income settings, for example many of the countries of Eastern Europe and South America (Semrau et al. 2011; Knapp et al. 2007) indicates that modest levels of resource are usually allocated for mental health care compared with communicable and infectious diseases (Furedi et al 2006). In addition, as resources allow, the BCM indicates that the five elements of 'general adult' mental health services are advisable as discussed below.

2.1. Out-patient/ambulatory clinics. There is surprisingly little evidence on the effectiveness of outpatient clinic or ambulatory care (Becker and Koesters 2011,179-91), but there is a strong clinical consensus in many countries that they are a relatively efficient way to organise the provision of assessment and treatment, providing that the clinic sites are accessible to local populations. Nevertheless these clinics are simply methods of arranging clinical contact between staff and patients, and so the key issue is the content of the clinical interventions, namely to deliver treatments which are effective (Nathan and Gorman 2002; Roth and Fonagy 2005).

2.2. Community mental health teams (CMHTs) are the basic building block of community mental health services. The simplest model of provision of community care is for generic (non-specialised) CMHTs to provide the full range of interventions, staffed by multi-disciplinary personnel. These often prioritise adults with severe mental illness, for a local defined geographical catchment area (Thornicroft et al. 1999; Thornicroft et al. 1998; Simmonds et al. 2001; Tyrer et al. 2003; Burns 2011, 231-41).

The central issue here is that CMHTs can offer case management and continuity of care, as well as mobility. In other words they can arrange appointments with patients at hospitals, clinics, community mental health centres, or at the patient's own homes. At the same time it needs to be recognised that for patients not able or not willing to go to health facilities, this flexibility is necessary but not sufficient for proper care. Alongside the need for mobility is once again the requirement to deliver effective treatment when clinical encounters do take place (Malone et al. 2007).

2.3. Acute in-patient care. There continues to be relatively weak evidence about most aspects of in-patient care, and these studies are usually descriptive accounts (Holloway and Sederer 2011, 223-231). More generally, although there is a consensus that acute in-patient services are necessary, the number of beds provided is highly contingent upon

which other services exist locally, and upon local social, economic and cultural characteristics (Thornicroft and Tansella 1999).

A related policy issue concerns how to provide acute beds in a humane and non-institutionalised way that is acceptable to patients, for example in general hospital units (Totman et al. 2010; Quirk and Lelliott 2001; Tomov 2001, 216-227; The ITHACA 2011).

2.4. Long-term community-based residential care. It is important to know whether patients with severe and long-term disabilities should be cared for in larger, traditional institutions, or be transferred to long-term community-based residential care. While there is no strong evidence on this question from low-income settings, the evidence from medium and high-income settings is reasonably clear. When deinstitutionalisation is carefully carried out, when patients who have previously received long-term in-patient care for many years are discharged to community care, then the outcomes are favourable for the majority (Shepherd and MacPherson 2011, 178-187).

2.5. Work and occupation. Rates of unemployment among people with mental disorders are usually much higher than in the general. Traditional methods of occupation have not been shown to be effective in leading to open market employment (Shepherd 1990; Rosen and Barfoot 2001, 296-308).

For settings with medium levels of resources it is reasonable at this stage to make pragmatic decisions about the provision of work and day care services, especially based upon the priorities and preferences of the patient/service user and carer/family members concerned (Cleary Freeman and Walter 2006, 189-94), where this is increasingly focussing upon the importance of personal recovery (Slade 2009).

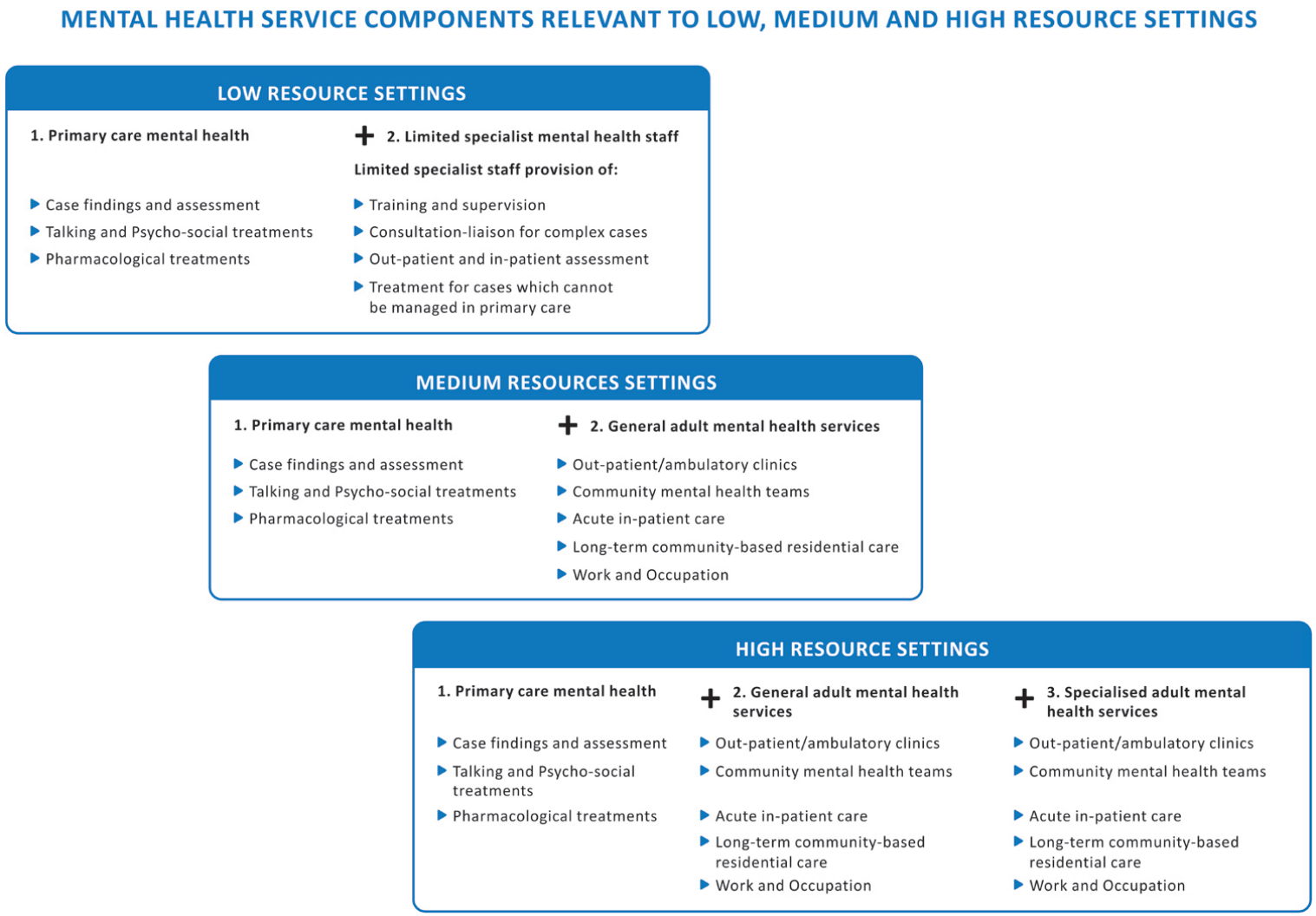
In medium resource settings the BCM approach proposes that services are provided in all of the five categories of care. If no provision for employment, or for community-based residential care, for example, is made, then in our view this is not a comprehensive and balanced system of care.

3. High income settings

Superimposed upon a basic primary care system (Gask 2005, 1785-1794), and also in addition to the provision of general adult mental health services, for high-income settings the application of the BCM implies that a series of specialised services can be provided, as

resources allow (see Figure 5). In fact, however, it is often the case that specialised services is developed in the absence of the first two layers of general services. This is often because advocates for a new team or service take a 'component view' of treatment, rather than public health orientation, using a 'system view' of the wider pattern of care, and how the constituent parts contribute to the whole. Such specialised services can be developed in the same five categories described above for medium income settings, with diversified types of each provision, as resources allow. The figure 5 below illustrates the mix of services relevant for different resource countries.

Figure 5. Mental health service components relevant to low, medium and high resource settings



The BCM model was used in the study to advise the effective set of services according to resources, though I have adjusted the model for the aims of the study and Georgian context. – I have investigated types of services within the country according to resources. I have differentiated only 2 settings: low- and medium- resource areas (Gori, Zugdidi) and high-resource areas (e.g. Tbilisi, Kutaisi, Batumi), as there is a small difference regarding MH services of low and medium-resource regions in the country.

The experts survey contained the questions related to both models. Thus, combination of the described frameworks A and B provided the guidance in developing appropriate set of services for war-affected populations in Georgia and drafting relevant recommendations for the MH policy.

Rationale, aims and objectives of the study

Much of the research on mental health of war-affected populations focuses on the trauma-exposure related disorders, as PTSD or depression, also there is big body of evidence on social determinants of mental health problems in such populations.

Nevertheless, the international studies are lacking in scientific evidence on designing of services for large groups of IDPs, addressing their mental health needs, and integrating these services in the general mental health policy and care system.

My research seeks to address 3 main topics:

- To identify the mental health disorders in Older (the 90s')& Newer (2008) IDPs and Returnees in Georgia, their comorbidity and burden on disability and look at service utilization patters among these big groups;
- To collect experts' opinions on the best effective models of service delivery meeting the identified needs;
- To develop trauma-informed mental health policy recommendations to important stakeholders.

The overall aim of this study is to examine patterns of common mental disorders among conflict-affected populations in Georgia and to elaborate the explicit mental healthcare policy recommendations.

The specific objectives are to:

- Measure the prevalence of common mental health disorders as PTSD, depression and anxiety among 3 main conflict-affected target groups;
- Explore the characteristics associated with these mental disorders;
- Examine the influence of the mental disorders and their co-morbidity on functional disability;
- Study the healthcare services utilization and identify gaps of mental health care;
- Investigate experts opinions on the most effective services addressing identified needs and taking into consideration existed resources; and
- Draft evidence-based recommendations for mental health reform to relevant governmental and non-governmental bodies.

The study consists of 2 main parts:

1. The quantitative research is designed to collect data on mental health problems of conflict affected populations, namely 3 big groups of the 90's IDPs, 2008 IDPs and Returnees; this is a cross-sectional household survey of 3600 persons;(This is a part of the big study on mental health among IDPs and Returnees in Georgia conducted the London School of Hygiene and Tropical Medicine (LSHTM). I have been serving as a technical expert in this large study: helping the team in designing of the survey questionnaire, piloting it, training and supervising of field workers/interviewers and taking a part in analyzing of data, writing and peer-reviewing papers.)

2. The experts' survey part is an electronic examination on perceived usefulness of commonly used services/methods to address MH needs of people with mental disorders, especially of war-affected populations, completed by foreign and local experts with substantial knowledge of MH policies and systems and/or with experience of care for trauma affected big groups.

I. MH care and policies in Low- and Middle-Income Countries (LMICS)

Mental Health as a public health priority, burden of MH and barriers to better care

Mental health is an indivisible part of personal and public health. There is no health without mental health. Consequently, public mental health is critical in achieving better mental health for populations (Saraceno, Freeman and Funk 2011). The authors define mental health (MH) as a public health priority and demonstrate this by compelling evidence using various criteria and perspectives for prioritizing MH. These include epidemiological data on MH, comorbidity with physical health, treatment efficacy, gaps in current treatment, impacts on individuals and their families, and the ideology of health (ibid.) Authors also argue that accessible, affordable and acceptable MH care requires MH systems and services that take account of culture, available resources and optimal mix of levels of care. Public mental health is needed to facilitate this.

Mental disorders account for 13% of the global burden of disease, and this figure will rise to nearly 15% by 2030. Depression alone is likely to be the second highest contributor to the global burden of disease by that date (Mathers and Loncar 2006, 2011-2030).

Mental disorders also are associated with more than 90% of the one million suicides that occur annually. In reality the number is likely to be far greater, due to common underreporting of this cause of death (WHO 2007).

Mental Health (MH) problems account for approximately 20 per cent of the total disability burden of ill health across Europe, but the "treatment gap" between the need for, and receipt of, appropriate services remain wide (Kohn et al. 2004).

People with mental disorders have a heightened risk of suffering from physical illnesses because of diminished immune function, poor health behaviour, poor adherence to medical treatments, and social barriers to obtaining treatment (WHO 2006).

The economic and social costs of mental disorders also are substantial. In the United States of America, direct treatment costs of mental disorders were estimated to be around 2.5% of the gross national product (Rice et al. 1990).

Indirect treatment costs are two to six times higher. In developing countries, families bear a significant proportion of both the economic and social burden, because of the absence of a publicly funded network of comprehensive mental health services. Families are also affected by social discrimination and stigmatization (Thornicroft 2006).

The prevalence of mental disorders worldwide is approximately 30% (Demyttenaere et al. 2004, 2581– 2590). In addition, mental disorders account for 37% of healthy years lost from disease (Wang et al. 2007, 841-850), and are the leading cause of disability worldwide (Lopez et al. 2006).

According to a recent WHO World Mental Health Survey, disorder severity was associated with service use, yet service availability was directly proportional to a country's Gross Domestic Product (Wang et al. 2007). Moreover, among patients who initiated treatment in settings with impoverished resources and infrastructure, few received treatment meeting minimum standards for adequacy or follow-up care (*ibid.*). Despite the remarkable need, only a small fraction of those with mental disorders receive effective treatment, even in well-resourced settings like the United States.

While a growing evidence base exists for higher income countries, far less research has been conducted regarding the treatment gap in LMICs, which face special human resource challenges. For example, the WHO Africa region has the fewest psychiatrists per capita with approximately four psychiatrists for every 10,000,000 people (Compare, for instance, with UK that in 2005 had 11 psychiatrists for 100,000 people (that means 1,100 for 10,000,000 population); or Azerbaijan - with 5 psychiatrists for 100,000 (500 for 10,000,000 people). (WHO 2005). Across South East Asia, there is, on average, one psychiatric nurse for every million people, compared with 248 per million people in Europe. These limitations also apply to other mental health specialists.

Formal mental health services in many parts of the world, especially in poorer countries, are characterized by poor accessibility, inadequate resources, and far from optimal organization of services. Most people with mental disorders do not have medical care for their conditions (Funk et al. 2004).

Many people rely on traditional remedies and traditional healers for their mental health care. Availability of mental health professionals is a major inhibitor to treatment. People with mental disorders often access health care in large isolated mental health institutions (WHO 2014). A

disproportionate proportion of most country's mental health budget is spent in these institutions (WHO 2001). However, it can be seen that despite significant discharge of patients from psychiatric hospitals in higher-income countries and a concomitant development of community mental health services, there are still far more beds per capita in high-income than in lower-income countries. Hence, though the vast majority of mental health resources in low- and middle-income countries are indeed spent on psychiatric hospitals, these facilities still have far fewer beds per 10,000 populations than is available in higher-income countries. Though for low- and middle-income countries, moving resources out of psychiatric hospitals is a necessity, as additional resources for much needed mental health care in the community is often not available, reduction of bed numbers is from an already very low base (Saraceno 2011; Knapp et al. 1997; Sederer 2010; Lelliott and Bleksley 2010).

Conflict, displacement, poverty, gender-based violence, and other social determinants of ill health increase the risk for mental disorders (WHO 2010).

The experts (Saraceno 2011) draw our attention to the financial availability of services in LMICs. Different countries have different policies on the financing of health care and mental health care in particular. Where mental health services are not free, this has critical consequences for accessibility. It will be shown that many people who need mental health services are poor, and even if they did not start that way, many drift into poverty. In addition, because many mental health conditions are chronic, health expenses tend to be relatively high. For an individual, on-going medication and occasional hospitalization may be required.

Where mental health care is not obtainable at a local level (but also then), there may be a number of additional costs for the individual and their family. For example, transport to the facility to get medication and review may be prohibitive. Furthermore, because of their condition, the patient may need to be accompanied to the place they receive care. The accompanying person would then also endure transport costs, they may also have to take leave from their employment to accompany the patient, and both the patient and the person accompanying them may need to buy food and so forth. As a result of these expenses, the person may be denied access to mental health care. As in the geographical accessibility scenario, the consequence of not accessing treatment due to no finances is often false economy, as the person may land up in expensive and long-term care.

The challenges of too few mental health professionals in LMICs have strengthened the argument that mental health care should be integrated into primary care, enabling access to these services in the community. This example of task shifting, defined as the rational redistribution of tasks among health workforce teams, involves the appropriate transfer of specific tasks from specialists to those with abbreviated training (WHO 2007).

Task shifting permits judicious use of valuable human resources by engaging qualified health workers in the community. In the context of mental health services where systems lack specialists, primary care providers (i.e., doctors, nurses, community health workers, etc.) may offer much-needed care for mental disorders in the community. A sizable and growing body of research demonstrates that task shifting in both high-income countries and LMICs can be efficient, cost-effective, and sustainable for the delivery of HIV services, improving tuberculosis treatment outcomes, and a wide range of maternal and child health interventions (WHO2007). Recent recommendations from the WHO address areas of task shifting in the delivery of HIV services that may be relevant to the strategic delivery of other health services, including mental health interventions (*Ibid.*). While a small, but growing evidence base on the use of non-specialist mental health workers is emerging from LMICs, many empirical questions remain.

An expanded mental health evidence base in LMICs is needed; studies from these countries are underrepresented in scientific literature. Notable gaps in research exist in the domains of health policy and systems, cost-effectiveness of interventions, and scale-up of evidence-based services. A range of factors contributes to the scarcity of mental health research in these settings, from limited access to relevant literature to the lack of collaborative networks of investigators of all experience levels. Enhancing resources and improving capacity have been identified as priorities in enriching mental health research in LMICs (Wang et al., 2007).

Research partnerships are key to enhancing resources and improving capacity for mental health research in LMICs. A partnership model of research, in which LMIC nationals lead research projects with any needed technical support from colleagues in more developed countries, can lead to ownership, sustainability, and the development of local and national research capacity (Costello and Zumla 2000). Cultural and national influences play a large role in the interpretation and application of research findings *(Ibid.).* Similarly, local and national researchers in LMICs have critical knowledge of the cultural and national influences regarding

health problems and treatment issues. Thus, in mental health research conducted in LMICs, local and national researchers should engage in partnerships, as needed, to provide technical assistance, enhance resources, and build capacity.

At this point it is hard to predict the future of MH services in Post-soviet Countries where political transition started in the early 90's. There are many priorities on a health agenda that share a common root – the culture bound disregard of the importance of mental well being for prosperity and happiness (Tomov et al. 2007).

Nevertheless, these countries are moving forward and struggle with resistance and reluctance of policy-makers, professionals, and community members. The role of human rights defenders and reform-minded individuals and organizations is pivotal in this process (see a chapter below).

Stigma and Mental Health Burden

The stigma still very commonly associated to people with mental disorders and disabilities (PMD) may help to explain a certain resistance and reluctance of decision-makers as well as societies in general. Given the evidence of the damaging consequences of mental ill health, one might expect a practical recognition of the problem in terms of prioritizing MH in national policies and increasing of funding for MH services. This is not a case in most countries and Post-Soviet Block countries are not exempt. Institution-focused services continue to dominate, community-based care is underdeveloped and PMD continue to be under-represented in decision-making processes, excluded and often abused (van Voren 2014.; Thornicroft 2008; Thornicroft 2007, 192-193).

Effective MH care requires a coordinated and well-considered, multi-agency and cross-sectorial approach. When an effective MH policy/strategy is in place and relevant services are developed, the system can advance mental health, strengthen social cohesion, and avoid associated social and economic burdens that will significantly improve the life quality of the whole society (WHO 2004). It takes a strong and long-term, culturally sensitive advocacy efforts to influence society, users of MH services& their family members and policy-makers to reduce stigma and discrimination (WHO 2003).

One of the key remaining barriers to understanding the development and prognosis of mental health disorders, and to unlocking the full potential of treatments, has been an incomplete picture of the size and scope of the true burden of mental illness (WHO 2001). The severe MH disorders - for example, schizophrenia, depression, epilepsy, dementia, and alcohol dependence - collectively account for more years of life lost to poor health, disability, or early death than either cardiovascular disease or cancer. Yet, compared to illnesses like cardiovascular disease and cancer, there are far fewer effective treatments or preventive methods. In addition, interventions are not widely available to those who need them most (WHO 2008).

WHO has identified 2 types of burden of mental health problems:

The **undefined burden** of mental problems refers to the economic and social burden for families, communities and countries. Although obviously substantial, this burden has not been efficiently measured. This is because of the lack of quantitative data and difficulties in measuring and evaluating.

The **hidden burden** refers to the burden associated with stigma and violations of human rights and freedoms. Again, this burden is difficult to quantify. This is a major problem throughout the world, as many cases remain concealed and unreported.

In recognizing the need to address the imbalance and huge treatment gap and also to reduce mental ill health burden, the top five challenges have been identified (Collins et al. 2011, 27-30). These top challenges call for following actions:

Integrate screening and core packages of services into routine primary health care

Reduce the cost and improve the supply of effective medications

Improve children's access to evidence-based care by trained health providers in low- and middle-income countries

Provide effective and affordable community-based care and rehabilitation

Strengthen the mental health component in the training of all health care personnel.

These top five challenges were ranked according to the ability to reduce the burden of disease, ability to reduce inequalities in health and health care, length of time until results can be observed, and the ability for the topic to be researched effectively.

Human Rights and Mental Health

One of the fundamental principles that shape modern MH practices is respect for human rights of PMD. All policies and programs should be rights-based and rights-informed.

The Universal Declaration of Human Rights stipulates that "all people are free and equal in rights and dignity" and asserts that people with mental disorders and disabilities are protected by human rights legislation by virtue of being human beings. International agreements and treaties such as the European Convention for the Protection of Human Rights and Fundamental Freedoms the United Nations Convention on the Rights of the Child, European Convention for the Protection of Human Rights and Fundamental Freedoms, Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

While international human rights law has grown tremendously over the last thirty-forty years, the development of international law to protect specifically the rights of people with mental disabilities has been relatively slow and limited (WHO 2004). Human rights oversight bodies that monitor the mainstream conventions and establish reporting guidelines have dedicated little attention to the rights of people with mental disabilities (Alston, 1995).

The lack of language that pertains specifically to people with mental disabilities in the International Bill of Rights and other mainstream conventions has long hampered the application of these conventions to people with mental disabilities. As a practical matter governments that have ratified the International Bill of Rights, as well as activists and mental health professionals, simply do not know what the specific requirements of international conventions are as they apply to people with mental disabilities. In recent years, there have been a number of important developments that greatly aid the application of convention-based rights. In 1991, the United Nations General Assembly adopted the "Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care" (the MI Principles 1991).

The MI Principles are a non-binding UN General Assembly resolution, but they can be used as a guide to the interpretation of related provisions of international human rights conventions (Rosenthal 1993).

The Convention on the Rights of Persons with Disabilities (CRPD) and its Optional Protocol (A/RES/61/106) was adopted on 13 December 2006 at the United Nations Headquarters in New York, and was opened for signature on 30 March 2007. There were 82 signatories to the Convention, 44 signatories to the Optional Protocol, and 1 ratification of the Convention. This is the highest number of signatories in history to a UN Convention on its opening day. It is the first comprehensive human rights treaty of the 21st century and is the first human rights convention to be open for signature by regional integration organizations. The Convention entered into force on 3 May 2008.

The Convention follows decades of work by the United Nations to change attitudes and approaches to persons with disabilities. It takes to a new height the movement from viewing persons with disabilities as "objects" of charity, medical treatment and social protection towards viewing persons with disabilities as "subjects" with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent as well as being active members of society (UN 2006).

The CRPD – a powerful instrument to promote rights of all people with disabilities, among others with mental and psychosocial disabilities - provides stakeholders with robust mechanisms for assuring quality of care and services; for instance:

Participation: “Civil society, in particular persons with disabilities and their representative organizations, shall be involved and participate fully in the monitoring process” (Art. 33(3).

Consultation and partnership: “In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States Parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations” (Art 4(3).

Monitoring: “States Parties shall, in accordance with their legal and administrative systems, maintain, strengthen, designate or establish within the State Party, a framework, including one or more independent mechanisms, as appropriate, to promote, protect and monitor implementation of the present Convention. When designating or establishing such a mechanism, States Parties shall take into account the principles relating to the status and functioning of national institutions for protection and promotion of human rights” (Art. 33(2).

These international agreements affect policies and programs in many countries that are striving to achieve social inclusion and equity of care. Human rights concepts shape MH strategies and legislation and improve (living) conditions, ways of treatment and rehabilitation programs for PMD (WHO 2005).

MH Policy and Action Plan

The important step towards providing well-considered and comprehensive mental health care is the drafting of a policy and a plan that will guide mental health system and services development. A mental health policy is an official statement by a government or health authority that provides the overall direction for mental health by defining the vision, values, principles, and objectives, and establishes a broad model for action to achieve that vision. To be effective, a policy should be accompanied by a more detailed and specific action plan to be implemented in a systematic and well-coordinated way (WHO 2009).

The Key Messages in this regard are as following:

Mental health issues should be incorporated within general health policies and plans, and supplementary mental health policies and plans also should be developed to provide the details required for implementation.

Policies and plans in themselves can just be pieces of papers, or alternatively, they can be highly effective and efficient drivers of improved mental health in a region or country. Specific actions are necessary to facilitate their effective implementation.

Policies and plans must be monitored carefully and evaluated to determine whether they are creating their desired outcomes.

The content areas of a mental health policy and plan, as well as the level of detail that goes into a mental health policy, will invariably differ from country to country. Nonetheless, fundamental steps based on good practice principles and experience can be followed to ensure that the most important processes have been undertaken and key content issues have been included.

WHO states: “As scientific evidence mounts concerning the cause, course, and consequences of mental disorders, and new treatments are emerging that can make real differences in the lives of sufferers, most people with mental disorders do not receive even the most basic treatment,

and suffer from stigma and discrimination. National policies and programmes in mental health are urgently needed to change this situation, yet over 40% of countries have no mental health policy, and over 30% have no mental health programme" (WHO, 2001).

The realistic and needs-based policy/programme development in MH field should be informed by scientific evidence regarding needs of the population of PMD.

People with mental health problems have a range of health and social needs that result in both illness and disability. Needs assessments by service providers have often focused narrowly on health needs. However, health cannot be meaningfully separated - at an individual level - from both a person's social needs and their citizenship needs. The latter - enabling people to participate effectively in the life of the society, including exercising rights to freedom, property, etc. Many of the factors which contribute to an individual's quality of life -good housing, a job, adequate income - are not, or cannot be provided by mental health services alone or at all. However, services do need to create the conditions, which enable people to have access to - and use these opportunities; failure to do this will mean that people's level of disability (that is, the social effects of their mental illness) will remain unnecessarily high (Smith 2003).

A lack of clarity about what constitute real needs in relation to mental health services is among other important reasons (i.e. deficiency of political commitment to engage properly and ensure good care) that results in services being planned in LMICs not on the basis of need, but on historical patterns of service use. This tendency is compounded by the absence of a national framework of mental health needs to guide strategy and practice of MH reform.

WHO (WHO 2005) suggests 7 essential steps to be considered for developing a mental health policy (see table 3 below).

Step 1: Gather information for policy development. Collect information about the mental health needs of the population, as well as the current mental health system and services. Determine population needs from, for example, prevalence and incidence studies, community-identified problems, and information about the major reasons people seek assistance. Prioritize key mental health issues.
Step 2: Gather evidence for effective policy. Obtain evidence by visiting and evaluating local services, and by reviewing national and international literature.

Step 3: Consult and negotiate. Listen to various stakeholders and make proposals that blend their different views with evidence derived from national and international experiences.

Step 4: Exchange with other countries. Share experiences with other countries to learn about the latest advances and any creative experiences for effective mental health interventions that should be incorporated into policy.

Step 5: Define the vision, values, principles, and objectives. Establish the substance of the policy through describing the vision, values, principles, and objectives for mental health.

- The vision usually sets high but realistic expectations for mental health, describing what is desirable for a country or region.
- Values and principles represent ethical standards and core rules driving the policy.
- Objectives should aim to improve the health of the population, respond to people's expectations, and provide financial protection against the cost of ill health.

Step 6: Determine areas for action. Transform the objectives of the mental health policy into specific areas for action. Consider the simultaneous development of several areas such as:

- legislation and human rights;
- financing;
- organization of services, planning, and budgeting;
- drug procurement and distribution;
- human resources and training;
- information systems;
- quality improvement;
- advocacy;
- evaluation of policy and plans;
- special interests (e.g. child and adolescent mental health issues).

Step 7: Identify the major roles and responsibilities of different sectors. Decide on the specific roles and responsibilities for:

- governmental agencies (health, education, employment, social welfare, housing, justice);
- academic institutions;
- professional associations;
- general health and mental health workers;

• consumer and family groups; • nongovernmental organizations.

Table 3. Developing a mental health policy. WHO, 2005.

At the initial stage it is crucial for mental health service providers and policy makers to understand how the totality of an individual's needs is met - by institutional services in order to develop innovative services focused on actual needs than using the existing services as the basis of planning.

To carry out reforms that increase financial affordability to services, service efficiency and quality it is necessary to develop of adequate funding models that, within limited budget resources, will guarantee introduction of effective systems for planning, financing and supervision of budgets.

Thus, it is desirable to carry out a study that would propose how to go about conducting a needs assessment. This would then be discussed with relevant stakeholders as to how it could be used for (at least) in-patient mental health service development. The given component aims to fill in the gap and study MH needs for informing MH strategy elaboration process:

- provides a structure to bring together quantitative and qualitative information on the needs of people with mental health problems, and
- organizes it into manageable and useful categories for further planning of services

To achieve these objectives the information on needs has to be collected and organized in a way that helps to identify a range of service responses. The major categories of mental health needs will give an overall picture of what needs have to be met and enable health managers and service providers to plan for a comprehensive service response.

A strategic plan includes the concrete strategies and activities that will be implemented to tackle mental disorders and associated disability, as well as specifying the targets to be achieved by the government. It is an instrument to inform annual state budget processes. A strategy can be used to advocate and mobilize adequate resources (financial and technical) for the MH field development. “When properly formulated and implemented it can have a significant impact on the mental health of the population concerned. The outcomes described in the literature

include improvements in the organization and quality of service delivery, accessibility, community care, the engagement of people with mental disorders and their carers, and in several indicators of mental health"(WHO 2004). If no overall national plan exists there is a risk of fragmentation or duplication of plans developed. We are convinced that it is essential to work out the comprehensive strategy for the field development: the research-based, inclusive document that will guide the reform process inevitable to improved mental health care and decreased burden on vulnerable people and general society (see Figure 6 below).

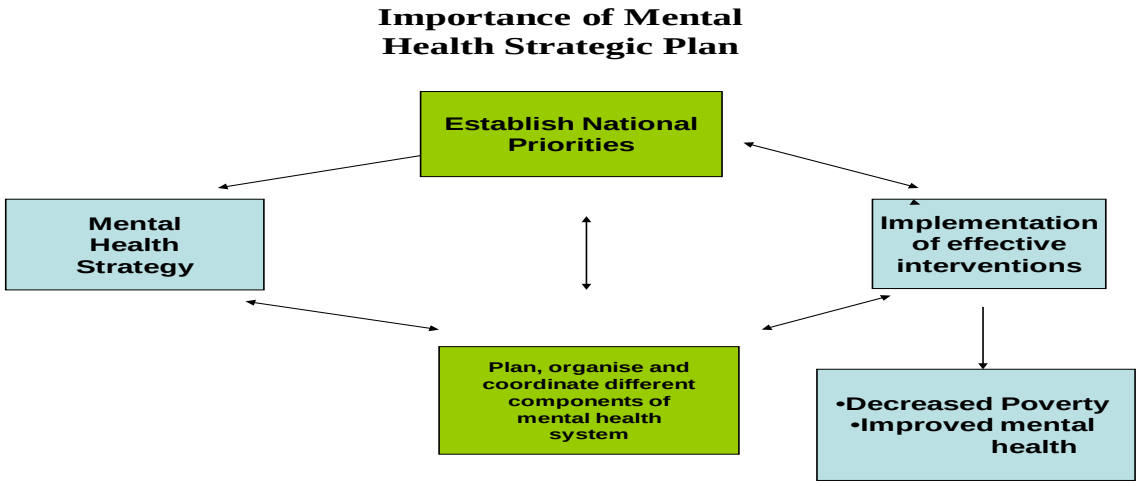


Figure 6. Importance of MH strategic plan (WHO, 2004)

Development of the National Mental Health Strategy should be based on following basic principles:

- Achieving synergies: close collaboration of different stakeholders, including users, carers, ministries of health and social care, parliament of the country, etc.
- Ensuring local ownership: through meaningful participation of stakeholders in the entire process of the strategy development
- Promoting transparency and accountability

Therefore, to address the actual needs of PMD, the gathering of evidence-based data is pivotal. Also, to foster modern practices, programs focusing on capacity building and professional development should be further strengthened and institutionalized.

The starting point of this process is a notion that mental heath services should be user-oriented, community-based and focused on (re-) integration of PMD and maintaining their social

environment to the maximum possible. In chapter III the model of optimal mix of services has been discussed and an overview of necessary services is provided.

The *basic principles* that should inspire the establishment of effective community services are the general ones applicable to healthcare (Levesque, Harris and and Russel 2013).

Accessibility: newly established services should be accessible to all people in need for care. In order to make this principle "real" it is necessary to establish catchment areas matching with the services;

Comprehensiveness: service should be able to respond to whole range of mental disorders offering the whole range of cost effective interventions;

Continuity: care wherever is provided across the system should be coherently coordinated by only one sector of the system, preferably the community mental health service.

During the last decade the guiding document for European countries was a Mental Health Declaration for Europe (WHO 2005). The Declaration does acknowledge that mental health and mental well being are fundamental to the quality of life and productivity of individuals, families, communities and nations, enabling people to experience life as meaningful and to be creative and active citizens.

States stated that they "believe that the primary aim of mental health activity is to enhance people's well-being and functioning by focusing on their strengths and resources, reinforcing resilience and enhancing protective external factors".

The Declaration recognized that the promotion of mental health and the prevention, treatment, care and rehabilitation of mental health problems are a priority for WHO and it's Member States, the European Union (EU) and the Council of Europe.

The document identified the main priorities for the next decade:

i. Foster awareness of the importance of mental well being;

ii. Collectively tackle stigma, discrimination and inequality, and empower and support people with mental health problems and their families to be actively engaged in this process;

iii. Design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery

iv. Address the need for a competent workforce, effective in all these areas;

v. Recognize the experience and knowledge of service users and carers as an important basis for planning and developing mental health services.

Georgia, as a signatory party of the Declaration, employed the document to guide a reform process in the country (Makhashvili 2011). There was some advancement mentioned above and also in our recent article (Makhashvili and van Voren, 2013).

New and important development for field is development of the WHO action plan (AP). WHO's comprehensive mental health action plan 2013-2020has been adopted by the 66th World Health Assembly (WHO 2013).The action plan is the outcome of extensive global and regional consultations over the last year with a broad array of stakeholders including: 135 Member States; 60 WHO CCs and other academic centres; 76 NGOs and 17 other stakeholders and experts (WHO 2013).

The four major objectives of the action plan are to:

- Strengthen effective leadership and governance for mental health.
- Provide comprehensive, integrated and responsive mental health and social care services in community-based settings.
- Implement strategies for promotion and prevention in mental health.
- Strengthen information systems, evidence and research for mental health.

The plan sets important new directions for mental health including a central role for provision of community-based care and a greater emphasis on human rights. It introduces the notion of recovery, moving away from a pure medical model, and addresses income generation and education opportunities, housing and social services and other social determinants of mental health in order to ensure a comprehensive response to mental health.

The action plan also emphasizes the empowerment of people with mental disabilities, the need to develop a strong civil society and the importance of promotion and prevention activities including for preventing suicides. The document outlines specific actions for Member States, international, regional and national level partners, and the Secretariat and includes several indicators and targets, such as a 20% increase in service coverage for severe mental disorders and a 10% reduction of the suicide rate in countries by the year 2020, that can be used to evaluate levels of implementation, progress and impact.

In a parallel process, WHO-Europe declared a challenge «The promotion of mental health and the prevention and treatment of mental disorders are 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» and drafted the European Mental Health Action Plan (WHO 2013).

The four core objectives of the European AP are:

(a) everyone has an equal opportunity to realize mental well being throughout their lifespan, particularly those who are most vulnerable or at risk;

(b) people with mental health problems are citizens whose human rights are fully valued, protected and promoted;

(c) mental health services are accessible and affordable, available in the community according to need; and

(d) people are entitled to respectful, safe and effective treatment.

The AP also set up the three more crosscutting objectives:

(e) health systems provide good physical and mental health care for all;

(f) mental health systems work in well-coordinated partnerships with other sectors; and

(g) mental health governance and delivery are driven by good information and knowledge.

Each objective is supplied with outcomes and proposed action activities and a whole document serves as a reference for European countries.

Georgian experts have been guided by these texts while drafting a policy document and national action plan of mental health care.

II. Trauma and Mental Health

Psychological trauma

Experiencing trauma is an essential part of being human; although art and literature have always been preoccupied with how people cope with inevitable tragedies of life, the large scale scientific study of the effects of trauma on body and mind has had to wait till the late XX century (Van der Kolk and McFarlane 1996, 3-9).

Trauma is "the disruption or breakdown that occurs when the psychic apparatus is suddenly presented with stimuli, either within or from without, that are too powerful to be dealt with or assimilated in the usual way" – this is a description of trauma by the American Psychoanalytical Association (Moore &. Fine 1990, 199-200). This involved "a state of helplessness results, ranging from total apathy and withdrawal to an emotional storm accompanied by disorganized behavior-bordering panic. Signs of autonomic dysfunction are frequently present".

The concept of trauma played an integral part in Freud's early theory of neurosis (Freud 1967, 235-245) Although he first thought of affective reactions (such as fright, anxiety, shame, or physical pain) as determining a trauma, later studies delineated factors that constitute the preconditions for trauma or determine its outcome (Rappaport 1968, 719-731; Krystal 1978, 81-116). Freud developed two separate models of "trauma" – one was the "unbearable situation" model and the other was the "unacceptable impulse" model, in which symptoms may be produced through the mobilization of defence mechanisms. Another important name in trauma history is Pierre Janet at the Salpetriere in Paris. In his doctoral thesis, in 1889, Janet has documented the relationships between trauma and psychological automatisms (van der Kolk, Weisaeth & van der Hart 1996, 47-70). He studied the nature of dissociation and traumatic memories and coined the word "subconscious" to describe the collection of memories that form the mental schemes that guide a person's interaction with the environment; Janet proposed that when people experience "vehement emotions", their minds may become incapable of matching their frightening experiences with existing cognitive schemes. As a result, the memories of the experience cannot be integrated into personal awareness.

Though recognized for centuries under various names, traumatic neurosis has received most attention in connection with psychological casualties of war. In 1941 Abram Kardiner, who was treating traumatized U.S. war veterans from WWI, published the important study *The traumatic neurosis of war* (Kardiner 1941), where like the previous great pioneers of psychological trauma, he carefully detailed descriptions of complex and unusual symptoms of his patients and defined PTSD (Post Traumatic Stress Disorder) for the remainder of the 20th century.

It should be noted that after decades all the other syndromes, i.e. Vietnam veterans syndrome, etc. were finally subsumed under the new diagnosis, proposed by American Psychiatric

Association (APA) in 1980's edition of DSM-III (American Psychiatric Association 1980), and that was resembling Kardiner's PTSD. After the introduction of the new diagnosis the massive body of research in trauma field was carried out that resulted in new data and evidence of psychotraumatology and defined new diagnosis of PTSD in ICD-10 (WHO 1994), and also in DSM IV-TR (APA 2000), and DSM-5 (APA 2013).

Traumatic experiences range from collective events like mass violence, war, terrorism and natural disasters to personal, even "everyday life" traumas such as road traffic accidents and the loss of a loved one. People around the world are affected by such experiences and the aftermath of trauma is an international matter (Krupuick & Horowitz 1981,428-435).

Conflict-exposed groups and trauma

It is well recognised that populations affected by armed conflict are frequently exposed to traumatic events and daily stressors and at risk of elevated levels of mental health disorders (Miller and Rasmussen 2010, 7-16; Steel et al 2009, 537-549).

The impact of conflict may be exacerbated or mediated by displacement. Over the last 80 years there has been an exponential increase in the number of refugees and internally displaced persons worldwide. For example, in 1930 there were 2.5 million refugees receiving international protection through the League of Nations; by the late 2000s there were 15.2 million refugees worldwide, as well as a reported 27.1 million people who were internally displaced within their country of origin due to violence or conflict, and a further 25 million who were internally displaced due to natural disasters (IDMC & NRC 2009). Almost 25 million people (10.5 million refugees and 14.4 million internally displaced persons) were receiving protection by the United Nations, and most refugees came from over forty low- or middle-income countries (UNHCR 2009).

There is a substantial body of evidence on the prevalence of common mental health disorders among such populations, particularly post-traumatic stress disorder (PTSD), depression and anxiety (Porter and Haslam 2005, 602-12; Steel et al. 2009, 537-49; de Jong,. Komproe, and Van Ommeren 2003, 2128-30). Studies suggest that levels of posttraumatic stress disorder (PTSD) recede over time (Steel et al. 2009), but the evidence remains sparse – particularly for refugees and internally displaced persons who have returned to their home areas.

Common MH Disorders

Common mental health disorders, such as depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and social anxiety disorder, may affect up to 15% of the population at any one time. Depression and anxiety disorders can have a lifelong course of relapse and remission. There is considerable variation in the severity of common mental health disorders, but all can be associated with significant long-term disability. For example, depression is estimated to be the second greatest contributor to disability-adjusted life years throughout the developed world. It is also associated with high levels of morbidity and mortality, and is the most common disorder contributing to suicide (NICE 2011).

The prevalence of individual common mental health disorders varies considerably. The 1-week prevalence rates from the Office of National Statistics 2007 national survey (McManus et al. 2007) were 4.4% for generalised anxiety disorder, 3.0% for PTSD, 2.3% for depression, 1.4% for phobias, 1.1% for OCD, and 1.1% for panic disorder. Estimates of the proportion of people who are likely to experience specific disorders during their lifetime are from 4% to 10% for major depression, 2.5% to 5% for dysthymia, 5.7% for generalised anxiety disorder, 1.4% for panic disorder, 12.5% for specific phobias, 12.1% for social anxiety disorder, 1.6% for OCD and 6.8% for PTSD. More than half of people aged 16 to 64 years who meet the diagnostic criteria for at least one common mental health disorder experience comorbid anxiety and depressive disorders.

The vast majority (up to 90%) of depressive and anxiety disorders that are diagnosed are treated in primary care. However, many individuals do not seek treatment, and both anxiety and depression often go undiagnosed. Although under-recognition is generally more common in mild rather than severe cases, mild disorders are still a source of concern. Recognition of anxiety disorders by General Practitioners (GPs) is particularly poor, and only a small minority of people who experience anxiety disorders ever receive treatment. In part this may stem from GPs' difficulties in recognising the disorder, but it may also be caused by patients' worries about stigma, and avoidance on the part of individual patients.

For the purpose of our study we will briefly describe the most prevalent common MH disorders – PTSD, depression and generalized anxiety disorder.

Post-traumatic stress disorder (PTSD) develops following a stressful event or situation of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. PTSD does not therefore develop following those upsetting situations that are described as 'traumatic' in everyday language, for example, divorce, loss of job, or failing an exam. PTSD is a disorder that can affect people of all ages. Around 25–30% of people experiencing a traumatic event may go on to develop PTSD (NICE 2005).

Depression is a broad and heterogeneous diagnosis. Central to it is depressed mood and/or loss of pleasure in most activities. A chronic physical health problem can both cause and exacerbate depression: pain, functional impairment and disability associated with chronic physical health problems can greatly increase the risk of depression in people with physical illness, and depression can also exacerbate the pain and distress associated with physical illnesses and adversely affect outcomes, including shortening life expectancy. Furthermore, depression can be a risk factor in the development of a range of physical illnesses, such as cardiovascular disease. When a person has both depression and a chronic physical health problem, functional impairment is likely to be greater than if a person has depression or the physical health problem alone (NICE (2009).

Depression is approximately two to three times more common in patients with a chronic physical health problem than in people who have good physical health and occurs in about 20% of people with a chronic physical health problem.

Both the number and severity of symptoms, as well as the degree of functional impairment determine severity of depression. A formal diagnosis using the ICD-10 classification system requires at least four out of ten depressive symptoms, whereas the DSM-IV system requires at least five out of nine for a diagnosis of major depression (referred to in this guideline as 'depression'). Symptoms should be present for at least 2 weeks and each symptom should be present at sufficient severity for most of every day. Both diagnostic systems require at least one (DSM-IV) or two (ICD-10) key symptoms (low mood, loss of interest and pleasure or loss of energy) to be present.

Increasingly, it is recognised that depressive symptoms below the DSM-IV and ICD-10 threshold criteria can be distressing and disabling if persistent. Therefore this guideline covers 'sub threshold depressive symptoms', which fall below the criteria for a diagnosis of major

depression, and are defined as at least one key symptom of depression but with insufficient other symptoms and/or functional impairment to meet the criteria for full diagnosis. Symptoms are considered persistent if they continue despite active monitoring and/or low-intensity intervention, or have been present for a considerable time, typically several months. (For a diagnosis of dysthymia, symptoms should be present for at least 2 years.).

Anxiety disorders are the most common of emotional disorders and affect more than 25 million Americans (APA 2014). Anxiety disorders differ from normal feelings of nervousness. Untreated anxiety disorders can push people into avoiding situations that trigger or worsen their symptoms. People with anxiety disorders are likely to suffer from depression, and they also may abuse alcohol and other drugs in an effort to gain relief from their symptoms. Job performance, schoolwork, and personal relationships can also suffer.

Generalised anxiety disorder (GAD) is one of a range of anxiety disorders. Anxiety disorders can exist in isolation but more commonly occur with other anxiety and depressive disorders. GAD is a common disorder, of which the central feature is excessive worry about a number of different events associated with heightened tension. A formal diagnosis using the DSM-IV classification system requires two major symptoms (excessive anxiety and worry about a number of events and activities, and difficulty controlling the worry) and three or more additional symptoms from a list of six (APA 1994). Symptoms should be present for at least 6 months and should cause clinically significant distress or impairment in social, occupational or other important areas of functioning. GAD varies in severity and complexity and this has implications for response to treatment (NICE 2011).

Trauma as a global policy issue

In his editorial U. Schnyder (Schnyder 2013) stated that a) trauma is a global issue; b) trauma is more than just ‘‘psychological trauma’’ and best be understood using an interdisciplinary, multi-professional, biopsychosocial approach; c) trauma work should be integrated in the mainstream of psychology and medicine, including psychiatry and public health, as well as in neuroscience, sociology, anthropology, law, and many other fields; and d) the traumatic stress research community needs to ensure that all trauma related research and mental health needs are met regardless of nationality. The rationale is that effective health care practice and feasible policies rely on evidence derived from research (Patel 2000, 363-377).

In particular, research is needed to develop culturally sensitive, effective and feasible assessment measures and interventions. To achieve adequate mental health care systems around the world, research into traumatic mental health should be just as global as the impact of the phenomenon.

Nevertheless, there is evidence that trauma research has not been evenly occurring in different areas of the world (Bedard, Greif & Buckley 2004; Olff & Vermetten 2013; Patel 2001, 247-262). Often, economically weak regions are not reached by the beneficial effects of such research, leading to mental health inequalities worldwide (Saxena, et al. 2011, 123-125).

On the other hand, the risk of experiencing a potentially traumatic event and developing mental health disorders has been reported to be higher in countries with a low economic status (Demyttenaere et al. 2004, 2581-2590) due to the risk factors associated with poverty, social exclusion (Patel, 2001; Patel & Kleinman 2003, 609-615) and experiences of loss, trauma and displacement associated with war experiences (De Jong et al 2001, 555-562; Fazel Wheeler & Danesh 2005, 1309-1314; Steel et al. 2009, 537-549). Today, 83% of the world's population live in low- and middle-income countries (LMIC), with the fastest growth of population occurring in the countries with the lowest incomes (UN 2013). Between 1996 and 1998, 90% of the global population was covered by only 6% of all peer-reviewed psychiatry articles (Patel & Sumathipala 2001, 406-409).

Research findings in LMICs regarding common mental health disorders among traumatized populations are very limited furthermore (Kinga et al. 2014).

There is similarly inadequate evidence on co-morbidity between mental disorders among conflict-affected populations in low and middle income countries, despite evidence from other settings showing high levels of co-morbidity between PTSD, depression and anxiety (Ayazi et al. 2012; O'Donnell, Creamer & Pattison 2004, 1390-1396). Moreover there is a need for more evidence on the impact of the mental disorders on broader emotional, social and economic functioning of persons affected by armed conflict (Blanchet & Roberts 2013).

There is some relevant evidence, especially that which addresses needs assessment (de Jong and Komproe 2002, 1793-1794; Allden et al. 2009), building resiliency (Ghosh, Mohit and Murthy 2004, 268-270.), using treatment guidelines (Eisenman et al. 2006), supporting staff (Collins and Long 2003, 417-424.), or developing rehabilitation services (Medeiros 2007). Yet the bigger

picture is that while the mental health needs of people in post-conflict situations have been reasonably well characterized, evidence on the health service system and programme implications is relatively weak (Roberts and Browne 2001, 814-829; J. Grubaugh et al. 2011, 883-899; Silove2004, 90-96).

Georgian data

There have been a limited number of studies on the mental health impact of war on the Georgian population. Most of these were published prior to the 2008 conflict. For instance, Buck et al. (2000) describes the impact of the civil wars of the 1990s on women (Buck, et al. 2000, 1-13). They note high level of PTSD and depression, elevated rates of non-communicable and communicable diseases, and a rapid decline in the living standard. Women were particularly traumatized by the loss of partners and family members, as well as homes and property. Post-conflict related stressors included arduous living conditions and economic difficulties (Pol 1999, 149-366).

Buck et al. (2000) also draw attention to the impact of the conflict on gender roles in Georgian society. Before the wars in the 1990s, men were heads of the family, responsible for making critical decisions regarding livelihood. Women were responsible for the household, including the maintenance of family order, health, and welfare, and minding children. Similarly, Pol (1999) notes that traditional gender roles were preserved in Abkhazia, despite communist ideology. Prior to displacement, most men were employed or working on the land, while women were housewives, teachers, or employed in trading.

Buck et al. (2000) state, "women have been much more successful [than men] at adapting to the difficult conditions and strains of everyday life in the IDP community" (Buck et al. 2000, 6). They observed how displaced women worked to provide desperately needed income for their families through trading activity and other menial labour. In contrast, men have largely been unwilling to engage in menial labour in order to generate income, and instead are idle for large periods.

Though Pol (1999) and Buck et al. (2000) were published prior to the 2008 conflict, their findings provide evidence that conflicts in Georgia affected displaced men and women in different ways, and may have altered how families function.

The organizations Global Initiative on Psychiatry – Tbilisi (GIP – Tbilisi) and Georgian Society of Psycho-trauma (GSP) studied 290 people (84% women and 16 % – men) among Tbilisi Collective Centres and also in buffer. The research outcomes revealed high index of post-traumatic symptoms – 67,85%; reduced interests – 48,8%; decreased mood – 51,2%; behavioral disturbances – 24,5% (GIP-Tbilisi & GSP 2009).

A survey in 2009 by the Global Initiative on Psychiatry-Tbilisi (GIP-T), found increased rates of post-traumatic symptoms, depression, and addictive behaviours among New IDPs (displaced due to 2008 war), and identified that symptomatic recovery had been disrupted by on-going threats to personal security (GIP-Tbilisi 2009). Qualitative assessments have been conducted among IDPs, noting increased feelings of aggression, fear, anxiety, isolation, loss of hope and dignity, and use of alcohol, and lack of individual and community resources.

There is no evidence on how different are mental health problems among men and women IDPs - our survey explores the gender differences as well.

A large study conducted by WHO (Tbilisi office) and NGO Children of Georgia in 2009 with new IDPs found out that "physical ailments have been increased since the conflict. The main ones are: increased blood pressure problems, sleep problems, headaches and loss of energy. Many could be consequences of trauma and could signal associated psychological distress. Health professionals need to be able to differentially diagnose these in order to provide appropriate care" (WHO 2009).

The authors identified psychosocial or mental health problems, as "mood (e.g. anger, depression) and sleep problems; worry, fear and anxiety; somatic problems; and concentration and derealisation problems. A number of their problems suggest stress reactions and/or PTSD symptoms. Alcohol and, to a much lesser extent, narcotics are being used". The members of communities also remarked "these problems have overflowed into their communities and have the potential to further erode family and community life". The study finds that distance and transport costs impact on access to medicines and other hospital- or polyclinic-based healthcare services for displaced groups.

Georgian Mental Health Coalition carried out study on appropriate responses after the war (Georgian Mental Health Coalition 2009); the drawbacks have been revealed during rendering

the primary psychosocial aid by local and international organizations in the first month after the war, still persist in the following period.

The research indicated at expansive magnitude of the consequences of forced displacement both in IDPs and returnees to the buffer zone villages and illuminated the need of a comprehensive and systemic approach in supporting their psychosocial wellbeing.

The authors regret that "after several months from the crisis there are rigorous deficiencies in the system of psychosocial care of IDPs and returnees in Georgia; the poor psychosocial support system is characterized by lack of available, accessible, affordable and high quality chain of psychosocial aid services". The immediate problems that should have been addressed were as following: Lack of adequate funding that is resulted in fragmented, non-sustainable initiatives; lack of IDPs psychosocial care component in the state budget; lack of well-coordinated, multi-sectorial support strategy.

There is surprisingly little information on the mental health of conflict-affected big groups and its determinants. While qualitative assessments have been conducted, only a single epidemiological study appears to have been conducted and this was limited to elderly (≥60 years) internally displaced persons and did not examine levels co-morbidity or adjusted risk-factors (JHBSPH/IPS 2012).

Still, mental health policies and programs do not reflect the needs of displaced persons and there is no evidence informing the strategy to address the healthcare of such big groups (Makhashvili and van Voren 2013).

III. Addressing treatment gap

As stated above, mental health is a growing public health concern. Most people in the world who have mental illnesses receive no effective treatment (Thornicroft 2007, 807-808; Wang et al. 2007; Patel et al 2010; .; Kessler et al. 2009). For example, of all adults affected by mental illnesses, the proportion who are treated ranges from 30.5% in the USA (Kessler et al. 2005, 2515-23), and 27% across Europe (Wittchen and Jacobi, 2005; Alonso et al. 2007) to less than 1% in Nigeria (Kohn et al. 2004, 858-66.). This phenomenon, described by the WHO as the 'treatment gap' (Dua et al. 2011). is increasingly appreciated worldwide, and is seen as the difference between the true prevalence rate and the proportion who receive any kind of

treatment. (Prince et al. 2007; Patel et al. 2007, 991-1005; Saxena 2007, 878-89; Chisholm et al. 2007, 1241-52).

In relation to met and unmet meet at the population level, international studies such as the World Mental Health Surveys suggest that at least 20% of the populations of many countries have a diagnosable mental health disorders in any year (Wang et al. 2007, 841-50). Therefore approximately about 20,000 in every 100,000 will have such a disorder this year. If about 2,000 are currently treated in Georgia (WHO 2011), then the proportion of people who have a mental disorder who receive treatment ("coverage") is bout 10%, and therefore about 90% of these people are not treated (thus "treatment gap" reaches 90%).

Although effective treatments exist for most mental health conditions (WHO 2010), the treatment gap is remarkably evident in low, middle and high income countries (Alonso et al. 200,858-866). Studies confirm that prevalence of common mental disorders is particularly high among war-affected populations and war traumatisation can have long-term effect on their mental and physical health (Steel et al. 2009, 537-549; Porter and Haslam 2005, 602-12.; Sabas-Figuera et al. 2012).

Understanding of health service utilization patterns is important for better planning of services and adjusting them for populations needs. Health service utilization among persons exposed to armed conflict has been studied in various settings, however most of the research has been conducted in asylum countries or among military veterans,while relatively small number of studies investigated health service utilization in post-war countries (Chikovani et al. 2015).

In 2008 the World Health Organisation launched the *mental health Gap Action Programme (mhGAP)* "Scaling up care for mental, neurological, and substance use disorders" to address the lack of care for people suffering from mental, neurological, and substance (MNS) use disorders. The WHO Mental Health Gap Action Programme (mhGAP) aims at scaling up services for mental, neurological and substance use disorders for countries especially with low- and middle-income. The programme asserts that with proper care, psychosocial assistance and medication, tens of millions could be treated for depression, schizophrenia, and epilepsy, prevented from suicide and begin to lead normal lives– even where resources are scarce.

The mhGAP Mental Health Gap Action Programme has supported by the mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings

(WHO, 2010). The Guide was developed through a process of systematic evidence review and broad international consultation. The mhGAP-IG provides simple algorithms and clinical protocols for decision making that can be non-specialist health care providers for assessment and management of people presenting to health facilities with mental, neurological and substance use disorders. The mhGAP Training Package to train non-specialist health care providers based on mhGAP-IG was also produced. The mhGAP Intervention Guide (IG) is a clinical guide on mental, neurological and substance use disorders for general health care workers who work in non-specialized health care settings, particularly in low- and middle-income countries. These health care workers include general physicians, family physicians, nurses and clinical officers. The mhGAP programme provides a range of tools to support the work of health care providers as well as health policy makers and planners.

WHO & UNHCR have published an assessment toolkit on mental health in humanitarian settings, which includes assessment tools for non-specialized health care settings that are relevant to mhGAP implementation (WHO, 2013) This new mhGAP module on Conditions Specifically Related to Stress by WHO and UNHCR contains assessment and management advice related to acute stress, post-traumatic stress and grief in non-specialized health settings.

The same year WHO produced a new document Guidelines for the management of conditions specifically related to stress (WHO 2013). This guide is an adaptation of the mhGAP Intervention Guide to be used in humanitarian settings. These settings include a broad range of acute and chronic emergency situations, arising from armed conflicts, natural disasters, and industrial disasters and may include mass displacement of populations (e.g. refugees and/or internally displaced people).

WHO understanding is that “Humanitarian settings differ from normal settings in a number of different ways. First, the population`s need for care overwhelms the local system. Second, resources vary depending on the extent and availability of humanitarian assistance”. Humanitarian crises pose a set of challenges as well as opportunities for provision of health services.

The document lists some typical challenges of humanitarian settings as:

- heightened need to prioritize and allocate scarce resources
- limited time to train health care providers,

- limited access to specialists.
- difficulties accessing pharmacological treatments because of disruption to normal supply

This Guidelines was developed to provide recommended management strategies for problems and disorders that are specifically related to the occurrence of a major stressful event. The recommended strategies will form the basis of a new module to be added to the mhGAP Intervention Guide for use in non-specialized specialized health-care settings.

The scope of the problems covered by these guidelines is:

- symptoms of acute stress in the first month after a potentially traumatic event, with the following subtypes:
- symptoms of acute traumatic stress (intrusion, avoidance and hyperarousal) in the first month after a potentially traumatic event;
- symptoms of dissociative (conversion) disorders in the first month after a potentially traumatic event;
- non-organic (secondary) enuresis in the first month after a potentially traumatic event (in children);
- hyperventilation in the first month after a potentially traumatic event;
- insomnia in the first month after a potentially traumatic event;
- posttraumatic stress disorder (PTSD);
- bereavement in the absence of a mental disorder.

The Guidelines summarises relevant evidence and expertise from around the world. It has used the GRADE system for assessing quality of evidence and using evidence to inform decisions was applied to inform drafting of recommendations. For each question, an evidence profile was developed summarizing the evidence retrieved, including discussion of values, preferences, benefits, harms and feasibility. Wherever possible, the evidence retrieved was graded and GRADE tables provided.

The primary audience of the Guidelines is 'non-specialized specialized health-care providers working at first- and second-level health-care facilities. They include general physicians, family physicians, nurses and clinical officers. They also include those specialist medical doctors who work in areas other than mental health and substance abuse, such as paediatricians, emergency

medicine physicians, obstetricians, gynaecologists and internists. A secondary audience is those tasked with the organization of health care at the district or sub-district level, including programme managers responsible for primary or non-mental health secondary care services'.

The guidelines have separate recommendations for children, adolescents and adults. For the purpose of these guidelines, adolescents are 10–19 years old while children are younger than 10 years old.

All recommendations (differentiated by strength of evidence and marked as "Strong" or "Standard") come with remarks. For example, the remarks note that even in instances where there is no recommendation for treatment, all individuals presenting with a potential mental health problem should be fully assessed to exclude physical causes of the problem. Similarly, the remarks refer to previous WHO mhGAP Guidelines recommendations, such as the recommendation to make available psychological first aid to people who have recently been exposed to a potentially traumatic event. Also, the remarks emphasize applying mhGAP general principles of care, such as good communication and mobilizing social support.

Overall, these remarks help communicate that people who suffer mental health problems should not be ignored and that certain practical steps can be taken, even in cases when there are no (new) recommendations for the management of problems and disorders specifically related to stress.

It should be stated that before this publication there were efforts to address needs of big groups that are traumatised by emergencies and crisis.

One of the most important documents is IASC Guidelines. IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings has produced Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC, 2007); it gives an overview of essential knowledge that humanitarian health actors should have about mental health and psychosocial support (MHPSS) in humanitarian emergencies.

The Guidelines state "Armed conflicts and natural disasters cause significant psychological and social suffering to affected populations. The psychological and social impacts of emergencies may be acute in the short term, but they can also undermine the long-term mental health and psychosocial well being of the affected population. These impacts may threaten peace, human

rights and development. One of the priorities in emergencies is thus to protect and improve people's mental health and psychosocial well-being."

The IASC Guidelines offers a very practical and useful model of differentiated Multi-Layered Supports - a "pyramid model" (see figure 7 below)

Differentiated Multi-Layered Supports

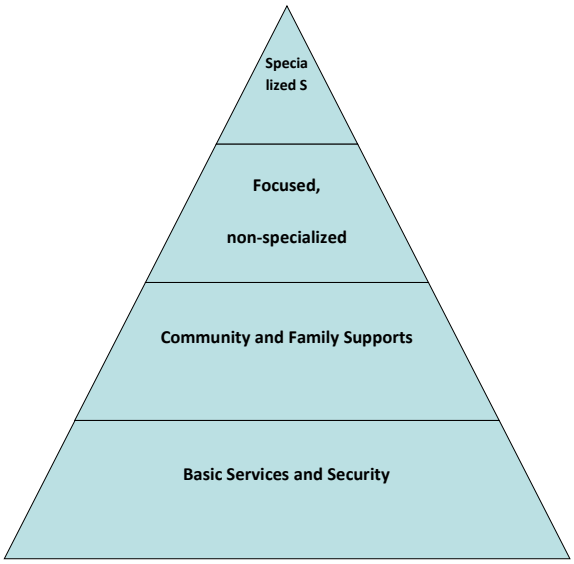


Figure 7. Multi-Layered Supports

These levels propose 4 distinct approaches and services depending on conditions of the affected populations.

I. Basic Services and Security – advocating that services that address basic needs are put in place with responsible actors; documenting their impact on MH and p/s well-being; influencing humanitarian actors to deliver them in a way that promotes MH and p/s well-being. These basic services should be established in participatory, safe and socially appropriate ways that protect people dignity, strengthen local social supports and mobilize community networks.

II. Community and family supports – the second layer represents the emergency response for a smaller number of people who are able to maintain their MH and psychosocial well-being if they receive help in accessing key community and family supports. Useful responses include: family tracing and reunification, assisted mourning and communal ceremonies, mass

communication on constructive coping methods, supportive parenting programs, formal and non-formal educational activities, livelihood activities and activation of social networks, such as through women's groups and youth clubs.

III. Focused, non-specialized supports – supports necessary for the still smaller number of people who additionally require more focused individual, family or group interventions by trained and supervised workers. Includes psychological interventions and basic MH care.

IV. Specialized services – the top layer of the pyramid represents the additional support required for the small percentage of the population whose suffering, despite the supports already mentioned, is intolerable and who may have significant difficulties in basic daily functioning. This assistance includes psychological and specialized MH services; such problems require a) referral to MH care services and b) initiation of longer-term training and supervision of primary/general health care provides.

Although these services are needed only for a small percentage of the population, in most large emergencies this group amounts to thousands of individuals.

Trauma-informed care

To be trauma-informed is to understand the involvement and impact of violence and victimization in the lives of most consumers of mental health, substance abuse, and other services. It is also to apply that understanding in providing services and designing service systems to accommodate the requirements and vulnerabilities of trauma survivors and to facilitate their participation in treatment (Butler et al, 2011).

This shift in perspective and practice implies a significant adaptation in how mental health patients are understood and cared for by helping professionals, as well as in the conduct of support staff and administration. A trauma-informed approach to care (Harris and Fallot 2001, 3-22; Jennings 2008) perceives trauma not simply as a past event but as a formative one that may be contributing to the client's current state or circumstances. To be trauma-informed is to understand clients and their symptoms in the context of their life experiences and cultures, with an appreciation that some symptoms may represent efforts at coping.

Butler and her colleagues state that «"Trauma-informed" services and "trauma-specific" services are not the same. Trauma-informed services are informed about, and sensitive to, the potential for trauma-related issues to be present in patients, regardless of whether the issues are directly or obviously related to the presenting complaint or condition. Moreover, trauma-informed services are not designed to treat the sequelae of physical and sexual abuse or other traumatic experience. Trauma-specific services, in contrast, are designed expressly to treat the symptoms and syndromes related to current or past trauma» (Edwards et al. 2003).

The impetus for the development of a trauma-informed care perspective in mental health and social service delivery came in part from growing recognition over the past two decades of the wide prevalence of early traumatic events and their associations with later psychological and physical difficulties and disorders (Green et al. 2010; Molnar, Buka and Kessler 2001).

In mental health settings, reports indicate exceedingly high rates of trauma histories among psychiatric patients. In one study examining psychiatric outpatient charts, (Posner et al. 2008) 50% were positive for a history of trauma (e.g., physical and sexual abuse and catastrophic events that threatened physical integrity were assessed). Among poor inner-city youth using an urban outpatient mental health clinic, 94% had experienced at least one lifetime trauma (most commonly physical attack, rape, or being threatened with a weapon), and 42% met criteria in the previous year for posttraumatic stress disorder (PTSD) (Switzer et al. 1999).

Rates are also high in adult inpatients. In one study, 81% of the participants had experienced physical or sexual abuse, and two thirds of that group had experienced the abuse in childhood (Jacobson and Richardson 1987).

Momentum for the trauma-informed care movement was also boosted by the leadership of the Substance and Mental Health Services Administration (SAMHSA), which, among other efforts, implemented a large-scale research program—the Women, Co-occurring Disorders and Violence Study (1998-2003) (Huntington, Moses and Veysey 2005)—and supported the founding of the National Center for Trauma- Informed Care (www.samhsa.gov) and the National Child Traumatic Stress Network.

Around the same time, publication of Harris and Fallot's Using Trauma Theory to Design Service Systems clarified (Harris and Fallot 2001) the conceptualization of trauma-informed

care and provided the needed vocabulary, rationale, and plan for implementing this type of care.

This convergence of factors—accumulating trauma prevalence data, institutional leadership and innovation, elucidation of conceptual frameworks, and consumer demand and support—catalysed into an appreciation of the need for a fundamental change in mental health delivery. In short, that it become trauma-informed.

Becoming trauma-informed has implications for the practitioner and the setting or system in which care is provided. At a systems level, to become a trauma-informed organization or department necessitates multilevel changes across many domains. (Harris and Fallot 2001). All aspects of services and programs need to be organized with an awareness of the pervasiveness of trauma, its impact, and its self-perpetuating nature, as well as familiarity concerning the multiple and complex paths to healing and recovery.

Much of the trauma-informed literature was spawned by, and reflects the concerns of, adult survivors of childhood maltreatment. However, certain populations—such as children, the elderly, religious and ethnic minorities, the lesbian, gay, bisexual, and transgender (LGBT) community, veterans, the disabled, and immigrants and refugees—have elements to their histories that suggest distinct vulnerabilities and needs specific to their experience as a member of that group (Butler, 2011). Although trauma-informed care principles are widely applicable, they may also need to be tailored to the distinctive exigencies of the population being assessed or treated.

Understanding the complex interplay of trauma, dislocation, and adjustment in the migration process is an essential foundation for a trauma-informed perspective. The migration process consists of multiple stages, and each stage contains a number of potential stressors. (Pumariega A, Roethe and Pumariega J 2005).

As a result of the many stressors immigrants and refugees face during their physical and psychological odyssey, they are at high risk for mental health problems (Brune et al. 2002, 451-458; Keyes 2000, 397-410). Among adults, the main problems reported are depression and anxiety disorders, particularly posttraumatic stress disorders (Fox et al. 2001, 778-792; Hermansson, Timpka and Thyberg 2002, 374-380; Maddern 2004, 36-39; Mollica et al. 2001, 546-554).

Torture and cumulative trauma are the strongest predictors of posttraumatic stress disorder and are associated with chronic physical and mental health problems (Carlson 2005). Meta-analyses indicate that on average only 20% of those who experience traumatic events develop PTSD (Rousseau and Measham 2007, 275-295).

Immigrants and refugees may lose a sense of coherence and find that capacities that the migrants have relied upon throughout their lives may not work in their new setting. Social and economic strain, discrimination, and loss of status pose additional stresses (Mollica 2008). Interventions that engage and support existing strengths and capabilities and incorporate traditional support mechanisms are recommended. Fostering social agency and the enterprise that traditionally characterizes migrants should also be emphasized (Silove et al. 1997, 351-357; Blanch 2008).

Awareness of cultural variations in presentation of symptoms (i.e., somatic symptoms), ways of coping, and the stigma attached to mental health problems are necessary to improve detection and treatment of any psychiatric conditions (CDC 2015). Power sharing is also developed through trauma education focused on normalizing trauma experiences and symptoms, which can also help minimize the stigma of mental health care (The Center for Victims of Torture).

Concluding:

To be trauma-informed is to understand the involvement and impact of violence and victimization in the lives of most consumers of mental health, substance abuse, and other services. It is also to apply that understanding in providing services and designing service systems to accommodate the requirements and vulnerabilities of trauma survivors and to facilitate their participation in treatment. This shift in perspective and practice implies important changes in mental health settings and in the provision of care, particularly in the recognition that symptoms may reflect coping efforts and of the potential for inadvertent client retraumatization in practice settings.

Trauma-informed care is not a treatment per se; it is an approach that starts with the premise that practitioners do no (more) harm, and proceeds with sensitivity to the distinctive issues that arise in the context of trauma and broader client-cantered principles of practice. Some have described the trauma-informed perspective as a paradigm shift inasmuch as this perspective represents a change in the framework for understanding clients and the context of their

presenting complaints. Given the prevalence of traumatic experiences, especially those endured during development, and their longstanding effects on clients' lives, the trauma-informed perspective offers a compelling and humane organizing principle for conceptualizing and addressing many of the problems and challenges facing those seeking mental health and other services.

This is necessary to promote the health and wellbeing of survivors and their families, and to set the stage for health and mental health professionals, organizations providing services to trauma survivors, law enforcement and criminal justice officials, emergency responders, and others to effectively and seamlessly integrate trauma understanding into their existing programs and procedures. And there is no time to lose in developing trauma-informed solutions for the growing population of violence and disaster victims.

III. Methodology

To achieve the objectives of this research I have used the mixed methodology of quantitative and qualitative studies. The research consisted of two main rounds/parts:

1. The study on common mental health disorders has been conducted among both Older (the 90'), Newer (2008) IDPs, and Returnees; the study investigated issues as prevalence of mental disorders among the big groups of conflict-affected populations, the associated factors, disability impact, co-morbidity issues, utilization of existing health and mental health services.

2. The experts' survey has been conducted to explore experiences and opinions of prominent international and local mental health reformers and to capitalise on their vision of relevant and most effective services applicable to conflict-affected big groups in Georgia.

1. The Quantitative study of conflict-affected populations:

This past of the overall research project has been designed to collect data on mental health problems and needs of conflict-affected populations. We have conducted a cross-sectional household survey of 3600 older IDPs, newer IDPs, and returnees (Makhashvili et al. 2014).

This section of my study is a part of the larger research coordinated by London School of Hygiene and Tropical Medicine (LSHTM), UK and Georgian partners- "An investigation on community-level influences on mental health amongst internally displaced persons and returnees in Georgia using innovative methodological and analytical techniques"(2011-2013). The project's principal investigator is Professor Bayards Roberts at LSHTM; Welcome Trust (UK) funded the research. I have served as a technical expert of this project and has been involved in all vital phases of the research – formulation of the study questions, selecting the study method, designing of the instrument, piloting it, training and supervising of field workers, analysing data and developing of scientific papers.

In this part of my research I have used the database of the above-mentioned study. The survey has examined the sample characteristics and levels of exposure to traumatic events; the prevalence of the common mental health conditions, and their comorbidity in three different affected groups. We also studied the characteristics associated with outcomes of PTSD,

depression and anxiety. The study has provided a data on functional disability, service utilization and couple of other important issues that have strong policy implications (see annex I – the study questionnaire in English and Georgian).

Participants and Study Background

The study used a cross-sectional survey design and multi-stage random sampling, with stratification by region and displacement status, seeking maximum representation of the conflict-affected populations in Georgia. A total sample size of 3,600 men and women aged ≥18 years was determined to meet the statistical requirements of the overall study. This consisted of 1,200 respondents from each of the 3 main conflict-affected populations in Georgia: those displaced as a result of conflicts in the 1990s ('1990s IDPs'); those displaced after the 2008 conflict ('2008 IDPs'); and former 2008 IDPs who have returned to their home areas after being displaced due to the 2008 conflict ('Returnees').

Primary sampling units (n = 360; 120 per population group) were selected based on probability proportion to size method using a sampling frame of formal and informal IDP settlement population sizes throughout Georgia provided by the Ministry of Internally Displaced Persons, and lists of villages in the border region with South Ossetia provided by the Governor's office in Shida Kartli region.

Within each primary sampling unit, the random walk method was then used to randomly select households in each primary sampling unit. This involved selecting a random starting direction from a central location in the cluster, with households lying on this transect from the center to the border of the cluster counted, with one of them then chosen at random and the next X nearest households subsequently visited (WHO 2008). Households per cluster were identical in number in order to maintain sample weightening generated through the probability to proportion to size method. Within the selected household one person (aged ≥18 years) was selected to be interviewed (based on nearest birthday). If there was no response at the household after 3 visits (on different days and at different times), the next household on the route was visited, with the same process used for refusals or interrupted interviews to ensure the desired sample size. For the purposes of this study, the overall sample (N = 3,600) was restricted to only those who were current IDPs from the 1990s conflicts (1990s IDPs) or current IDPs from the 2008 conflict (2008 IDPs) or former IDPs from the 2008 conflict who had

returned to their home areas in South Ossetia (Returnees), with respondents who had been displaced from both the 1990s and 2008 conflicts excluded (n = 256) as were those who reported that they had never been displaced (n = 319). The final sample size used for this study was therefore 3,025 with a response rate of 84%.

Procedures

Data collection took place between October and December 2011. The questionnaires were interviewer-administered by experienced, additionally trained and supervised professional fieldworkers through face-to-face interviews in the respondents' homes, with all interviews were conducted in Georgian. All respondents provided informed consent prior to their inclusion in the study. Full respondent anonymity was assured. Respondents were also able to stop the interview and drop out of the study at any point, and were informed accordingly.

Exclusion criteria included people deemed under the influence of alcohol or drugs, and those with severe intellectual or mental impairment using pre-defined criteria related to understanding, expression, communication, and behaviour. The National Council on Bioethics in Georgia and the London School of Hygiene and Tropical Medicine, UK provided ethics approval.

Measures

A. Measures of MH problems, disability and exposure

PTSD was measured using the Trauma Screening Questionnaire (TSQ) which consists of 10 items on PTSD symptoms over the past 1 week, with No (= 0) and Yes (= 1) responses which are summed to produce an overall score range of 0-10, with TSQ's cut-off of ≥6 used to indicate possible PTSD (Brewin et al. 2002, 158-162).

The Trauma Screening Questionnaire (TSQ) is a self-report measure of responses to a traumatic event. It consists of 10 questions measuring re-experiencing and arousal symptoms adapted from the Post-traumatic Stress Disorder (PTSD) Symptom Scale (Foa et al. 1993, 459-474.). Recent studies have indicated that the instrument's specificity may be sensitive to what population and when post-trauma is being studied (Bisson et al. 2010; Brewin, et al. 2010).It is

designed for use a month or more following exposure to a traumatic event to identify individuals who are likely to be currently suffering from PTSD.

Administration - The TSQ is a self-report questionnaire and takes only a few minutes to complete. Instructions are given at the top of the questionnaire.

Scoring- Scoring is straightforward. The 10 questions require a yes or no answer. Six or more positive responses mean that the client is at risk of having PTSD according to the DSM-IV (APA 1994) and requires a more detailed assessment.

Interpretation- The time frame of the scale is a month or more following exposure to a traumatic event. It assesses current symptoms. It does not diagnose Post-traumatic Stress Disorder. Its use is recommended in liaison services, primary care, etc.

Psychometric Details:

Evaluation - The TSQ was originally administered to forty-one train crash survivors, all of who were interviewed one week later with a structured diagnostic interview for PTSD, the Clinician Administered PTSD Scale (Blake et al. 1995). The rate of PTSD in this sample was 34%. Using a cut-off of 6 or more positive responses the TSQ performed as follows: sensitivity .86, specificity .93, positive predictive power .86, negative predictive power .93, and overall efficiency .90). In a replication sample of 157 victims of violent crime, where the rate of PTSD as determined by a questionnaire was 26.8%, the TSQ performed as follows: sensitivity .76, specificity .97, positive predictive power .91, negative predictive power .92, overall efficiency .92). The utility of the cut-off score of 6 has been replicated by Walters et al. (Walters, Bisson and Shepherd 2007).

Comparison - While there are now many questionnaires designed to assess PTSD symptoms that could be employed for screening purposes (Brewin 2005, 53-62.), the TSQ is possibly the simplest and shortest self-report measure currently available. The performance of the TSQ is as good if not better than other available instruments and has been found to be equivalent to that obtained from the comparison of diagnoses yielded by the two most highly regarded interview assessments currently available for PTSD: the Structured Clinical Interview for DSM-IV (First et al. 1996) PTSD module and the CAPS.

Brewin (2002) indicates that there appear to be two main *limitations.* Firstly, the TSQ was not designed to assess multiple or very extended trauma and may underestimate the effects of this.

Secondly, interpretation of the findings should be cautious while its use is explored further with populations differing in type of trauma and in base rates of PTSD.

Depression was measured using the Patient Health Questionnaire (PHQ-9) which consists of 9 questions on depression symptoms over the last 2 weeks, with responses of: *not at all* (= 0), *several days* (= 1), *more than half the days* (= 2), and *nearly every day* (= 3), with item scores summed to produce a total score range of 0-27, with the PHQ-9's suggested cut-off of ≥10 used to indicate at least moderate depression (Kroenke, Spitzer & Williams 2001).

Description of the PHQ-9. This easy to use patient questionnaire is a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders *(Ibid.).* The PHQ-9 is the depression module, which scores each of the nine DSM-IV criteria. It has been validated for use in primary care – the PHQ-9 was completed by 6,000 patients in 8 primary care clinics and 7 obstetrics-gynaecology clinics. Construct validity was assessed using the 20-item Short-Form General Health Survey, self-reported sick days and clinic visits, and symptom-related difficulty. Criterion validity was assessed against an independent structured mental health professional (MHP) interview in a sample of 580 patients. (Cameron et al. 2008, 32-6.).

The PHQ-9 is used to monitor the severity of depression and response to treatment. It can be used to make a tentative diagnosis of depression in at-risk populations - e.g., those with coronary heart disease or after stroke. (Haddad et al. 2013; de Man-van Ginkel et al. 2012, 333-41).

Psychometric details. The PHQ-9 has 61% sensitivity and 94% specificity in adults. Validity has been assessed against an independent structured mental health professional (MHP) interview. PHQ-9 score ≥10 had a sensitivity of 88% and a specificity of 88% for major depression. (Kroenke et al. 2001).

Some authors recommend it for usage over the telephone (Pinto-Meza et al. 2005, 738-42).

In addition to making criteria-based diagnoses of depressive disorders, the PHQ-9 is also a reliable and valid measure of depression severity. These characteristics plus its brevity make the PHQ-9 a useful clinical and research tool.

Anxiety was measured using the Generalised Anxiety Disorder (GAD-7) instrument which consists of 7 questions on anxiety symptoms over the last 2 weeks, with the same response options and scoring as the PHQ-9 which produces a total score range of 0-21, with the GAD-7's suggested cut-off of ≥10 used to indicate at least moderate anxiety (Spitzer et al. 2006).

Description of the instrument. This easy to use self-administered patient questionnaire is used as a screening tool and severity measure for generalized anxiety disorder (Swinson2006).

The GAD-7 score is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively, and adding together the scores for the seven questions (Kroenke et al. 2007, 317-25).

Scores of 5, 10, and 15 are taken as the cut off points for mild, moderate, and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for generalized anxiety disorder. It is moderately good at screening three other common anxiety disorders – panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%), and post-traumatic stress disorder (sensitivity 66%, specificity 81%). *(Ibid.)*

This Scale is a practical self-report anxiety questionnaire that proved valid in primary care and also was validated in the general population (Löwe et al. 2008, 266-274). (Nationally representative face-to-face household survey conducted in Germany with five thousand thirty subjects (53.6% female) with a mean age (SD) of 48.4 (18.0) years).

Evidence supports reliability and validity of the GAD-7 as a measure of anxiety in the general population. Thus, the GAD-7 is a valid and efficient tool for screening for GAD and assessing its severity in clinical practice and research.

Disability was assessed using the WHO Disability Assessment Schedule (WHODAS 2.0) (12 items version) which consists of 12 items on six activity domains for functional disability with a recall period of the previous 30 days, with response option scores ranging from 0 (none) to 4 (severe) which are recoded to produce a general disability score which is converted from a score range of 0-36 to 0-100 (with higher scores representing higher levels of disability) (Üstün et al. 2010a.; Üstün et al 2010b).

Description of the instrument. WHO Disability Assessment Schedule (WHODAS 2.0) is:

- A generic assessment instrument for health and disability
- A tool to produce standardized disability levels and profiles
- Applicable across cultures, in all adult populations

- Directly linked at the level of the concepts to the International Classification of Functioning, Disability and Health (ICF)
- Used across all diseases, including mental, neurological and addictive disorders
- Short, simple and easy to administer (5 to 20 minutes)
- Applicable in both clinical and general population settings
- A tool to produce standardized disability levels and profiles
- Applicable across cultures, in all adult populations
- Directly linked at the level of the concepts to the International Classification of Functioning, Disability and Health (ICF)

WHODAS 2.0 covers 6 Domains of Functioning, including: Cognition – understanding & communicating; Mobility– moving & getting around; Self-care– hygiene, dressing, eating & staying alone; Getting along– interacting with other people; Life activities– domestic responsibilities, leisure, work & school; Participation– joining in community activities

WHODAS 2.0 is grounded in the conceptual framework of the ICF (WHO 2001). It integrates an individual's level of functioning in major life domains and directly corresponds with ICF's "activity and participation" dimensions.

The instrument was developed through a collaborative international approach with the aim of developing a single generic instrument for assessing health status and disability across different cultures and settings. 12-item version is useful for brief assessments of overall functioning in surveys; it allows to compute overall functioning scores.

Administration. Self-administration: A paper-and-pencil version of WHODAS 2.0 can be self-administered. Interview: WHODAS 2.0 can be administered in person or over the telephone. General interview techniques are sufficient to administer the interview in this mode. Proxy: Sometimes it may be desirable to obtain a third-party view of functioning such as; family members, caretakers or other observers.

Scoring. The scores assigned to each of the items – "none" (0), "mild" (1) "moderate" (2), "severe" (3) and "extreme" (4) – are summed. This method is referred to as simple scoring because the scores from each of the items are simply added up without recoding or collapsing of response categories; thus, there is no weighting of individual items. This approach is practical to use as a hand-scoring approach, and may be the method of choice in busy clinical settings or in

paper–pencil interview situations. As a result, the simple sum of the scores of the items across all domains constitutes a statistic that is sufficient to describe the degree of functional limitations. WHODAS 2.0 produces domain-specific scores for six different functioning domains – cognition, mobility, self-care, getting along, life activities (household and work) and participation.

Regarding all these instruments standard procedures have been used, involving:

Translation from English into Georgian using professional translators, with translations reviewed by Georgian mental health experts individually and then as a group for cultural relevance, content and concept consistency, clarity and understanding;

A back-translation to check for accuracy, consistency and equivalence, with adjustments made accordingly; and

Piloting and field-testing to refine the instruments further (Mollica et al. 2004; Van Ommeren et al. 1999, 285-301).

In this study, the TSQ, PHQ-9, GAD-7 and WHODAS 2.0 showed good internal reliability, with Cronbach's alpha scores of 0.86, 0.86, 0.90, and 0.91 respectively.

We have also conducted a separate pilot survey of 110 randomly selected internally displaced persons living in Tbilisi to assess the instruments' test-retest reliability by administering the TSQ, PHQ-9, GAD-7 and WHODAS 2.0 to the same respondent 4 days apart, and the intraclass correlation results for them were 0.97, 0.98, 0.96, and 0.98 respectively (with scores above 0.80 indicating excellent agreement between the two time periods (Bartko 1966).

The TSQ, PHQ-9, GAD-7 and WHODAS 2.0 also showed good validity. For example, for known groups validity, higher levels of exposure to traumatic events correlated with higher levels of disorders (see Tables 4 and 5 below); inter-instrument correlations (see results of Pearson's test for correlation below); and construct validity, with the PHQ-9 and GAD-7 each showing a single eigenvalue of >1 indicating a single construct, while TSQ showed 2 eigenvalues >1 which related to the two constructs in TSQ of re-experiencing and arousal (Brewin et al. 2002, 158-162).

The main survey questionnaire also contained items on exposure to a range of violent and traumatic events adapted from the *Harvard Trauma Questionnaire*, which was designed to

measure experiences of violent and traumatic events among civilian populations in a range of cultural settings (Mollica et al. 1992).

Description of the instrument. The Harvard Trauma Questionnaire (HTQ) is a checklist developed by Harvard Program on Refugee Trauma (HPRT). It inquires about a variety of trauma events, as well as the emotional symptoms considered to be uniquely associated with trauma. Harvard Trauma Questionnaire (HTQ), have been translated into over thirty languages and are currently being used worldwide.

Currently there are six versions of this questionnaire. The Vietnamese, Cambodian, and Laotian versions of the HTQ were written for use with Southeast Asian refugees. The Japanese version was written for survivors of the 1995 Kobe earthquake. The Croatian Veterans' Version was written for soldiers who survived the wars in the Balkans, while the Bosnian version was written for civilian survivors of that conflict. The instrument was validated (i.e. Oruc et al. 2008), and found to be accurate and useful.

The early versions of the HTQ (Vietnamese, Laotian, and Cambodian) consist of four sections. Part I asks about 17 traumatic life events determined to have affected southeast Asian refugees. There are four possible responses for each event: "Experienced," "Witnessed," "Heard about it," or "No." Respondents are asked to check all that apply. Part II is an open-ended question that asks respondents for a subjective description of the most traumatic event(s) they experienced. Part III asks about events that may have led to head injury. Part IV includes 30 trauma symptoms. The first 16 items were derived from the DSM criteria for posttraumatic stress disorder (PTSD). The other 14 items were developed by HPRT to describe symptoms related to specifically refugee trauma. The scale for each question in Part IV includes four categories of response: "Not at all," "A little," "Quite a bit," "Extremely," rated 1 to 4, respectively.

In later versions of the HTQ, Part I was expanded to include 46 to 82 traumatic events, and the Experienced/Witnessed/Heard About/No scale was replaced with a simple Yes/No response to each question. The events listed were changed to better reflect the experiences of military and civilian survivors of the wars in the former Yugoslavia, and the survivors of the Kobe earthquake. Part II, the open-ended description of the most traumatic events, was unchanged. Part III, head injury, was expanded slightly in the Bosnian and Croatian versions of the HTQ and omitted in the Japanese version.

The first 16 trauma symptom items, derived from the DSM-IV PTSD criteria, are the same in every version of the HTQ. In the Japanese version, all 30 trauma symptoms from the early versions of the HTQ are used, and 7 more culture-specific questions that deal with trauma symptoms in the Japanese idiom are added. In the most recent versions of HTQ, the Bosnian and Croatian Veterans versions, Section IV includes the 16 DSM-IV PTSD questions and 24 additional symptom items that focus on the impact of trauma on an individual's perception of his/her ability to function in everyday life. In HPRT's experience, these symptoms are extremely important because traumatized people are usually more concerned about social functioning than about emotional distress. Screening instrument is to be administered by health care workers under the supervision and support of a psychiatrist, medical doctor, and/or psychiatric nurse.

We have selected items from HTQ that were deemed most pertinent to the Georgian context (see Table 3 below for selected items). Items from the HTQ were treated as both individual items and cumulatively (0,1,2,$\geq$3).

Other data - A history of displacement was recorded (current displacement status and when displaced). A range of demographic and socio-economic characteristics were also recorded, including: sex, age, education level, marital status, general living conditions and conditions in the community (each with 5 response options ranging from *very satisfactory* to *very unsatisfactory* which were later condensed into *satisfactory/very satisfactory*, neither satisfactory/not satisfactory, *unsatisfactory/very unsatisfactory* to ensure sufficient statistical power for the statistical analysis), employment status, household assets, and household economic situation (with 5 response options ranging from *very bad* to *very good* which was later condensed into *very good/good/average* versus *bad/very bad* to ensure sufficient statistical power for the statistical analysis).

B. Measure of health service utilization

Respondents were asked whether they had feelings such as anxiety, nervousness, depression, insomnia or any other emotional or behavioural problems for which they sought health care for the last 12 months. For those that had sought some kind of care, they were then asked what type of care they had received. The Types of health care services were classified as: pharmacy;

GP office, ambulatory or policlinic; neurologist at policlinic; neurologist or therapist at hospital; psychiatrist at outpatient clinic (dispensary); psychiatrist at hospital; psychosocial centre, private mental health specialist; outreach/mobile services.

The respondents who had sought care were also asked what types of treatment they received and these were classified as: drug treatment, counselling and psychotherapy/psychosocial support. The terms "counselling" and "psychotherapy/psychosocial support" were not specifically explained, as they are commonly understood. Respondents who self-reported having mental or behavioural problems, but did not use health services - were further asked for reasons of not seeking care.

Data Analysis

A. Mental disorders, co-morbidity, functioning disability

Descriptive analysis was conducted on the sample characteristics; and the prevalence of the 3 common mental health conditions, of having any of the 3 conditions (i.e. ≥1 condition), co-morbidity of more than one condition, having all 3 conditions, and having a single condition with no co-morbidity. Correlation coefficients between the 3 conditions were also calculated using Pearson's test for correlation.

Multivariate logistic regression analysis was then used to examine the association of displacement status and time, trauma exposure, and demographic and socio-economic characteristics with outcomes of PTSD, depression and anxiety, 'any condition' (i.e. ≥1 condition) and co-morbidity (i.e. >1 condition). Exploratory bivariate analysis was initially conducted with the outcome of 'any condition' and a stepwise approach used to select variables in the final model, which remained statistically significant ($p<.05$). The same variables were then used in separate models for PTSD, depression, anxiety and co-morbidity to examine any differences between the disorders. In this regression analysis, the data were weighted to reflect actual proportions of '1990s internally displaced persons', '2008 internally displaced persons' and 'Returnees' in the overall conflict-affected population of Georgia, based upon the sampling frames noted above.

To examine the association of the disorders and their co-morbidity on functional disability, separate regression models were run for each disorder, and adjusted for displacement status, sex, age and having a long-term illness, health problem or disability which evidence has shown are strongly related to disability (Üstün et al., 2010). The WHODAS 2.0 functional disability outcome is a continuous measure, with the coefficient results representing equivalent changes in the WHODAS 2.0 scoring range of 0-100 following the instrument guidelines. The analyses adjusted for the cluster sampling design. The statistical analysis was performed using Stata 13.1.

B. Service Utilization

Patterns of service utilization by type of mental health disorder, reasons of not using services and type of services used were analysed by computing frequencies. Multivariate logistic regression was carried out to assess influence of different variables on health service utilization. At the first stage two groups of independent variables were formed: Socio-demographic and health. The variables such as gender, age, marital status, education, economic status, employment, displacement status and possessing of health insurance were grouped together under the socio-demographic group. Health group (1) included PTSD, depression, anxiety and disability status. Health group (2) included co-morbidity (existence of more than one mental health disorders) and disability status. At initial stage multivariate regression analyses was run separately for each group. Variables that did not show significant contribution in the first analyses were excluded from the final model. In the final model significant predictors from the first analyses were entered in the final regression model. Multicolinearity was tested for the predictors in each group separately and for the predictors in the final model. None of the variable showed multicolinearity between each other. The sample was weighted to reflect the actual proportions of 'old IDPs', 'new IDPs' and 'returnees' in the overall conflict-affected population of Georgia. An analysis was performed in IBM SPSS 18.0. Statistical significance was considered at $P < 0.05$.

2. Mental Health Services for Conflict-affected Populations - Experts Survey

The study aimed to explore several policy options regarding the services that would meet the exposed needs of conflict-affected big groups was conducted after the first phase of the research project was over (Makhashvili and Pilauri, 2015). During the first phase of the research we had

gathered a sufficient data on prevalence rates of common MH disorders, their comorbidity and impact on disability and also on service utilization patterns among three war-affected groups.

The purpose of the survey was to a. collect experts' opinion on the best effective models of service delivery meeting needs of conflict-affected populations in Georgia and b. propose recommendations for the trauma-informed mental health services for influencing MH policy and program.

Method

The data was collected by an electronic survey of mental health experts. For the purpose of the survey, experts were defined according to their working experience in the field of mental health from different countries. Foreign and local experts with substantial knowledge of MH polices and systems and/or with experience of care for trauma affected big groups were identified using purposive sampling procedures. Of the 32 experts invited to participate, 21 returned a completed survey. The experts represented 9 countries, both LMICS (Georgia, Nepal, Sri Lanka, Azerbaijan) and developed ones (UK, Netherlands, Italy).

These persons are gratefully acknowledged below for contributing their insights and expertise.

Ajdukovich, Dean	Croatia
Bisson, Jonathan	UK
Bruni, Andrea	Italy
Drozdek, Boris	Netherland
Gabashvili, Manana	Georgia
Ganesan, Mahesan	Sri Lanka
Geleishvili, Giorgi	Georgia
Ismailov, Fuad	Azerbaijan
Javakhishvili, Jana	Georgia
Jordans, M	Nepal
Khundadze, Maia	Georgia
Pankratova, Elsa	Georgia

Roberts, Bayard	UK
Sar, Vedat	Turkey
Saraceno, Benedetto	Italy
Semrau, Maya	UK
Sharashidze, Manana	Georgia
Tabagua, Sofio	Georgia
Tsiskarishvili, Lela	Georgia
Van Voren, Robert	Netherlands& Lithuania
Zavradashvili, Nana	Georgia

Respondents completed questionnaire on the perceived usefulness of different methods to address MH needs of war-affected populations. The questionnaire contained both open-ended and close-ended ordinal response scale questions.

The instrument was developed using a phased process. First, the theoretical models of mentioned above (WHO 'Pyramid of services' and BCM) were employed to identify the range of services offered to people with MH disorders; the services were augmented with the specific ones that are offered to war-affected populations. Additional methods, besides the types of services, as funding, lobbying, etc. were also offered for experts' consideration. There were questions about high and low & middle-resource areas within the country and on type of services appropriate for such areas. The experts were also asked to share their opinions and suggestions regarding trauma-informed and trauma-specific services. Before final utilization, the entire survey was completed as a test run by two foreign and two local experts. Changes to the survey were made based on their feedback. The questionnaire initially was composed in English; then translated into Georgian (See Annex II).

Using 1-5 ordinal scale (1= not at all useful to 5= very useful), respondents were asked to rate how useful they found different methods for working with war-affected populations from their experience. They also were provided a not applicable option for each method, denoting that the method has not been used in their experience. Respondents were also provided with opportunities to write freely about other important factors, not included within the pre-defined methods, that they felt were important expanding community based services for the target

groups. Besides, the experts were asked to identify the three most effective/useful services to address mental health needs of war affected population in low/middle resource and higher resource areas, rate some additional methods using 1-5 scale and comment on the resource-related service development approach for Georgia and share their understanding of trauma informed care, trauma-specific services and their interaction. Additional open-ended questions were stated for local experts only to specify the essential MH services that would meet needs of war affected populations in relatively low/middle resource and relatively high resource areas in Georgia. Responses were tabulated and summarized to identify those services that participants were most likely to rate as quite useful or very useful for war-affected population.

Data Analysis of the survey

Responses on the close-ended questions were analysed using IBM SPSS statistics 20. In order to identify effective services and additional methods responses "useful" and "most useful" were calculated; services/methods rated as "useful" and "very useful" by more then 50% of respondents were considered as effective and appropriate for targeted groups. Calculating frequencies and defining the ranges identified effective services for the low &middle and higher resource areas. Services ranked as 1 to 3 were considered as effective.

Information gathered on the open-ended questions were analysed by the descriptive content analysis. Information was categorized according previously defined themes/questions, reduced and described. Descriptive summary of the key informational contents is presented by the following topics: Types of services, Resource related service development in Georgia and Using Trauma informed and trauma specific services.

IV. Overview of Findings

1. Mental Health problems in war-affected populations

The findings of the MH problems, their comorbidity and association with disability are discussed in our paper (Makhashvili et al. 2015).

The respondent characteristics, by displacement status, are shown in Table 4. Overall, around two-thirds of respondents were women, reflecting findings of studies of the general population in Georgia as many men have left to find employment elsewhere (Caucasus Research Resource Centres 2010). There were a number of significant differences ($p<.05$) between the three population groups in exposure to traumatic events (Table 1). These include a greater proportion of internally displaced persons from both the 1990s and 2008 conflicts reporting having experienced a lack of shelter and being directly caught in a combat situation than the returnees. The 1990s internally displaced persons reported significantly higher levels than 2008 internally displaced persons and returnees of: serious injury; witnessing the murder or violent acts against family/friends and strangers; and the death of family member/close friend during conflict/displacement.

Table 4: Sample Characteristics, by Population Group

	1990s displaced n = 1,193		2008 displaced n = 996		Returnees n = 836	
	n	%	n	%	n	%
Sex:						
Men	414	34.7	331	33.2	275	32.9
Women	779	65.3	665	66.8	561	67.1
Age:						
18-39	438	36.7	430	43.2	291	34.8
40-59	418	35.0	300	30.1	321	38.4

60+	337	28.3	266	26.7	224	26.8
Marital status:						
Married/cohabiting	640	53.6	716	71.8	571	68.3
Single	319	26.7	148	14.9	132	15.8
Widowed	234	19.7	132	13.3	133	15.9
Education status:						
Completed higher education	301	25.2	204	20.4	130	15.6
Completed secondary school	808	67.8	671	67.4	632	75.5
Primary/incomplete secondary	84	7.0	121	12.2	74	8.9
Employment status:						
Fully employed/self-employed	194	18.4	187	21.1	114	15.7
Irregular paid work	42	4.0	35	4.0	4	0.6
Farmer	3	0.3	3	0.3	127	17.5
Unemployed	397	37.5	219	24.7	141	19.4
Housewife	127	12.0	203	22.9	137	18.9
Retired	294	27.8	239	27.0	202	27.9
Household economic status:						
Very good	4	0.3	3	0.3	3	0.4
Good	17	1.4	25	2.5	10	1.2
Average	539	45.3	533	53.6	332	39.7
Bad	406	34.0	346	34.7	356	42.5
Very bad	227	19.0	89	8.9	135	16.2
Trauma exposure:						
Lack of shelter	532	44.6	471	47.3	302	36.1
Serious injury	251	21.0	132	13.3	98	11.7
Directly in combat situation	585	49.0	476	47.8	290	34.7
Abducted	23	1.9	12	1.2	4	0.5
Been tortured	23	1.9	14	1.4	3	0.4
Witnessed murder, violence acts against family/friends	396	33.2	172	17.3	56	6.7

Witnessed murder, violence acts against stranger	127	10.7	49	4.9	13	1.6
Death of family member/close friend during conflict/displacement	487	40.8	185	18.6	104	12.4
Multiple events:						
No events	257	21.5	261	26.2	311	37.2
1 event	262	22.0	282	28.3	270	32.3
2 events	227	19.0	241	24.2	183	21.9
3+ events	447	37.5	212	21.3	72	8.6

Prevalence and co-morbidity of mental disorders

The proportion of respondents for the combined sample (N = 3,025) with the mental disorders and with co-morbidity is shown in Figure 8. For this combined sample, the levels were 23.3% [95% CI 21.76, 24.80] for PTSD, 14.0% [95% CI 12.76, 15.24] for depression, and 10.4% [95% CI 9.39, 11.56] for anxiety. Nearly a third of the combined sample reported at least 1 condition (29.44% [95% CI 27.81, 31.06], and 12.4% [95% CI 11.24, 13.61] reported more than 1 disorder, and 5.4% [95% CI 4.59, 6.21] reported all 3 disorders. When limited to only respondents who had any mental health disorder, this equates to 41.5% [95% CI 38.23, 44.79] having a co-morbidity, and 18.3% [95% CI 15.76, 20.92] having all 3 disorders. There were significant (p<.001) correlations between the 3 mental disorders, with a Pearson correlation coefficient of .40 for PTSD with depression, .38 for PTSD with anxiety, and 0.52 for depression with anxiety. At between .30 and .60, these can be considered moderate levels of correlation (Hinkle Jurs and Wiersma 1988).

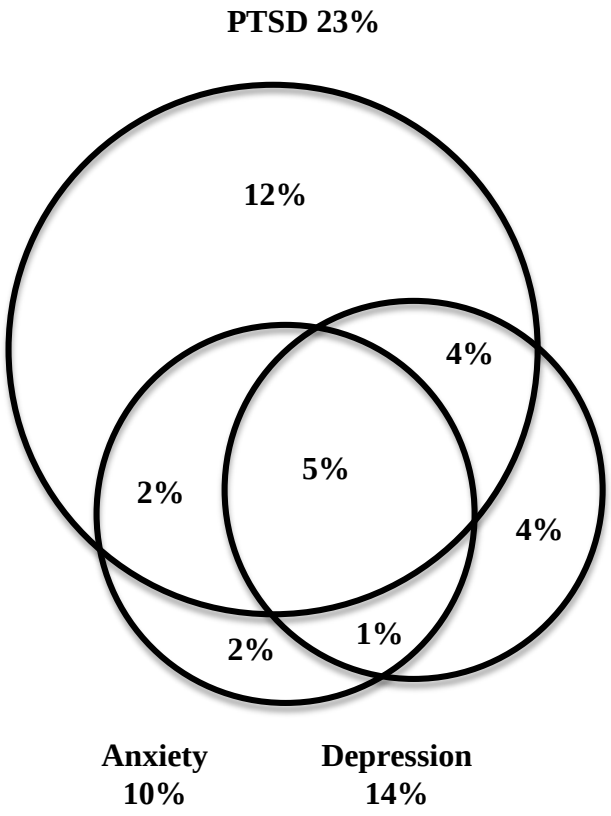


Figure 8: proportion of respondents with single disorders and with co-morbidity (N = 3,025)

There were significantly higher mean scores (*t tests*, $p<.001$) for the 1990s internally displaced persons compared with the 2008 internally displaced persons and returnees for: PTSD (3.53, 3.14, 2.49, respectively); depression (5.43, 3.62, 3.82, respectively); and anxiety (4.42, 3.56, 3.34, respectively). The only significant difference between the mean scores for 2008 internally displaced persons and returnees was for PTSD ($p<.001$).

When using the instrument cut offs, there were significantly higher levels of mental disorders among 1990s internally displaced persons than returnees for all disorders, and also significantly higher levels of depression and co-morbidity for 1990s internally displaced persons than for the 2008 internally displaced persons (Table 4). Levels of co-morbidity for all 3 conditions were also significantly higher among the 1990s internally displaced persons (7.3% [95% CI 5.81, 8.77]) than for the 2008 internally displaced persons (3.8% [95% CI 2.62, 5.01]) and the returnees (2.6% [95% CI 1.54, 3.72]).

The Pearson correlation coefficients ($p<.001$) for PTSD with depression, PTSD with anxiety, and depression with anxiety were slightly higher among the 1990s internally displaced persons (0.41, 039, 0.53, respectively) than the 2008 internally displaced persons (0.37, 0.30, 0.44, respectively) and returnees (0.33, 0.35, 0.49, respectively).

Table 5: Prevalence of mental disorders and co-morbidity, by population group (N = 3,025)

	1990s internally displaced persons			2008 internally displaced persons			Returnees		
	n	%	[95% CI]	n	%	[95% CI]	n	%	[95% CI]
PTSD	317	27.1	[23.5; 31.1]	226	22.9	[18.9; 27.4]	140	17.0	[13.8; 20.8]
Depression	223	18.7	[15.5; 22.4]	99	9.9	[7.8; 12.6]	60	7.2	[5.3; 9.6]
Anxiety	155	13.0	[10.4; 16.1]	92	9.2	[7.3; 11.7]	55	6.6	[4.3; 10.0]
Any condition	415	34.8	[30.7; 39.1]	282	28.3	[24.2; 32.9]	173	20.7	[17.1; 24.8]
>1 more condition	187	16.0	[13.3; 19.1]	97	9.8	[7.6; 12.6]	59	7.2	[5.1; 10.0]

Characteristics associated with mental disorders

The characteristics associated with the 3 disorders and then comorbidity is shown in Tables 5 and 6 respectively. These highlight that being a returnee was associated with significantly lower prevalence of mental disorders when compared with the reference population of 1990s internally displaced persons, after adjusting for the influence of other factors, with the odds of having a condition ranging from a one-third lower probability for PTSD (*OR* 0.63), and around two-thirds for depression (*OR* 0.33), and around half for any disorder (*OR* 0.52). 2008 internally displaced persons were also associated with a significantly lower probability of depression (*OR* 0.54) and having ≥1 condition (*OR* 0.67) than 1990s internally displaced persons. The same models were also run but comparing returnees with a reference category of 2008 internally displaced persons (i.e. excluding 1990s internally displaced persons) and these also showed a significantly lower probability among returnees compared to 2008 internally displaced persons for PTSD (*OR* 0.67) depression (*OR* 0.61), anxiety (*OR* 0.64), any condition (*OR* 0.60); and ≥1 condition (*OR* 0.67).

Trauma exposure events involving lack of shelter, serious injury, physical abuse, and witnessing the murder or violence acts against a stranger were commonly associated with the disorders and their comorbidity, as were cumulative trauma events. Other significant characteristics associated with the mental disorders and comorbidity include sex (women), older age, and bad/very bad household economic situation and community conditions (Tables 5 and 6).

Table 6: Regression Analyses of Characteristics Associated with Individual Mental Disorders (N = 3,025)

	PTSD					Depression					Anxiety				
	n	%	OR	[95% CI]		n	%	OR	[95% CI]		n	%	OR	[95% CI]	
Displacement status (all): [a]															
1990s displaced	317	27.1	1.00			223	18.7	1.00			155	13.0	1.00		
2008 displaced	226	22.9	1.00	[0.80,	1.24]	99	9.9	0.54	[0.41,	0.71]**	92	9.2	0.81	[0.60,	1.09]
Returnees	140	17.0	0.63	[0.49,	0.81]**	60	7.2	0.33	[0.23,	0.45]**	55	6.6	0.51	[0.36,	0.73]**
Displacement status (2008 & returnees): [a]															
2008 displaced	226	22.9	1.00			99	9.9	1.00			92	9.9	1.00		
Returnees	140	17.0	0.67	[0.52,	0.87]*	60	7.2	0.61	[0.42,	0.88]*	55	7.2	0.64	[0.44,	0.93]*
Sex:															
Men	188	18.7	1.00			116	11.4	1.00			77	7.6	1.00		
Women	507	25.6	1.67	[1.33,	2.09]**	308	15.4	1.50	[1.13,	1.98]**	240	12.0	1.79	[1.31,	2.46]**
Age:															
18-39	139	12.1	1.00			77	6.6	1.00			66	5.7	1.00		
40-59	246	24.1	1.80	[1.37,	2.37]**	153	14.7	2.00	[1.41,	2.85]**	113	10.9	1.56	[1.07,	2.29]*
60+	302	37.0	3.07	[2.33,	4.04]**	189	22.9	2.89	[2.02,	4.14]**	135	16.3	2.11	[1.43,	3.10]**
Education:															
Completed higher educ.	106	16.9	1.00			63	9.9	1.00			46	7.2	1.00		
Completed secondary	502	24.1	1.52	[1.14,	2.03]**	299	14.2	1.53	[1.07,	2.19]*	230	10.9	1.54	[1.04,	2.28]*
Primary/incomplete secondary	90	32.8	2.02	[1.35,	3.03]**	65	23.4	2.68	[1.63,	4.42]**	44	15.6	2.15	[1.24,	3.71]**
Trauma events: [b]															
Lack of shelter	389	30.4	1.52	[1.23,	1.89]**	208	15.9				157	12.0			

Serious injury	174	37.0	1.66	[1.28,	2.16]**	112	23.4	1.57	[1.16,	2.13]**	88	18.3	1.71	[1.24,	2.37]**
Physical abuse	30	36.4				23	28.5	2.16	[1.10,	4.25]*	27	32.4	3.79	[2.07,	6.92]**
Witnessed murder, violence against stranger	88	46.9	2.12	[1.44,	3.11]**	54	28.7	1.58	[1.05,	2.40]*	40	21.4	1.62	[1.03,	2.53]*
Cumulative trauma events: [b]															
No events	111	13.5	1.00			74	8.9	1.00			56	6.7	1.00		
1 event	164	20.3	1.57	[1.15,	2.14]**	96	11.8	1.26	[0.86,	1.85]	64	7.8	1.09	[0.71,	1.68]
2 events	153	23.9	1.80	[1.31,	2.48]**	90	13.9	1.35	[0.91,	2.00]	71	10.9	1.47	[0.96,	2.26]
3+ events	258	36.2	2.76	[2.02,	3.77]**	158	21.6	1.65	[1.14,	2.40]**	122	16.7	1.97	[1.30,	2.97]**
Household economic situation:															
Good/very good	208	14.4	1.00			102	7.0	1.00			78	5.3	1.00		
Bad/very bad	473	30.7	1.88	[1.50,	2.36]**	311	20.0	2.53	[1.89,	3.38]**	232	14.9	2.41	[1.74,	3.34]**
Community conditions:															
Good/very good	231	19.6	1.00			125	10.5	1.00			100	8.4	1.00		
Average	210	20.7	1.13	[0.87,	1.46]	127	12.4	1.35	[0.98,	1.87]	101	9.9	1.30	[0.91,	1.84]
Bad/very bad	244	30.8	1.71	[1.33,	2.20]**	163	20.2	1.89	[1.39,	2.57]**	112	13.9	1.52	[1.08,	2.14]*
	Pseudo R^2 =.25 P <.001					Pseudo R^2 =.25 P <.001					Pseudo R^2 =.21 P <.001				

Note: [a] Separate multivariate regression models run for the two displacement groupings. Regression results for other independent variables based on the first model (1990s internally displaced persons, 2008 internally displaced persons, and returnees). [b] Separate multivariate regression models run for cumulative events and individual trauma events. Regression results for other independent variables based on cumulative events model. There were no significant differences (p<.05) for the results of the other independent variables between the two regression models. Referent category for trauma events was no exposure. Blank cells indicate where independent variables omitted after stepwise regression analysis.

*p<.05 ** p<.01.

Table 7: Regression Analyses of Characteristics Associated with Co-morbidity (N = 3,025)

	Any condition					More than 1 condition				
	n	%	OR	[95% CI]		n	%	OR	[95% CI]	
Displacement (all groups): [a]										
1990s displaced	415	34.8	1.00			187	16.0	1.00		
2008 displaced persons	282	28.3	0.90	[0.73,	1.10]	97	9.8	0.67	[0.50,	0.90]*
Returnees	173	20.7	0.52	[0.41,	0.66]**	59	7.2	0.40	[0.28,	0.57]**
Displacement (2008 & returnees): [a]										
2008 displaced persons	282	28.3	1.00			97	9.8	1.00		
Returnees	173	20.7	0.60	[0.47,	0.77] *	59	7.2	0.67	[0.46,	0.97]**
Sex:										
Men	250	24.5	1.00			89	8.9	1.00		
Women	641	32.0	1.63	[1.33,	2.01]**	282	14.2	1.85	[1.36,	2.51]**
Age:										
18-39	202	17.4	1.00			52	4.6	1.00		
40-59	331	31.9	1.78	[1.39,	2.27]**	129	12.7	2.42	[1.62,	3.61]**
60+	349	42.2	2.44	[1.89,	3.16]**	184	22.6	4.23	[2.83,	6.31]**
Education:										
Completed higher educ.	139	21.9	1.00			51	8.2	1.00		
Completed secondary	645	30.6	1.57	[1.21,	2.04]**	267	12.8	1.62	[1.11,	2.38]*
Primary/incomplete secondary	111	39.8	2.22	[1.51,	3.27]**	55	20.0	2.34	[1.37,	3.99]**
Trauma events: [b]										
Lack of shelter	466	35.7	1.25	[1.02,	1.52]*	190	14.8			
Serious injury	220	45.7	1.72	[1.34,	2.20]**	103	21.9	1.83	[1.33,	2.51]**
Physical abuse	45	54.4	2.48	[1.42,	4.31]**	23	27.8	2.71	[1.37,	5.35]**
Witnessed murder, violence against stranger	108	56.9	2.26	[1.55,	3.29]**	47	25.1			

Cumulative trauma events: [b]										
No events	152	18.3	1.00			58	7.1	1.00		
1 event	204	31.3	1.41	[1.06,	1.86]*	87	10.8	1.49	[0.99,	2.24]
2 events	321	43.9	1.81	[1.35,	2.41]**	81	12.6	1.58	[1.03,	2.41]*
3+ events	277	18.9	2.55	[1.92,	3.37]**	140	19.6	1.97	[1.31,	2.97]**
Household economic situation:										
Good/very good	277	18.9	1.00			80	5.5	1.00		
Bad/very bad	598	38.4	2.05	[1.67,	2.52]**	281	18.3	2.68	[1.94,	3.68]**
Community conditions:										
Good/very good	294	24.6	1.00			105	9.0	1.00		
Average	281	27.4	1.26	[0.99,	1.59]	116	11.4	1.46	[1.03,	2.06]*
Bad/very bad	304	37.8	1.70	[1.35,	2.16]**	142	17.9	2.00	[1.43,	2.78]**
	Pseudo R^2 =.25 P <.001					Pseudo R^2 =.29 P <.001				

Note: [a] Separate multivariate regression models run for the two displacement groupings. Regression results for other independent variables based on the first model (1990s internally displaced persons, 2008 internally displaced persons, and returnees). [b] Separate multivariate regression models run for cumulative events and individual trauma events. Regression results for other independent variables based on cumulative events model. There were no significant differences ($p<.05$) for the results of the other independent variables between the two regression models. Referent category for trauma events was no exposure. Blank cells indicate where independent variables omitted after stepwise regression analysis.
* $p<.05$ ** $p<.01$.

Associations of mental disorders with disability

The mean functional disability score for 1990s internally displaced persons (14.61) was significantly higher (i.e. worse disability) than the 2008 internally displaced persons (8.99) and returnees (9.37). The other characteristics associated with worse disability are shown in Table 7. The mental disorders all showed significant associations with worse disability, with more than 1 disorder having the strongest association. Sex, older age and having an existing disability/long-term illness were also all significantly associated with higher disability.

Table 8: Regression Analyses of Characteristics Associated with Outcome of Functional Disability, by Displacement Status (N = 3,025)

	Combined population			1990s displaced			2008 displaced			Returnees		
	Coef.	[95% CI]		Coef.	[95% CI]		Coef.	[95% CI]		Coef.	[95% CI]	
Mental disorders:												
PTSD	6.38	[6.03,	6.74]**	7.57	[6.99,	8.15]**	5.21	[4.61,	5.81]**	6.19	[5.54,	6.84]**
Depression	9.67	[9.19,	10.15]**	9.32	[8.61,	10.03]**	11.07	[10.17,	11.97]**	8.08	[7.07,	9.08]**
Anxiety	6.25	[5.72,	6.77]**	6.68	[5.87,	7.49]**	5.84	[4.94,	6.74]**	4.36	[3.29,	5.43]**
Any condition	10.57	[10.25,	10.89]**	12.42	[11.89,	12.95]**	9.73	[9.18,	10.28]**	8.04	[7.46,	8.63]**
>1 condition	15.91	[15.46,	16.36]**	17.12	[16.44,	17.79]**	14.62	[13.78,	15.47]**	13.76	[12.86,	14.66]**
Sex:												
Women	2.29	[2.01,	2.56]**	3.43	[2.95,	3.90]**	.60	[0.11,	1.09]*	2.93	[2.46,	3.40]**
Age:												
40-59	3.08	[2.77,	3.40]**	2.76	[2.22,	3.31]**	2.07	[1.51,	2.63]**	3.97	[3.45,	4.49]**
60+	11.49	[11.14,	11.83]**	9.89	[9.28,	10.49]**	11.42	[10.81,	12.03]**	12.65	[12.08,	13.23]**
Disability/long-term illness:												
Yes	8.56	[8.25,	8.88]**	8.40	[7.88,	8.91]**	10.85	[10.26,	11.45]**	6.45	[5.94,	6.96]**
Displacement status:												
2008 displaced	-3.13	[-3.44,	-2.82]**									
Returnees	-2.62	[-2.95,	-2.29]**									
	Adj R^2 = .36 p<.001			Adj R^2 = .36 p<.001			Adj R^2 = .36 p<.001			Adj R^2 = .29 p<.001		

Note: Referent categories are: no PTSD, no depression, no conditions (for any condition), no condition (for >1 condition), men, age 18-39 years, no disability, 1990s displaced. Separate multivariate regression models used: (1) PTSD, depression and anxiety plus sex, age, disability, (2) 'any condition' plus sex, age, disability, (3) '>1 condition' plus sex, age, disability. The results for sex, age and disability/long-term illness and Adj R2 results shown in table from model 1. Same process applied for each population group.

* p<.05 ** p<.01

Service utilization

The paper on service utilization (Chikovani et al. 2015) discusses the findings.

Service utilisation by presence of MH problems

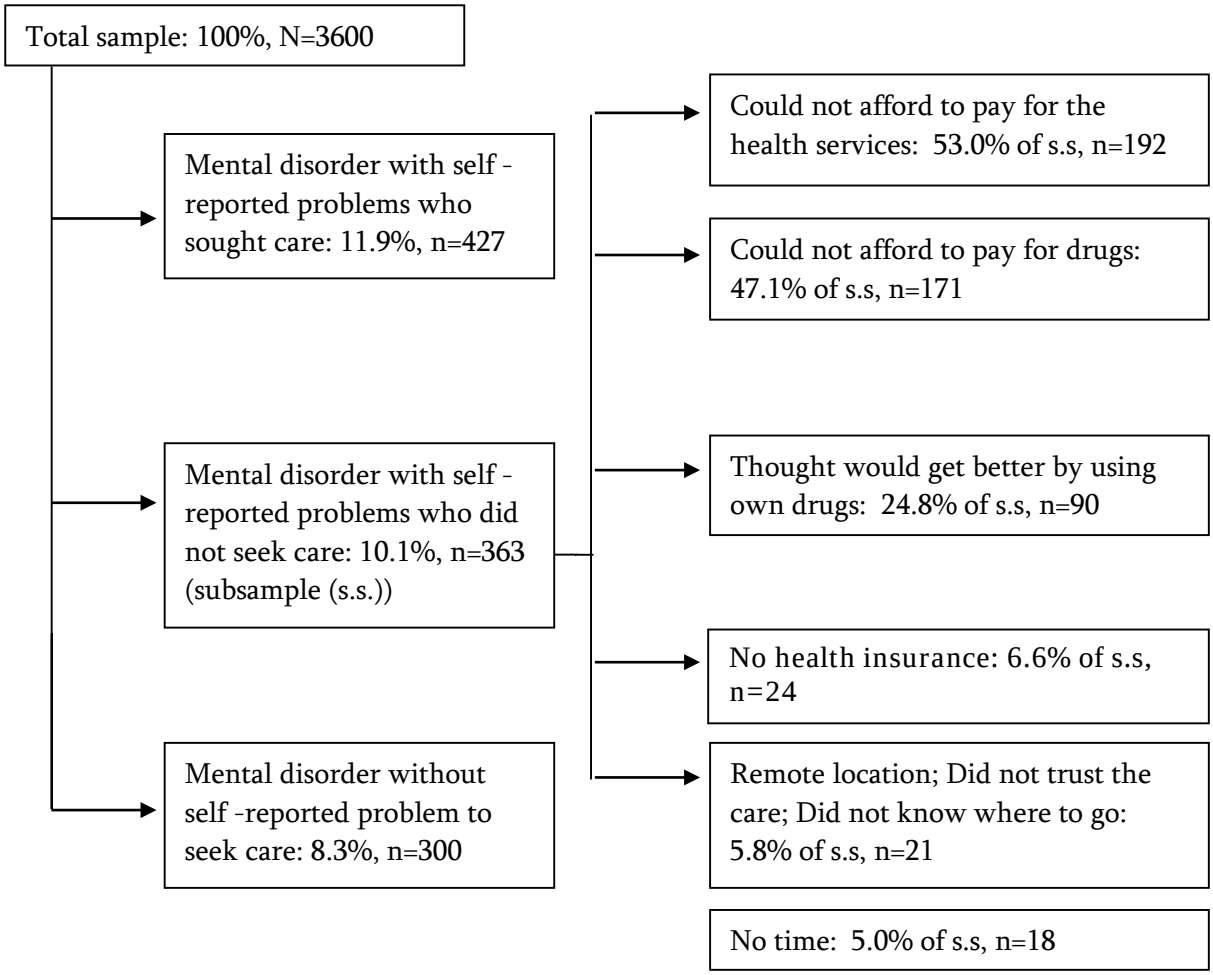
Table 9 shows that a quarter of all respondents reported health problems and sought formal care during the preceding 12-month period. However, it is more informative to focus on those meeting the criteria for having mental health disorders. Thirty nine percent of those with any disorder both reported emotional or behavioural problems and sought care, 33.1% reported problems but did not seek care, and 27.4% did not report problems or seek care. The frequency of those meeting the criteria for specific diagnoses who reported problems and sought care was higher for depression (48.1%), or when more than one disorder was present (47.5%). A third of those meeting the criteria for any mental disorder reported problems but did not seek care. The proportion is similar among those with PTSD, depression, anxiety and having more than one condition.

Table 9: Service utilization for mental health, any emotional or behavioural problems during last 12 months by presence of mental health disorder

	Total	Self-reported problem and sought care			Self-reported problems but did not seek care			Did not have self-reported problem to seek care for		
		n	%	95% CI	n	%	95% CI	n	%	95% CI
Total sample	N=3600	892	24.8	23.4-26.2	1971	19.6	18.3-20.9	706	54.8	53.2-56.4
Any mental health disorder	N=1096	427	39	35.7-42.3	363	33.1	30.0-36.4	300	27.4	24.4-30.5
Comorbidity	N=458	217	47.5	42.9-52.6	79	17.2	13.6-21.5	157	34.4	29.5-39-4
PTSD	N=844	335	39.7	36.4-43.0	234	32.5	29.3-35.6	274	27.7	24.7-30.7
Depression	N=519	250	48.1	43.8-52.4	86	34	29.9-38.1	176	16.7	13.4-19.9
Anxiety	N=394	168	42.7	37.7-47.6	85	34.9	30.1-39.6	137	21.6	17.6-25.7

The reasons why individuals who reported problems did not seek care are shown in Figure 9. Multiple responses were possible. The most common reasons were inability to afford care or drugs, with very few not seeking treatment because they either did not know where to go or had no insurance.

Figure 9: Reasons of not seeking health care in the presence of mental health, any emotional or behavioural problems during last 12 months (multiple answers allowed)



Types of services utilised

Table 10 presents the service providers and types of care used by those individuals who sought health care due to mental or emotional problems, separating those not having one of the mental disorders measured in the study (i.e. PTSD, depression or anxiety) from those with at least one of the disorders. Overall, there was little difference between the two groups. The majority (around 70%) in both groups used pharmacies. General practitioners

were seen by 46.6% of those with a mental disorder but so had 39.8% of those with no mental disorder, around half in both groups consulted neurologist at hospital or outpatient clinic. Those screened as having a mental disorder were more likely to use services specific to mental illnesses, either in health facilities or outreach services, although the latter was rare for either group. A further analysis (data not shown) found no statistically significant difference in the pattern of use among those screened with different mental health disorders.

Insured individuals were more likely to consult GPs for mental health problems than those without health insurance (45.8% and 37.3% respectively, p=0.019), while those insured were less likely to use only a pharmacy than those without insurance (13.8% and 19.8% respectively, p=0.025) (not shown in the table).

The most prevalent type of care was drug treatment followed by counselling and very few received psychotherapy or psychosocial support. No significant difference was found in type of care used between various mental disorders.

Table 10: Type of care used among individuals who contacted formal health services for any mental health, emotional or behavioural problems during last 12 months by presence of mental disorder

	No mental disorder N=465		Any mental disorder N=427	
Type of service provider	%	95% CI	%	95% CI
Pharmacy	72.3	68.2-76.4	69.1	64.7-73.5
Only pharmacy use	17.0	13.7-20.5	13.8	10.6-17.2
GP office /ambulatory / policlinic	39.8	35.4-43.2	46.6	44.2-51.3
Only GP use	29.0	24.5-33.9	28.6	23.9-33.6
Therapist/ Neurologist at Hospital	34.2	29.8-38.4	30.2	25.9-34.7
Neurologist at polyclinic	20.5	16.8-24.2	26.0	21.8-30.2
Outreach/mobile services	4.5	2.6-6.3	7.0	4.7-9.5
Psychiatric dispensary	0.6	0.1-1.1	2.3	1.2-3.9

Psychosocial centre, Private MH specialist	1.9	0.6-3.1	2.3	0.9-3.9
Psychiatric hospital	0.6	0.1-1.2	1.2	0.1-2.1
Type of care				
Drug treatment	81.5	78.0-85.1	90.2	87.2-92.9
Counselling	84.1	80.8-87.5	84.5	81.2-88.1
Psychotherapy/ psychosocial support	2.8	1.3-4.2	4.9	2.9-7.0

Characteristics associated with health care utilisation

The multivariate regression analysis shows that displacement status (Older, New IDPs and Returnees) and economic condition were not associated with the probability of using services. However, being female, being in middle and old age (40 years and up) and having state insurance coverage are significantly associated with higher rates of health service utilization for mental and behavioural problems (Table 11). Those who were employed were less likely to use services (OR 0.70, 95%CI 0.55-0.89). Being screened as having PTSD (OR 1.55, 95% CI 1.29-1.89) or depression (OR 2.12, 95%CI 1.70-2.65) significantly increased odds of service use but anxiety did not in the univariate analysis and so was not included in the final model. Respondents with more than one of the three disorders were more likely to consult health services.

Table 11. Correlates of service utilization, multivariate logistic regression, final model

	n	%	Odds Ratio		95% CI	
Gender						
Male	240	19.1	ref			
Female	652	27.9	1.50	**	1.25	1.80
Age						
18-39	187	15.0	ref			
40-59	343	27.4	1.83	**	1.48	2.26
60+	361	32.9	1.62	**	1.19	2.21

Economic status						
Very good/Good/ average	313	19.0	ref			
Bad/ Very bad	577	29.6	1.19		0.99	1.42
Employment						
Unemployed	298	23.1	ref			
Employed	139	16.8	.71	*	.55	.89
Housewife /on maternity leave	106	23.7	.84		.64	1.11
Retired due to age or disability	343	35.6	1.16		.87	1.56
Displacement status						
Returnee	257	21.2	ref			
New IDP	92	27.5	.93		.70	1.24
Old IDP	542	26.4	.84		.62	1.15
Health Insurance						
No insurance	268	18.0	ref			
Private or corporate insurance	18	23.7	1.44		.82	2.53
Government scheme	602	29.8	1.55	**	1.30	1.86
PTSD						
No disorder	556	20.2	ref			
Disorder	335	39.7	1.56	**	1.29	1.90
Depression						
No disorder	642	20.8	ref			
Disorder	250	48.2	2.12	**	1.70	2.65
Co-morbidity *						
One or no condition	675	21.5	ref			
More than one condition	217	47.4	2.29	**	1.85	2.84

Note: Separate regression model run for (1) socio-demographic variables and PTSD and depression; (2) socio-demographic variables and comorbidity. The results for socio-demographic variables, PTSD and depression are shown from the first model. There were no

statistically significant difference in the results of socio-demographic variables between the first and the second model.

* Co-morbidity is more than 1 disorder of PTSD, depression and anxiety.

2. Findings of the Experts Survey

The data was collected by an electronic survey of mental health experts. For the purpose of the survey, experts were defined according to their working experience in the field of mental health from different countries. Foreign and local experts with substantial knowledge of MH polices and systems and/or with experience of care for trauma affected big groups were identified using purposive sampling procedures. Of the 32 experts invited to participate, 21 returned a completed survey between August 2014 and October 2014. Demographic characteristics of the respondents are provided in Table 12.

Table 12. Demographic characteristics of survey respondents

COUNTRY			
	Georgian	European	Asian
	9 (43 %)	8 (38 %)	4 (19 %)
GENDER			
	Male	Female	
	9 (43%)	12 (57%)	
CURRENT AFFILIATION (MORE THAN ON AFFILIATION MIGHT APPLY)			
	Government	4 (19%)	
	Local NGO	8 (38%)	
	International NGO	3 (14%)	
	International Organization	3 (14%)	
	Academia	11 (52%)	
	Other (service provider)	2 (10%)	
PROFFESION			
	Psychiatrist	11 (52%)	
	Psychologist	6 (29%)	
	Psychotherapist	1 (5%)	

	Political Scientist	1 (5%)	
	Researcher	2 (10%)	
PROFESSIONAL EXPERIENCE (YEARS)			
	MEAN	ST.D	
	20.55	10.075	
AGE			
	25-35	1 (5%)	
	36-50	7 (33%)	
	51-65	11(52%)	
	>65	1 (5)	

Respondents completed questionnaire on the perceived usefulness of different methods to address MH needs of war-affected populations. The questionnaire contained both open-ended and close-ended ordinal response scale questions.

The instrument was developed using a phased process. First, the theoretical models of mentioned above (WHO 'Pyramid of services' and BCM) were employed to identify the range of services offered to people with MH disorders; the services were augmented with the specific ones that are offered to war-affected populations (UNHCR 2013) (IASC 2007). Additional methods, besides the types of services, were also listed for experts' consideration (WHO & Gulbenkian Foundation 2014).

As we were interested in resource-related approach, we have modified the Balanced Care Model (BCM) that offers a range of services according to countries' resourcefulness: we have included questions about high and low & middle-resource areas within the country and asked to reflect on the approach and also type of services appropriate for such areas. We have unified low and middle-resource regions into one category as there is rather small difference regarding MH services in such regions of Georgia.

The experts were also asked to share their opinions and suggestions regarding trauma-informed and trauma-specific services.

The content of the questionnaire was defined – the instrument offered experts the background information on Georgia and data of the quantitative study - prevalence of MH

disorders, their comorbidity, correlation to functional disability, and service utilization patterns.

The definitions of pre-selected services as methods were included in the annex section of the instrument; an explanation of trauma-informed and trauma-specific services was provided as well.

Before final utilization, the entire survey was completed as a test run by two foreign and two local experts. Changes to the survey were made based on their feedback. The questionnaire initially was composed in English; then translated into Georgian.

Using 1-5 ordinal scale (1= *not at all useful* to 5= *very useful*), respondents were asked to rate how useful they found different methods for working with war-affected populations from their experience. They also were provided a *not applicable* option for each method, denoting that the method has not been used in their experience. Respondents were also provided with opportunities to write freely about other important factors, not included within the pre-defined methods, that they felt were important expanding community based services for the target groups.

Besides, the experts were asked to identify the three most effective/useful services to address mental health needs of war affected population in low/middle resource and higher resource areas, rate some additional methods using 1-5 scale and comment on the resource-related service development approach for Georgia and share their understanding of trauma informed care, trauma-specific services and their interaction. Additional open-ended questions were stated for local experts only to specify the essential MH services that would meet needs of war affected populations in relatively low/middle resource and relatively high resource areas in Georgia.

Responses were tabulated and summarized to identify those services that participants were most likely to rate as quite useful or very useful for war-affected population. A summary is provided in table 13.

Table 13. Highly rated types of services for war-affected population: percentage of respondents rating service as “useful” or “very useful”

RANK ORDER	TYPE OF SERVICE FOR WAR AFFECTED POPULATION	PERCENTAGE OF RESPODENTS RATING SERVICE AS "USEFUL" OR "VERY USEFUL"
1	Psychosocial interventions	95
1	Community Mental health centres/Mental health outpatient facility/Ambulatories	95
2	Primary Healthcare Facilities/Policlinics	90
3	Crisis Intervention /crisis resolution teams	81
4	Mobile groups/Outreach teams/Home treatment	76
5	Rehabilitation services	72
5	Informal care	72
6	Community-based mental health inpatient unit/ acute department within general hospitals	57
6	Mental health day treatment facility	57

Psychosocial interventions and Community Mental health Centres /Outpatient facilities were rated as “quite useful” or “very useful” by 95% of respondents.

Several arguments for the psychosocial interventions are reported. One of them deals with its contextual nature. “ *. . . Interventions are crucial as they aim at tackling not only intra-psychic impacts of exposure to violence, but contextual ones, too,* ” “*it includes family members also*”. According to other experts psychosocial intervention is aimed at “*rehabilitation as well as prevention of mental health problems* ” and it enables “vulnerable populations to receive services without stigmatization”.

The most of respondents who rated effectiveness of community mental health services highly consider it as first choice service for war-affected population. “*The bulk of the efforts and funding should be directed to establish such services (together with PHC)*” – reports one

of the experts. Several reasons are described to argument the position. First of all Community mental health centres are easily assessable as it is considered to be closer to the survivors' community. Besides, this is the component of the service provision wherein the most of survivors' needs can be met. And finally, it enables to establish referral mechanisms, which keeps the number of clients low in specialized clinics by stopping revolving door patients. The main problem that can be encountered with the community mental health service is dealing with stigma. "*The advantage of a national center would be more anonymity for help-seeking survivor, being assisted of its own community in cases where seeking assistance is associated with a stigma of being a MH patient*". Another problem is connected to the lack of human resources in regions where there are many war-affected communities.

Next, primary healthcare facilities were rated as "quite useful" or "very useful" by the 90% of respondents. Besides the concerns about the primary health care workers qualifications local as well as foreign experts share the opinion on the effective use of primary health care facilities. Most experts report that in case primary care practitioners are well trained and supervised by the mental health professionals, it could be very useful service. As one of the experts reports " *. . . this is the key gap in many countries and should be the focus*". Some experts refer to the "MH gap" as a valuable resource for doing this. Three main reasons are reported; it is the most cost-effective service; it is accessible, especially in regions and it serves as a good mechanism for case detection and referral. Few experts doubt about the effective use of primary healthcare facilities in treating war-affected population and consider them only for referral system. One of the local experts - rating the service as "very useful" - considers ambulatory services to be integrated in primary health care facilities.

Crisis intervention/crisis resolution teams were rated as "quite useful" or "very useful" by 81% of respondents. In the word of one of the respondent "*people with PTSD and/or depression caused by war trauma are prone to crisis, so it is important to establish crisis resolution team addressing their needs during the crisis*". This type of service is reported to be especially useful for providing psychological firsts aid and referral immediately aftermath of traumatic event. Few experts suppose using crisis intervention services as only supplementary to other services. According to the local experts, who share the opinion about the effectiveness of the service, crisis intervention service is "*implemented sporadically and*

upon initiatives of non-state actors", " *. . . it is not financed by the government, we lack the qualified specialists, especially in region*".

Mobile groups/outreach teams/home treatment is also one of the highly rated service; 76% respondents rated it as "quite useful" or "very useful". The experts report several reasons; First of all it is "*important because war impacts a survivor and its context, and it is necessary to have means to influence the context. Outreach teams can provide a great assessment of contextual variables*"; Moreover, "*... stigmatization may be diminished in case of home visits*" and it is "*good for follow up, adherence to therapy*"; and finally it is most cost effective service among the community based mental health services as one multidisciplinary team can provide service to several compact settlements. Some experts consider some kind of overlap with other services. One of the expert reports that "crisis interventions including home visits", other consider it as part if the ambulatory service but in any cases it may be utilized effectively either with severe mental illness or for any "special cases".

Rehabilitation services were rated as "quite useful" or "very useful" for trauma affected population by the 72 % of respondents. Although some experts consider it more relevant for people with chronic conditions; "*Generally speaking this is not the case of war-affected populations*" - reports one of the experts. Others think that it is very useful specifically for its long-term nature as it enables to strengthen the achieved results after trauma and helps family members to deal with the great burden they have.

The same number of respondents (72%) rated informal care as "quite useful" or "very useful". Two main forms of informal care have been mentioned as very effective, self-help groups and care provided by informed family members. As we read in additional comments "*families are very valuable resource"* and in case they are well informed (psychoeducation) and supported they can greatly strengthen the natural processes of healing; "*engagement of family, friends and community in survivor's rehabilitation is a strong way of empowerment.*" As for self-help groups it is important as it prevents from secondary benefit, which often is the case in working with victims. However, Experts strongly note the necessity of professional support "for the sake of "non-nocere" principle".

Community-based mental health inpatient unit/ acute department within general hospitals and mental health day treatment facility are the last by ranking from highly rated services.

57% of respondents rate them as "quite useful" or "very useful". The majority of experts who provided additional comments on community based mental health in patient unit/acute department within general hospitals do not consider it relevant for affected population, stating that *"People suffering from war trauma hardly ever need inpatient treatment", "Most of the MH problems do not need acute interventions or are in need for inpatient treatment. These are reserved just for a minority of the war affected survivors".* According to them this kind of service could be relevant only in cases of high risk of suicide, psychosis, comorbid cases or other exceptional cases needing intensive, 24 hour care. Few experts, mainly local ones consider community mental health inpatient unit very important as it prevents IDPs from traveling to long distances.

Mental health day treatment centres are considered to be very useful in IDP's settlements or in regions with higher number of war affected populations. "*In case it is in densely populated region, the day center should provide service for trauma affected people in general both for IDPs and local habitants*". Few experts remain doubtful about necessity of intensive treatments noting, *"This service is intended for people with severe mental illness, "the majority of people with war-related traumatic disorders do not need this treatment".* Local expert exclude the possibility to establish this type of service in Georgia.

Three types of services were rated as less useful. Table 14 displays these services all of which were rated as "quite useful" or "very useful" by fewer than of 50% respondents.

Table 14. Types of services for war-affected population rated by fewer than 50% of respondents as: "useful" or "very useful"

RANK ORDER	TYPE OF SERVICE FOR WAR AFFECTED POPULATION	PERCENTAGE OF RESPODENTS RATING SERVICE AS "USEFUL" OR "VERY USEFUL"
9	Other specialists	48
10	Community residential health facility	24
11	Mental hospital	14

Relatively small number of respondents considers the necessity of other specialists in treating war-affected populations. Part of them, who provided with additional comments, does not recommend "specialized" treatment and care. "*Mental health problems of war affected populations should not be treated separately by separated specialists*", they need more assistance in dealing with their "*social and legal problems . . . so social (non-medical) service [is needed]*"; Those who consider involvement of other specialists think that apart from the typical multidisciplinary team neurologist, paediatricians, counselling or school psychologist, psychotherapist, gynaecologist, physiotherapist and lower would be useful according to the clients' needs.

Community residential health facility was rated as "quite useful" or "very useful" by the 24% of respondents. Those who provided comments bout this type of service suppose it effective in special cases, e.g. *"for clients without families",* or those with "long-term mentally ill patients who have no other residential facilities" or those who are affected by the family violence. So experts share the opinion that this type of service could provide shelter for trauma-affected people. One of the expert considers it ineffective even in this case; he suppose one or several residential facility to be established in each region which provide shelter for other citizens as well as for war affected ones.

Mental hospitals were rated as least effective and not useful service. Only 14 % of respondents rated it as "quite useful". The most of the experts consider avoiding clients to be placed in closed institutions as it may increase risk of invalidating them, especially in Georgia. It suppose to have more negative effects on war-affected population; *"Mental hospital may represent a risk factor for war-affected populations rather than a therapeutic interventions."* Local as well as foreign experts share the opinion that it is the least effective service not only for war-affects palpation but also for any human being with mental health problems. Even in acute cases they prefer different types of services, which exclude long term stay in hospital. *"We seriously advocate against such institutions"* – reports one of the experts.

Resource-related ratings

Despite the rating the effectiveness of services from their experience, experts were asked to consider the possibility of using them in low/middle and higher resources areas and choose

the three the most effective one fro each type or region. In table 15 and table 16 the most effective services are displayed for low/middle and higher resource areas respectively.

Table 15. Types of services most frequently rated as effective or useful in low and middle resource area

RANK	TYPE OF SERVICE	NUMBER OF EXPERTS (%)
1	Psychosocial interventions	61.9
2	Primary healthcare facilities	52.4
3	Informal care in communities	47.6

Table 16. Types of services most frequently rated as effective or useful in higher resource area

RANK	TYPE OF SERVICE	NUMBER OF EXPERTS (%)
1	Crisis Intervention teams	33.3
2	Community mental health centres	23.8
2	Mental health day treatment facility	23.8
3	Rehabilitation services	19
3	Inpatient care in general hospitals	19

As seen from the data presented in tables above, psychosocial interventions are considered to be the most effective, first choice option for both low/middle and higher resources areas. It is noteworthy that this type of service is rated as most effective from experts' experience. Primary healthcare facilities and informal care are considered to be the next most effective services for the low/middle resource areas. As for higher resource areas more than 3 services were chosen as they were rated by the same number of experts and shared the same rank. Crisis intervention centres together with psychosocial interventions seems to be the first choice services for the higher resource areas. Primary healthcare facilities, community mental health centres and mental health day treatment facilities rated by the 23.8% of respondents as the most effective, share the second rank for the higher resource areas. The next choice falls on rehabilitation services and inpatient care, rated as most useful by the 19% of respondents.

Despite the discrepancy in numbers of services for low/middle and higher resource areas, it is interesting that each service chosen as most effective for the low/middle resource area are rated as such by approximately 50% of respondents while services allocated for the higher resource areas are rated by one third of respondents. Such a discrepancy maybe caused by the variety of services available in higher resource areas.

It is also noteworthy that no residential service is chosen not for the low/middle resource areas nor for higher resource areas and we see the inpatient care as one of the most useful service only in higher resource areas.

Additional Methods

Experts rated also additional methods that might be useful to develop the appropriate services for conflict-affected populations. Table 17 summarizes the "useful" and "very useful" ratings.

Table 17. Additional methods for war-affected population: percentage of respondents rating service as "useful" or "very useful"

RANK ORDER	ADDITIONAL METHODS FOR WAR AFFECTED POPULATION	PERCENTAGE OF RESPODENTS RATING SERVICE AS "USEFUL" OR "VERY USEFUL
1	Capacity building of professionals	95
1	On-going performance improvement and evaluation	95
2	Training, supervision and supporting primary health workers	91
3	Programs and strategies at regional levels/municipalities	86
4	Finances	81
4	Advocacy via-a-vis Central and local government	81
4	Evidence-based and emerging best practices	81
4	Research	81
5	Early screening for trauma histories and assessment	76
5	Awareness rising on MH issues	76
5	Employment and vocation training	76

As indicated in the Table above, most experts found capacity building of professionals alongside with on-going performance and evaluation most useful methods (95%); Training, supervision and supporting PHC workers is rated as 91%. Regional level, community-tailored programs and strategies are also ranked as third most useful methods (86%). 81% is provided to finances, advocacy, evidence-based practices and research methods. Interestingly, employment and vocational training was rated rather low (76%), alongside with awareness rising on MH issues and early identification of trauma symptoms. This is suggestive as vocational training and sheltered employment activities are the elements of the highly rated psychosocial interventions.

Qualitative Results of the survey

1. Type of Services

Experts rate psychosocial interventions as the most useful method to meet the needs of target population. They comment, *"In most cases these interventions may be even more useful than traditional psychopharmacological treatment".* However, we should be aware that – as one of the experts explain, *"here we do not talk anymore about the setting, but an intervention. Within the contextual approach, these interventions are crucial as they aim at tackling not only intra-psychic impacts of exposure to violence, but the contextual ones, too".* One expert warns that *"more evidence on what psychosocial interventions actually mean, and whether and how they work"* is needed. Another comments that *"Psychosocial interventions alongside with pharmacotherapy: would lead to the balanced approach to interventions".*

While discussing community MH centres/MH outpatient facilities/ambulatories some experts state that *"must be considered as the first choice service for war-affected populations"* and *"This would be a priority"*; also *"The bulk of the efforts (and funding) should be directed to establish/expand/reform such services (together with integration in PHC)".*

Most experts agree that these services are *"the most important component of the services provision wherein the most needs of survivors can be met. Moreover, community center is preferred beyond a national center since it is closer to the survivors' community and more easily accessible. The advantage of a national center would be more anonymity for the help-*

seeking survivor, being assisted outside of its own community in cases where seeking assistance is associated with a stigma of being a MH patient".

Regarding the crisis intervention/crisis resolution teams one expert introduces the phases of emergency and states *"these services should be utilized afterwards of acute situation, i.e. after the catastrophe, for the primary psychological assistance, for acute cases and for referrals".*

Mobile teams/outreach teams/home treatment is considered *"Very important because war impacts a survivor and its context, and it is necessary to have means to influence the context. Outreach teams can provide a great assessment of contextual variables. Moreover, here again stigmatization may be diminished in case of home visits"*. One expert again warns that they are *"potentially important but need much more evidence on their sustained effectiveness".*

Rehabilitation services *"need to be well-defined";* one expert states that rehab services should be incorporated in package delivered by mobile teams or offered by community MH centres; another remarks *"Also very important, because healing is not only about lowering of symptoms of MH complaints, but about enhancing one's functioning in daily life"*.

Experts are not very elaborative regarding the informal care. One of them mentions, *"I think about self help groups which may be important"* and another states, *"Need more evidence on how informal care can be effectively, ethically and safely delivered"* and another adds *"- Often informal care provided within the community is a very useful complement to specialist care"*.

Community –based MH inpatient unit/acute department within general hospitals is considered *"Useful only in exceptional cases, namely during acute crisis needing intensive hospital care"* and *"when the trauma is fresh or we face an acute trauma or complicated comorbid conditions".* Though one of them comments, *"Not convinced by a lot of inpatient provision in terms of cost-effectiveness"*.

One expert assigns the specific tasks to mental health day treatment facility: *"Can be important in case of more intensive treatments, for example in group settings"*.

Regarding PHC, there are statements as *"Provided that PHC personnel are trained to manage mental health problems, this kind of services are probably the most cost effective"; "I suggest that this would be possible only in case of additional training, and sufficient time*

investment" and *"From my understanding, this is the key gap in many countries and should be the focus".*

Experts remark on "Other specialists" as follows: *"Not sure who – a multidisciplinary mental health team is vital with access to other specialists as required, e.g. for physical co-morbidities"* and "*Social (non-medical) services to assist in getting life back in order and solve social and legal problems".* Another expert shares his experience *"We use gynaecologists, paediatrician and others to provide services for Gender-Based Violence survivors and child protection services as partners with us. This will work if they are really motivated"*. Other assigns referral function to other specialists.

Almost all of them share the same position regarding Mental Hospital "may represent a risk factor for mental health war-affected populations rather than a therapeutic intervention".

2. Resource related service development in Georgia

The most experts believe that services should be distributed according to the local resources considering both human and infrastructural resources. Foreign experts, not familiar with Georgian context, consider specialized services to be established only in big cities; services, recommended for low and middle resource areas can be established in regions. One expert shares that in his country *"We use community workers selected from the displaced communities and trained by us to work in the communities. They have excellent connections within their communities and are trusted by them"* – this is an example of the low resource area (in Sri Lanka).

They strongly oppose to traditional psychiatric hospitals as a component of balanced care model.

Local experts fully share the importance of balanced care and advantage of out-of-hospital services. They consider *'figuring out the best available service and not the best practices';* one of them comments *"it is very important while implementing the strategy and action plan to be guided not by the notion of "an effective service", but by the awareness of what could be effective in limited resource conditions in this concrete country".*

As there are many low & middle resource areas in the country, easily accessible, mobile and cheap services should be developed, which "*will provide services to as much as possible to*

the large part of population". One of the experts notes, "In order the public health principles to be in place the psychiatric units should be established in general hospitals and non-hospital services, day centres, mobile groups, etc. should be developed which will provide psychosocial and rehabilitation services".

According to the local experts three services – Community mental health centres, mobile groups and psychosocial interventions – are considered to be effective in both big cities (Tbilisi, Kutaisi, Batumi) and regions. Primary health care facilities are rated also as useful for low and middle resource areas in Georgia, but not for the big cities/high resource areas. Acute department within general hospital, crisis intervention, rehabilitation services and mental health day treatment facility are reported to be effective for the higher resource areas. Local experts consider some *"mixed services to be cost effective",* e.g. mobile teams providing crisis intervention as well as psychosocial intervention.

Data gained form the expert survey suggests psychosocial interventions to be one of the most effective services for war-affected population. Both foreign and local experts rate it as useful or very useful for low/middle and high resource areas. The psychosocial intervention is the intervention using primarily psychological or social methods for the treatment and/or rehabilitation of a mental disorder or substantial reduction of psychosocial distress. It includes: Psychotherapy; counseling; activities with families; psycho-educational treatments; the provision of social support; rehabilitation activities (e.g. leisure and socializing activities, interpersonal and social skills training, occupational activities, vocational training, sheltered employment activities); also includes broader psychosocial support activities, as First Psychological Aid, community mobilization, etc.

The overall evaluation and allocation of useful services in low and middle resource areas are very similar to those indicated specifically for Georgia (rated by local experts). All types of services rated as potentially effective for Georgia for (for the low/middle as well as high resource areas) are also rated as useful or very useful by the majority of respondents. (Table 5.). The local experts do not consider only informal care. A minor discrepancy is found in service allocation for low/middle and high resource areas. In contrast of the overall evaluation, Georgian experts consider mobile teams as very effective for both areas, as it enables to reach more people and provide mixed services. Besides, they consider community

mental health centres to be effective for the law resource areas, while in the overall evaluation the services is considered to be effective only for high resource areas (Table 8). Another discrepancy is revealed in services defined as effective for higher resource areas. The Most of Local experts do not consider the primary health care and inpatient services. On the one hand, part of local experts suppose that it is important to find out services that could reach "as many as possible" in the affected populations, but, on the other hand, most of them do not consider the informal care and primary care facilities to be the target point.

3. Using Trauma informed and trauma specific services

The most experts share the understanding of trauma-informed care and trauma-specific services as well as the opinion about their coordinated, combined use for trauma affected people.

Trauma informed care is understood as an approach or treatment framework, which takes into consideration that a person or population has been exposed to traumatic stressors, recognizes their possible impact on mental health (of that person/population) and plans and delivers general MH or primary healthcare service according to their needs.

"Trauma-informed" services should be considered as the most rational and balanced approach for majority of countries," comments one the experts. The Trauma informed care can be provided by the general or primary healthcare facilities and /or through the informal care, by *"...peers, consumers, survivors, ex-patients ... mentoring by professionals".* One the respondent recommends, "*Integration into general health services is to be promoted".*

Trauma-informed services are also considered as a sort of filter for trauma-specific services, which will ensure screening and referral - *"In my view trauma-informed care should be able to deal with most of the issues and work as a sort of filter for trauma-specific services, in a way that a general practitioner should be the filter for mental health care services (which is at least theoretically the case in e.g. The Netherlands)".*

Somewhat different assumptions have experts about the volume /content of the trauma informed care. Some experts, mainly Georgian ones, state, "They do not provide treatment or rehabilitation". In contrast, some experts suppose that trauma informed services can treat the symptoms and syndromes related to current or past trauma and only in case of very complex, co-morbid disorders individual should be referred to the trauma-specific services.

Trauma-specific services imply an array of interventions aimed at treating trauma-related conditions; they may include different methods - CBT, Exposure Therapy, EMDR and others. Despite the method used, trauma-specific services are considered as one of the care component in the comprehensive treatment model, which will serve only to a small number of clients.

In general, most of the agree, *"Trauma-informed care is more general whereby all care is informed by a person's trauma history. Trauma-specific services focus on the trauma/those affected by trauma. I see trauma-specific services being more specialized and focused – all trauma-specific services should practice trauma-informed care, but not all trauma-informed care is trauma-specific".*

Most our respondents share the opinion that coordinated use of both types of services according to the clients' needs will ensure the continuous chain of care, as *"...their interaction will insure links between screening, referral, diagnosis, treatment and follow-up* ". "*The interaction is that any mental health care model in a conflict affected setting should be developed with a trauma-informed perspective, and one of the care components in the overall care approach/ spectrum should be trauma-specific treatment".*

Favoring this approach, experts also mention current threats and unmet needs as well as involving other then medical domains in interventions: *"I would think that trauma-informed care is probably the more useful approach, as it does not seem to put as heavy an emphasis on past trauma only. I think that distress symptoms may sometimes in fact be due to a complex interaction of different issues, including past trauma, but also for example current unmet needs. There is the possibility that some of the distress symptoms may be alleviated if these unmet needs are addressed and resolved";* "*Most of the issues should be dealt with in a non-medical or as-little-medical-as-possible manner".*

Few experts share their doubts about using the trauma-specific services for traumatized large groups. They consider more useful and effective specific services/programs to be integrated into general health services and to have trained staff, which can treat symptoms and syndromes related to trauma. "*I do not see the need of trauma-specific services and there is enough evidence of failure . . . when it was applied in large scale . . .* (refers to the post-war

situation in Bosnia). *What is needed is the presence of trauma specific staff working in normal services rather than trauma specific services*."

To summarize, *"Trauma informed care implies a taking into consideration specific, potential needs of individuals and/or communities affected by traumatizing events in the planning and delivery of general MH or primary healthcare services. Trauma specific services imply an array of interventions aimed at treating trauma related conditions. Trauma informed care contributes to effective planning and implementation of trauma specific services".*

V. Interpretation/Discussion

The paper on Georgian MH system highlights the need of integrating existing services and care for vulnerable groups (Makhashvili and van Voren, 2013). One of the big challenges in the reform process is the integration of rather fragmented programs and services. Some of them are under the roof of one and the same Ministry (MoLHSA); others are still independent and not integrated into the system. Changing this situation is a huge challenge and calls for a careful approach, as one has to deal with vested interests and a lot of anxieties about one's future roles and positions.

A big challenge to the reform is a lack of evidence that would guide the policy decisions. Apart from the care of people with severe mental disorders, the State should pay attention to the vulnerable big groups.

One of target groups that need to be considered separately is the war-affected population. Georgia went through a period of civil war (1991-1993) and breakaway regions (e.g. Abkhazia and S. Ossetia) as well as a short but very damaging war with Russia in August 2008. Currently, the country still has a large number of internally displaced persons (IDP's). To implement the National Strategy and Action Plan on MH successfully the policy-makers and professionals should be provided with reliable data and scientific insight into the problem.

The specific aims of the current study were twofold. The first aimed to identify prevalence of common mental disorders, their comorbidity and an impact on disability among three conflict-affected big groups as the 90's IDPs, 2008 IDPs and Returnees; and the second aimed to collect experts' opinion on relevant and effective mental health services for these groups to elaborate a set of policy recommendations.

Common MH problems among conflict-affected groups

This is one of the large studies in Georgia on the effects of war and displacement on civilians displaced within a war-torn country (Makhashvili, et al., 2015). The study provides the first representative data of adult IDP and Returnee populations and attempts to address the

research gap in a challenging investigation of common mental disorders in war-affected populations. The importance of the study, besides its epidemiological character, is that it explores long-term MH consequences among different conflict-affected groups in LMICS, and also compares IDPs with the Returnee population.

There is a rich body of research conducted in refugees emigrated in Western countries, but literature is rather scarce for LMICs and especially on returned and resettled former IDPs (e.g., Priebe et al. 2010; de Jong et al 2003; Başoğlu et al. 2005).

Some authors researching the LMICs, found out that the prevalence of mental disorders is similar to surveys in Western Europe, though unmet need for treatment is considerably higher than in Western countries (Karam et al. 2006; Karam et al 2008).

Our study recorded levels PTSD, depression and anxiety of 23%, 14%, and 10%, respectively, for the combined study sample. The findings show the persistence of PTSD, particularly among 1990s internally displaced persons. The levels of anxiety and depression in our study are lower than the rates of depression (70%) and anxiety (73%) recorded in the study of elderly internally displaced persons in Georgia (JHBSPH/IPS, 2012), but older age was associated with mental disorders in our study as well.

Research findings show that common mental disorders are frequent in post-conflict countries. This is in line with other studies. Levels of mental disorders reported among internally displaced persons and refugees globally vary considerably but estimated overall averages for PTSD and depression among conflict-affected civilian populations globally are around 30%; with the variances in prevalence between studies reflecting differences such as levels of exposure to traumatic events and daily stressors, time-periods, population types, study sampling, instrument selection and cut-offs (Porter and Haslam 2005; Steel et al. 2009).

Ethiopian refugees living in temporary shelters exhibit rates of PTSD, depression and anxiety of 15.8%, 5.2% and 9.6%, respectively (de Jong et al 2002). Cambodian displaced persons reported 15% and 55%symptom scores for PTSD and depression, correspondingly (Mollica et al. 1993, 581–586). PTSD symptom rates among refugees were reported to be 17% after the end of the war in Kosovo (Lopes 2000, 569-577).

The data for the prevalence of diagnosed common mental disorders in postconflict communities is scarce (de Jong et al 2002, 2128-30). Moreover, the recorded levels differ due

to sample characteristics, but different measures/instruments might account for the discrepancy as well. Some authors argue that the postconflict psychiatric research in LMICS has been based largely on non-representative samples and focused on symptoms rather than on full psychiatric diagnostic assessment (Van Ommeren et al 2001, 475–482).

Difference between IDPs and Returnees

The study findings provide deep insight into the conditions of IDPs and the big groups of previously uprooted population who have returned to their original villages - Returnees. This is the first study of this size to address this question of difference in mental conditions of such groups. *Originally, we hypothesized that the both group of 2008 IDPs and Returnees would have been exhibiting the almost same rates of problems as they were exposed to similar traumatic experiences and current threats though* different still are severe.

The rates as showed in findings section, differ for the 3 main groups of the study:PTSD rates are 27%, 22.9% and 17% for the 90's IDPs, 2008 IDPs and Returnees, respectively; Depression levels are 18.7%, 9.9% and 7.2, correspondingly and anxiety – 13%, 9.2% and 6.6% again. So, we see app. two times less depression and anxiety in Returnees and considerably less level of PTSD as well.This evidence suggests that returning to the original location/venues, even if these environments are relatively non-safe and are source of tension, influences mental wellbeing and recovery.

The data do not provide a clear explanation for the variance in levels of mental disorders between the three study groups. Potential explanations include that the 1990s conflict was much longer than the 2008 conflict and characterized by greater brutality as evidence by higher exposure to traumatic such as witnessing murder and violence and suffering physical abuse.

Mental disorders may also become entrenched over sustained period of time when also coupled with lack of access to adequate care and treatment as appears common in Georgia (Makhashvili & van Voren, 2013).

On-going impoverishment and poor living conditions may also exacerbate existing disorders such as PTSD or contribute to causing mental disorders such as depression and anxiety (Makhashvili, Tsiskarishvili and Drozdek 2010; Miller and Rasmussen 2010). Further

research is required on the persistence of mental disorders in long-term displaced populations and returnees and the effectiveness of interventions to address them.

The findings show significantly better mental health among Returnees than the 1990s internally displaced persons and even 2008 IDPs. The higher rates of mental disorders among the displaced are consistent with previous research examining the influence of forced displacement on mental health (Porter & Haslam, 2005; Steel et al., 2009). The findings contribute to the limited evidence globally on returnees, particularly as existing research has focused on returned refugees rather than returned internally displaced persons (Roth, Ekblad, & Agren, 2006; Toscani et al, 2007; von Lersner, Elbert, & Neuner, 2008). Studies indicate that IDPs may be at increased risk of trauma exposure compared to returnees, possibly due to the continual insecure and violence prone environments (i.e. compare with Sri Lankain sample in Husain et al. 2011, 522-531; Siriwardhana et al. 2013).

Persistence of MD over time

We have studied current mental disorders - symptoms assessed within the 1-2 weeks prior to the interviews. Thus, these rates reflect the present and on-going conditions of target populations and need to be discussed further as time passed from the exposure to conflict and war is substantial, especially for the 90's IDPs – app. 18-20 years; 2008 IDPs (and Returnees as well) were uprooted and exposed to traumatic events 3 years before the study. The challenge here is to reflect whether these levels of common mental disorders were higher in previous years and have decreased over the time?

Systematic studies on the long-term mental health consequences in war-affected communities are still rare (Priebe et al. 2010, 518-528). Most of the existing research evidence is on war veterans rather than civilians (Ager 1993; de Jong et al. 2003; Lee et al.1995, 516- 522; Shlosberg and Strous 2005, 693- 696; UNICEF 1986).

Within Western countries, a study in the Netherlands showed that experiences in World War II might still negatively affect mental health even 50 years after the end of the war (Bramsen and van der Ploeg 1999, 350- 358).

Studies are rather contradictory about the persistence of symptoms - stability or change of mental disorders across time. PTSD is the most widely researched disorder and surveys of

this nature generally pertain to large-scale epidemiological studies that are often retrospective (e.g., Kessler et al. 1995:1048–1060.) or based on combat veteran samples (e.g., Solomon and Mikulincer 2006, 659–666).

Overall, studies based on varying trauma samples have tended to report that PTSD symptomatology decreases across time (Riggs, Rothbaum and Foa 1995; Rothbaum et al 1992, 455–475; Van Griensven et al. 2006, 537–548; Wu and Cheung 2006, 923–936). Nevertheless the evidence of decreasing symptoms and levels remains still sparse - particularly for refugees and IDPs and who returned to their home areas.

Other studies have reported increasing PTSD symptoms (Kahana 1992; Clipp and Elder 1996; Port, Engdahl and Frazier. 2001). Remarkably, the large majority of studies that have reported an increase in PTSD symptoms across time are based on veteran samples and not civilians.

There is the rarer occurrence of delayed onset PTSD symptoms as well (Clipp and Elder1996; Koren, Arnon and Klein 1999, 367–373).

A recent study reported the occurrence of all three in one sample: decreasing, increasing, and delayed onset. Thus, it is reasonable to assume that varying PTSD trajectory groups exist. Whether the varying trajectories are a result of the varying sample characteristics is not clear.

Kohrt et al. (Kohrt et al. 2012, 268–275) recorded data before and after a period of conflict in Nepal and found that anxiety increased after war exposure, but high levels of depression remained constant, being closely related to persisting conditions of poverty. Their study shows that depression increased from 30.9 to 40.6%; anxiety increased from 26.2 to 47.7% and post-conflict post-traumatic stress disorder (PTSD) was 14.1%.

Mollica and authors (Mollica et al. 2001, 546-54) found that in 1999, 45% of the original respondents/Bosnian refugees who met criteria for depression, PTSD, or both continued to have these disorders and 16% of respondents who were asymptomatic in 1996 developed 1 or both disorders.

Our study could not provide the insight into trajectory of the symptomatology, since there is no information on pre-war prevalence estimates of our population; thus, we could not speculate about the dynamics of the mental conditions, though possibility of generally elevated rates of mental disorders cannot be excluded.

Exposure, age, sex and other factors

The study also highlights a number of factors associated with the mental disorders, including trauma exposure (particularly cumulative exposure), sex, age, education status, and daily stressors such as low household income and poor community conditions, and these findings reflect those from other studies of conflict-affected civilian populations (Miller and Rasmussen 2010; Porter and Haslam 2005, 602-612; Steel et al. 2009, 537-549.).

The association between an exposure to number of traumatic events and post-conflict socio-economic hardship and increased prevalence of psychiatric disorders, particularly PTSD, depression and anxiety has been documented numerous times in studies of displaced and non-displaced civilian survivors of war trauma in different parts of the world (e.g. Porter and Haslam 2005).

Some research found the psychiatric morbidity was strongly associated to experienced traumatic events even after 20 years of displacement (Sabinet et. al. 2003, 635-642). Experience of violence connected with armed conflict was associated with higher rates of disorder that ranged from a risk ratio of 2.10 (95% CI 1.38-2.85) for anxiety in Algeria to 10.03 (5.26-16.65) for PTSD in Palestine (de Jong, Komproe, and Van Ommeren 2003, 2128-30).

The strongest predictors of PTSD, depression and anxiety in our study were cumulative traumatic events (2 events, 3 and more events) and this finding is consistent with previous studies which showed that exposure to events and perceived stressfulness determines traumatic stress in war and torture survivors (Letica-Crepulja et al. 2011, 709–717; Basoglu et al. 2005, 580–90; Basoglu and Paker, 1995, 339–50)

In our sample the older age appeared the risk factor for all mental disorders. Persons above 60 years demonstrated highest rates of all 3 disorders as 37%, 22.9% and 16.3% for PTSD, Depression and Anxiety, consequently. Some studies support our findings and demonstrate that older respondents have higher levels of depression symptoms (Cardozo et al. 2004, 575-584) though there are studies that attribute younger age to high morbidity (Brewin, Andrews and Valentine 2000, 748–766).

Women were more vulnerable as well, showing rates of 25.6%, 15.4% and 12% for PTSD, depression and anxiety accordingly while men exhibited 18.7%, 11.4% and 7.6% of PTSD, depression and anxiety. This is consistent to other studies that document women

vulnerability to common MH disorders. Brewin and authors in their meta-analysis (Brewin, Andrews and Valentine 2000, 748–766) concluded that for some populations, factors such as being of female gender were regarded as risk factors.

This finding supported our hypothesis that internally displaced persons from war settings endure socioeconomic disadvantage, problems in family functioning, lack of access to occupational opportunities, loss of social support, and perhaps marginalization and isolation.

It needs to be noted, however, that high levels of MD is not possible to attribute this negative impact on life domains to displacement only, because our study participants were exposed to multiple war-related traumatic events, which have independent effects on adaptation and mental morbidity.

Co-morbidity of mental disorders

The study shows quite high levels of co-morbidity, with over 40% of respondents with a disorder having more than 1 mental disorder. PTSD has been found to be associated with high levels of co-morbidity in other settings (Ayazi et al. 2012; O'Donnell, Creamer and Pattison 2004,1390-1396), but in our study co-morbidity rates amongst those suffering with depression and anxiety (c. 80%) are significantly higher than for those with PTSD.

It is important to note that both exposure to traumatic events and these mental disorders are also associated with hazardous and harmful alcohol use, with alcohol consumption used as a form of self-medication to ameliorate symptoms of these disorders. The paper published by my co-authors (Roberts et al 2014) discusses the harmful alcohol consumption among our target groups. The data illustrated that 71% of men were current drinkers, compared with 16% of women. 14% of men drank more than once a week, compared to less than 1% of women. Wine was the most consumed alcohol beverage (53% men and women), followed by spirits (26% men; 29% women) and then beer (21% men; 17% women). The volume of pure alcohol consumption per year was considerably higher among current drinking men (13.12 L) compared to current drinking women (1.85 L). Of the current drinkers, 12% of the men and 2% of the women were classified as heavy episodic drinkers; and 28% of men and 1% of women classified with hazardous alcohol use (AUDIT score ≥8).

The findings suggest that the volume of alcohol consumed appears to be slightly lower for men in our study than reported by WHO for the general male population in Georgia (13.12 L

our study; 14.81 WHO) and substantially lower for women (1.85 L our study; 9.44 L WHO) (WHO 2011). However, the quantity of alcohol consumed by heavy episodic male and female drinkers in this study population was extremely high.

The study indicated an association of cumulative trauma exposure with hazardous drinking, but not with heavy episodic drinking. Of the individual trauma variables, experiencing a serious injury was associated with both harmful alcohol use and heavy episodic drinking.

PTSD was not associated with either alcohol outcome but depression was associated with hazardous alcohol use. This reflects studies from stable settings on the comorbidity between harmful alcohol use and common mental disorders, particularly depression (Kessler, 1997).

The findings suggest that alcohol control policies in Georgia also need to address community influences on harmful alcohol use, following international evidence and policy guidance on controlling alcohol availability, marketing and pricing; and that comorbidity issues should be addressed accordingly.

Disability

Finally, several studies of war-affected populations have demonstrated an association between psychiatric disorders (especially, depression and PTSD) and disability. (e.g., Mollica et al 1993), who showed that fifteen per cent to 20% reported health impairments limiting activity.

Our study also illustrated the strong link between mental disorders and functional disability. The mean functional disability score for 1990s internally displaced persons (14.61) was significantly higher (i.e. worse disability) than the 2008 internally displaced persons (8.99) and returnees (9.37).

Depression score was 9.67 in a combined population, while PTSD was 6.38 and anxiety – 6.25.

The mental disorders all showed significant associations with worse disability, with more than 1 disorder having the strongest association (Coef.15.91). Sex (female), older age (60+) and having an existing disability/long-term illness were also all significantly associated with higher disability rates.

These findings are in line with some other studies (Mollica et al. 2001, 546-54; Cardozo et al. 2004, 575-584), analysed the association between selected demographic factors, traumatic

events experienced, coping mechanisms, and feelings of hatred, and the social functioning and mental health outcomes for nondisabled and disabled respondents. Female sex was associated with lower prevalence of social functioning and higher prevalence of symptoms of depression, anxiety, and PTSD. Older respondents had significantly poorer social functioning and higher levels of depression symptoms. Respondents with little or no education had symptoms of anxiety more often than did respondents with higher levels of education. Though, in our sample we could not find correlation with education levels.

In conclusion, this population-based mental health study revealed high prevalence of exposure to trauma events and mental disorders among the conflict-affected population of Georgia in 2011.

Prevalence of symptoms of PTSD, depression and anxiety were high, and were higher for women than for men and elderlies. In this study, social functioning was strongly correlated to depression. Not unexpectedly, social functioning was lower in the elderly population.

The significantly higher prevalence for symptoms of depression, anxiety, and PTSD, and lower social functioning for women than men is also not surprising given the scientific body of the international evidence and fact that women are main bread-winners and work hard.

In this study, respondents who have experienced multiple trauma events were prone to higher rates of common mental disorders, especially in 1990 IDPs. Lower social functioning associated with mental conditions also was observed. Not unexpectedly, social functioning was lower in the surveyed elder population.

A study by Comellas (Comellas et al. 2015) demonstrates tha the same population has been exposed to Somatic Distress (SD) as well. Over 40% (41.7%) of the total study respondents were recorded as being at high risk of SD (29% men and 48% women). In terms of the relationship between SD and other mental disorders, 8.8% of respondents were at risk of PTSD-SD comorbidity, 6.7% depression-SD comorbidity, and 4.7% anxiety-SD comorbidity. Other factors signfiicantly associated with SD (Table 4) included gender, with women over twice as likely to be at risk of SD (OR 2.51). Similarly, older age increased the risk of SD.

We observed a consistent relationship between exposure to traumatic events and SD, in line with other studies (Steel et al. 2009,:537–49; Berg et al. 2005, 92-106; Morina et al. 2010,

1167-77; Morina, von Lersner and Prigerson. 2011. War and bereavement: consequences for mental and physical distress. PLoS One. Jan;6(7):e22140).

Specifically, serious injury, exposure to conflict situations, and experiencing the death of a family member appear to carry a particularly high burden. This study shows strong correlations between SD and PTSD, depression and anxiety, and these findings reflect those from other studies (Engel et al. 2000; Hoge et al. 2007, 150–153.).

The data also highlights the links between SD and functional disabilty (Ford et al. 2001, 842–9; De Waal MWM 2004, 470–476.).

The findings suggest that psychological processes during exposure to war stressors are the most important determinants of PTSD, depression, anxiety and their comorbidity in displaced persons; though current threats as bad and very bad household economic situation and displacement status are also correlated to levels of mental disorders.

These findings highlight the need for comprehensive evidence-based approaches that recognise and treat multiple disorders. The study also provides evidence on how these mental disorders influence functional disability and this reinforces how improvements in mental health could substantially strengthen broader individual, social and economic wellbeing.

The persistence of mental disorders and their co-morbidity suggests that the treatment gap for mental disorders among conflict-affected populations in Georgia may be large and leading to chronic disability. Our findings support the need for a scaled-up, comprehensive and trauma informed response to support the mental health of conflict-affected populations in Georgia. Given the protracted nature of the displacement in Georgia and its impact on mental disorders and functioning, the government of Georgia should seek to provide more durable long-term solutions, including strengthening socio-economic conditions. These findings suggest that it would be effective to use a trauma-focused approach in rehabilitation of war survivors

Service utilization

This study provides new information on patterns of use of health services among those with objectively assessed mental disorders among IDPs in Georgia. Since there was no significant

difference in service use among the different categories of IDPs and returnees, we henceforth refer to the war-affected population collectively.

We found that only just over a third of those with a current mental disorder sought any assistance from health services. The remainder (61%) did not use services because they did not report the presence of problems, despite meeting objective criteria for a mental health disorder (27.4%) or faced real or perceived barriers to accessing care (33.1%).

This study adds to a sparse existing literature on this topic among conflict-affected civilian populations in low and middle income countries, most of which has been conducted in the Balkans. A study conducted 8 years after the war in Kosovo found that 72% of people had used medical services in the past 12 months (Eytan and Gex-Farby 2012, 638-43). Another study from Kosovo, among female civilians 10 years after the war, found that more than half used health care services during the previous three months but only small minority used specialized mental health services. (Morina and Emmelkamp 2012). A study of war-affected population and refugees from the Balkan region observed that between 61% to 94% of service use was found in five Balkan in three Western European countries with psychiatric service use range between 1.9% to 20.9. The other study among traumatized population from war-affected Balkan countries examined service use from the beginning of the conflict among individuals with mental disorders (Franciskovic, Sukovic and Priebe 2013, 4-14.). Twenty six per cent of those with current PTSD used mental health services, as did 18.1% of those with other mental disorders. The study conducted using a similar methodology in Croatia found that 38.8% of individuals with current PTSD utilized mental health services since the beginning of the war% (Francisković et al. 2008, 483-90). However, comparison of these studies is challenging due to different study time periods and different health seeking behaviors although rates of service utilization by the war-affected population in Georgia is within the same range as in the Balkan countries.

Our study findings on the factors influencing service utilization are consistent with existing evidence. Being female and middle or old age (40 and up) was significantly associated with service use. Higher utilization by women is a consistent finding in studies among war-affected populations (Eytan and Gex-Farby 2012, 638-43; Alonso et al. 2004, 47-54).

Those who are employed were less likely to use health services for mental or behavioural problems but previous research finds an inconsistent association of employment and service use; one study of a war-affected population in Kosovo showed higher rates of utilization among employed persons (Eytan and Gex-Farby 2012, 638-43.), but another, of individuals with severe mental illness, found that steady employment was associated with significantly lower outpatient use (Bush et al. 2009).

Among mental health disorders depressive disorder and PTSD were associated with higher odds of services use. Increased likelihood of service use of individuals with depressive disorder was also reported by previous studies (Alonso et al. 2004, 47-54).

Our findings with regard to PTSD also resonate with other researches among war-affected population (Eytan et al. 2006; Franciskovic et al. 2013, 4-14; Calhoun and Beckham 2002, 2081-6; Schnurr et al. 2008, 496-504; PP, and among civilian population (Kartha, Brower and Saitz 2008, 388-93). As expected, co-existence of more than one disorder was associated with increased use of health services (Andrews, Henderson and Hall 2001,145-53).

Participation in the government insurance scheme was positively associated with service utilization and especially GPs. However, despite this, costs related to services and drugs still represent major barrier for many. This finding is supported by other research (but not specifically on mental health) conducted in Georgia showing that the MIP beneficiaries are more likely to use general practitioners and specialist services (UNICEF, USAID & HSSP 2011) and pay less out-of-pocket payments for health services (Bauhoff, Hotchkiss and Smith 2011, 1362-1378) than non-MIP beneficiaries. The latest research found that MIP helped to reduce monthly self-treatment and chronic disease management cost mainly among poorest households (Gotsadze et al. 2015).

However pharmaceuticals costs appear to have a high financial burden for both MIP beneficiaries and non-beneficiaries. Costs related to drugs are main cost drivers and a cause of catastrophic health expenditure (Gotsadze, Zoidze and Rukhadze.).

The other factor that may aggravate drug costs related barrier in mental health treatment is poor utilization of specialized mental health services. The SPMH implemented by specialized outpatient mental health clinics (dispensaries) covers treatment of majority of mental health conditions including moderate and severe depressive episodes, recurrent depressive disorder

and PTSD. The patients enrolled in the SPMH are provided with the free drugs. Anxiety disorders such as phobic anxiety and other anxiety disorders are not included in the program coverage, meaning that the patient with these diagnoses should pay for consultation and purchase drug if needed. Medications provided by the state program are mainly low cost old generation drugs and generics. Only 2.3% of our study population with mental health disorders used outpatient mental health services and all of them received drug benefits from the program. Although the numbers are small it could indicate that psychiatric dispensaries are mainly visited for drugs.

The majority of individuals with a mental disorder used pharmacy services and about one six used only a pharmacy without consulting health professional. Self-treatment is common in the Georgian population (Balabanova et al. 2012, 840-64) and it was found to be higher among uninsured persons as suggested by our study. Although the MIP benefit package does not cover mental health drugs, extra costs related to service use for uninsured individuals are additional financial barrier prompting them to self-treatment.

Relatively high use of GP consultations (46.6%) may reflect the gate-keeping role of primary care enforced by the MIP. Also people with mental disorders may have other physical complaints that prompt them to seek care from GPs. Interestingly about one third used only the GP service without referring to other specialists. GPs should be able to recognise mental health disorders and manage mild depressive episodes, while referring more severe cases to psychiatrists. They are also authorised to prescribe antidepressants, however real quality of services with regards to mental health provided by GPs is not known and was not explored by our study.

As expected, neurologists at primary or secondary level are main access points for mental health treatment. Insured and uninsured persons equally consult them. The explanation could be that neurologists are main health care providers from which care is sought in case of mental and behavioural problems, although they have not been recognized as such in the policy decisions of the government. As pathways of treatment were not investigated we may assume that those who were insured were referred by GPs to neurologists, while uninsured most likely access neurologists directly bypassing general practitioners. However, this assumption needs further exploration and research.

High utilization of neurologist services and low utilization of specialized mental health services could be explained by stigma associated with seeking psychiatric care. Stigma as a major barrier to use psychiatric care has been documented by various studies (Mann and Himelein 2004, 185-187; Rao et al. 2009, 279-84; Abbey et al. 2011, 1–9). Our study did not explore stigma and therefore this should be a subject for further research in Georgia.

A shortage of qualified staff is a recognized obstacle to mental health reform initiative in Georgia. Government funded outpatient care is characterized by the poor quality of psychiatric services and low utilization of modern treatment modalities. Psychosocial rehabilitation is provided by a few outpatient facilities under the SPMH, limited NGOs under the donor financial support and private clinics. The majority of respondents with mental disorders reported receiving drug treatment, with very few receiving psychotherapy or psychosocial support, indicating possible over-medicalization. This reflects the limited coverage by additional services such as by NGOs and the unaffordability of costly private services.

Unrecognized mental disorder is one of serious barriers in closing the mental health treatment gap. In our sample about one third of those who screened for mental illness did not acknowledge having a problem requiring professional help. This possibly suggests poor mental health knowledge among the study population. There is growing evidence that poor mental health knowledge negatively influences decisions about mental health treatment (Ten Have et al. 201; Rüsch et al. 2011, 675–678). Other explanation could be self-reliance, which also is considered as barrier in not receiving care (Prins et al. 2011, 1033-44; Ortega and Alegría 2002, 131-40).

Utilization of services is affected by many interacting factors, such as individual and help-seeking preferences, access, availability of services and referral practices (Costello et al. 1998). Health service utilization for mental health has not been studied in general population of Georgia. Our study among war-affected population may also provide some insight about utilization patterns in the general population in Georgia.

The Global Burden of Disease (2010) study identified mental health disorders as a leading cause of burden. It is estimated that depressive disorders are second leading cause of years

lived with disability in Eastern Europe (Ferrari et al. 2013). To reduce this disease burden the government of Georgia should consider mental health as public health priority and implement cost-effective interventions. Mental health reform has been recently initiated in Georgia. One of the directions and major challenges of the reform process is to integrate fragmented programs and services and close the treatment gap, including for war-affected populations in Georgia. However in view of the magnitude of the problem the government should make more proactive steps to meet the needs of people with mental disorders.

Experts Survey

Providing MH services to civilian population affected by war poses tremendous challenge to policy makers. There is less empirical information available to guide policymaker and clinician decisions about how best to address the MH needs of individuals directly and indirectly affected by war (Stein and Tenielian 2006). Such information is sorely needed, however, as the resources available to address MH needs in the aftermath of war are often limited, both in terms of adequate numbers of individuals prepared to approach MH issues and funding for MH services. As a result, difficult decisions must often be made regarding the priority of addressing MH needs during post-war reconstruction versus other priorities, including providing physical health care and services to meet public health needs.

This survey provides a new understanding and the expert consensus on MH services needed for war-affected populations in low-, middle- and relatively high resource-areas of Georgia. The study questions address policy issues to ensure that scarce resources are used in a manner most likely to reduce mental morbidity.

International expert consensus groups have recommended core elements that should exist in these MH interventions (Eisenman et al. 2006). These include addressing the individual's trauma in the context of his family, community, and society (Fairbank, Friedman and de Jong 2003, 57-72), addressing cultural influences on exposed individuals experiences (Green 2003, 17-32) and realizing that the appropriate interventions in the context of on-going conflict and its immediate aftermath may differ from those in subsequent periods (Eisenman et al, 2006).

While there is an increasing evidence base of effective interventions for traumatized individuals (Ursano et al. 2004, 3–31), there remains a paucity of empirical data to guide clinicians and policymakers with respect to the optimal content of interventions to be provided to individuals exposed to war.

The experts survey partially answers challenge to make more informed decisions about how to best address the MH needs of trauma-exposed big groups.

Based on the study data, five main themes have been emerged that defines the basis for recommendations/key-messages for better MH policy concerning conflict-affected populations.

Integration vs. Separate Services

'Mental Health problems of war-affected populations should not be treated separately by separated specialists in separated services'. The "mainstream" MH services should be strengthened and/or developed to address prevalent mental disorders of traumatized communities. There are some very useful services that would serve traumatized communities in a best way, as providing psychosocial interventions, community MH centres/MH outpatient facility/ambulatories, crisis resolution teams and mobile/outreach treatment as well as services integrated in Primary Health Care level. General MH services should be able to provide effective interventions for common MH disorders as depression, PTSD and anxiety, where the first line recommendation is psychosocial management of problems. The 'intervention content' is important as it could be delivered in a frame of different type of services. Consequently, services should be defined by their "content", functions and goals.

Trauma-informed perspective: chain of services

Any mental health care model in a conflict-affected setting should be developed with a trauma-informed perspective, "Trauma-informed" services should be considered as the most rational and balanced approach. All levels of care and support starting from informal care, PHC, etc. should be trauma-informed. Chain of services should be developed (see the most useful services and methods below) and one of the care components in the overall care approach/ spectrum should be trauma-specific treatment, delivered in the frame of any MH

service. Bio-Psycho-social approach should be emphasized and health care and other domains combined, utilizing psychological and/or social methods for the treatment care.

Resource-related approach

The services are better to be distributed/established according to the local resources contemplating both human and infrastructural resources of the regions; different services for different settings – high and low and middle-resource areas – should be developed considering their cost-effectiveness; Low and middle-resource areas (Gori, Zugdidi, etc.) would benefit from services as such: psychosocial interventions, trauma-informed PHC and informal care in communities; as for the high-resource areas as Tbilisi, Batumi, etc. the effective services include Crisis intervention teams, Community mental health centres and MH Day treatment centre as well as PHC facilities. The *'trauma-specific service should be established in a big city only and serve complicated, chronic and comorbid cases'*. The rehabilitation services and inpatients care in general hospitals could be considered for complicated cases requiring specific long-term treatment.

Capacity building and task-shifting

Capacity building is considered crucial: MH personnel should be sensitized of trauma sequel and be provided additional trainings in managing common MH disorders. Besides the trainings, on-going performance improvement and evaluation should be put in place to ensure service quality. Training, supervision, staff care and supporting primary health workers in managing common mental health problems should be a priority as well. Task shifting (or task-sharing) that promotes case management approach and multidisciplinary teamwork should be employed. In trauma-informed services it is necessary having staff able to treat the symptoms and syndromes related to current or past trauma. "What is needed is the presence of trauma-specific staff working in normal services rather than trauma-specific services".

Combination of different methods

Combination of diverse methods would safeguard the effective and comprehensive approach; programs and strategies designed locally at regional levels are specific and cost-effective; advocacy vis-à-vis central and local government is important as ensures on-going lobbying and sensitization in overcoming resistance and capitalizing on support and political will for changes; financial support should be guaranteed for developing effective services. Besides these methods, the culturally sensitive interventions are needed to address 'demand side barriers': community awareness on mental health impact, Information to correct misapprehensions, campaigns for overcoming stigma, information on health care choices/providers.

These themes are informing the general MH policy of Georgia to plan a relevant strategy and programs and implement the pertinent steps of developing the community based, trauma-informed, accessible and effective services that are part of the general MH system of the country. The recommendations that stem from the identified themes are in line with WHO cases studies of 10 countries after different emergencies. Emergencies, in spite of their tragic nature and adverse effects on mental health, are unparalleled opportunities to build better mental health systems for all people in need (WHO 2013). We assume that our evidence would guide the policy-makers and professionals as well as beneficial to better solutions. For instance, some of main prominent practices were as following: Mental health reform was supported through planning for long-term sustainability from the outset; the broad mental health needs of the emergency-affected population were addressed. In many cases in this report, reforms were undertaken that addressed a wide range of mental health problems. No case established stand-alone (vertical) services for just one disorder (e.g. post-traumatic stress disorder) that ignored other mental disorders; or that the government's central role was respected. During and following some of the emergencies described in this report, government structures were adversely affected but humanitarian aid helped subsequently to strengthen them. Examples included seconding professional staff and temporarily assigning certain functions to nongovernmental organizations (NGOs) under government oversight.

At present that Georgia has the national strategy and action plan (2015-2020) there is a strong opportunity to advance the evidence-informed planning, contribute to community-based service development and contribute to alleviation of MH impact and burden.

Study Limitations

The both parts of my study have a number of limitations. The cross-sectional design of quantitative part of the study the means that causation cannot be attributed and the temporal relationship between risk factors and outcomes cannot be determined. As a result, reverse causality cannot be excluded for the more subjective risk-factors (e.g. community conditions and household economic status). The lack of available data on the prevalence of mental disorders among the general population of Georgia also prevents comparisons with them.

In our study prevalence of mental disorder and service use period did not cover the same period. We screened for current mental disorder (in the previous one or two weeks), while health care utilization was investigated during the previous 12 months. In addition, the presence of a mental disorder may not, in fact, indicate a need for care. The study did not investigate participants' experiences with health services, their satisfaction with received care, pathways of care and the costs related to services and drugs.

The study did not include internally displaced persons hosted by relatives or friends or living independently away from the formal and informal settlements. It is less likely that this segment of IDPs have different service utilization pattern than those residing in collective centres.

The long recall period could increase potential recall bias for exposure to violent and traumatic events, particularly for the 1990s IDPs. The study did not assess respondents' mental health history and functioning levels prior to their exposure to the conflicts and forced displacement, largely due to concerns over recall bias (Simon and VonKorff 1995), but it is recommended that future studies should seek to assess these where possible.

Lastly, while we provide data above on the validity and reliability of the study instruments with the study population (they did go through a rigorous translation, adaption and piloting process, and the psychometric properties of the instruments were also tested and shown to be good), these instruments and their cut-offs were not comprehensively normed and so our data cannot support the instruments potential uses as diagnostic tools in Georgia.

Regarding the Experts Survey limitations, it seems that relatively restricted number of experts (21 experts in total; among them 15 foreign and 6 local experts) impedes the

opportunity to argue about the data on types of services and their distribution more strongly. The application of the findings to other settings in other countries will be difficult due to this fact and repeated survey would be needed for collecting more evidence.

Another argument is that we have combined experts from 2 rather distinct and alienated areas – MH policy & systems' and the psychotrauma fields - for receiving answers on trauma-informed MH policies. Among the invited persons only a restricted number had an experience and expertise in both fields (due to fact that, generally, there are not many who are active in this area). Thus, experts supposedly provided their opinions based on their field of expertise and influenced either by MH policy challenges (that refer mostly to organizing services for people with severe mental disorders) or trauma field experiences (that deal mostly with conflicts and emergencies' management and with care organization for common mental disorders). For instance, two prominent experts (from the UK and Norway) had returned the questionnaire with a remark that although they are experts in trauma field they could not comment on MH services and policy issues due to a lack of experience. Similarly, we got a letter from a researcher on MH systems (UK) that he is not competent in trauma issues and could not fill-in the questionnaire. Although the survey aim was exactly to bring these specialists together in this study and 'bridge' these fields, still the problem of a congruous linking should be taken into consideration.

Another issue to be considered is how the experts understand the service type. Despite the fact that participants were provided with detailed description of each service, it is probable that they ascribe slightly different meanings to some of them due to their experiences. It is also important that in descriptions there are some similarities and overlapping between a few services. E.g. "Psychosocial intervention" is described as treatment and/or rehabilitation of a mental disorder or substantial reduction of psychosocial distress using primarily psychological or social methods; while "Rehabilitation services" are described as treatment and support for patients with severe, established mental health problems, focusing on reducing disabilities. But some experts indicate to use rehab services not only with severe mental disorders, but also with IDPs who have milder problems, even incorporate them in the crisis services. Thus, the service differentiation provided by the description was

somehow lost due to a personal and the contextual meaning of some services - that probably had influenced the rating.

We became aware also that typology of services provided in our theoretical models and offered for rating and commenting was not accurate in a sense of form and content; i.e. a day care center or a community mental health center might offer care that is listed as a different type of service, for instance as crisis intervention or rehab intervention. There is no clear demarcation concerning these services that might affect the findings. We recommend that for the future research interests it is necessary to classify services according to aims, content/function, and location and target groups to gather more accurate data.

VI. Conclusions/ Policy Recommendations

Georgia is facing the reform of mental health care system (Makhashvili and van Voren, 2013). Despite stigma and resistance of the out-dated hospital-linked system, the certain steps are taken on a policy level and some modern approaches and methods have been piloted and implemented.

The understanding of the consequences of trauma has been increased enormously over the past decades; economic costs of disability are yet to calculated. The impact on society may reverberate for generations. Unfortunately, until now the State did not consider the needs of uprooted and trauma-affected populations and support has been scarce and fragmented.

In this study (Makhashvili et.al. 2014), we aimed to measure prevalence rates of mental disorders in people who experienced the war in Georgia between 3-4 and 18-20 years previously and identify factors associated with the occurrence of different mental disorders. We also investigated several policy options regarding the services that would meet the exposed needs of conflict-affected big groups.

The research studies long-term mental health consequences. It demonstrates that several years after the end of the war actions for different groups, the prevalence rates of common mental disorders among conflict-affected populations are high. War experiences appear to be linked to PTSD, anxiety and mood disorders and cause a substantial degree of disability among the survivors. Prevalence of symptoms of PTSD, depression and anxiety were higher for women than for men and elderlies. In this study, social functioning was strongly correlated to depression. Not unexpectedly, social functioning was lower in the elderly population. We have documented number of factors associated with the mental disorders, including trauma exposure (particularly cumulative exposure), sex, age, education status, and daily stressors such as low household income and poor community conditions. The study confirmed that availability of family and community supports provides considerable protective effect. Efforts of resettlement should be given a priority.

This study highlights the persistence of common MH disorders, high comorbidity and a strong association with disability among conflict-affected persons in Georgia and the need for a comprehensive approach to tackling of identified needs.

The study collected evidence on treatment gap in regard of service utilization (Chiqovani et al, 2015): only just over a third of those with a current mental disorder sought any assistance from health services. The remainder (61%) did not use services because either they did not report the presence of problems, despite meeting objective criteria for a mental health disorder (27.4%) or faced real or perceived barriers to accessing care (33.1%). This findings show that there are 2 sides of the problem to be considered – both supply and demand sides; effective services should be developed to meet the persistent MH needs of populations and the awareness should be raised within communities (as well as healthcare personnel) to increase the help-seeking behavior.

The study suggests that there is considerable unmet need for mental health services among the war-affected population in Georgia. This appears due those living with a mental disorder not recognising the need for care but also to the existence of barriers such as costs of services and drugs. Reducing financial access barriers, especially for drugs, seems critical and the government should consider expanding outpatient drug benefits and including the drugs needed for management of mental disorders. Other noteworthy finding of this study is that *de facto* GPs and non-mental health specialists (neurologists) are the main service providers of "mental health services". In contrast, specialised care is extremely underused and appears used only for free drug benefits. While many patients with mental health problems present to primary care, the real benefit to the patient is questionable, unless the capabilities of primary health care are enhanced to deal with mental disorders. Integration of mental health into primary care with improved capacity of primary care providers, multidisciplinary treatment approach and referral pathways could result in a timely identification and successful management of mental disorders among war affected and general population at large

The experts survey (Makhashvili and Pilauri, 2015) provided the consensus-based evidence on priority services and systems for our target groups. Foreign and local MH and health policy experts identified a set of services according to resourcefulness of regions across the

country. The study contributed to knowledge on integration of trauma-related services into the mainstream mental health care.

Based on the survey data, five main themes have been identified and provided a foundation to MH policy recommendations concerning conflict-affected populations.

Integration vs. Separate Services: there are some very useful services that would serve traumatized communities in a best way, as providing psychosocial interventions, community MH centers/MH outpatient facility/ambulatories, crisis resolution teams and mobile/outreach treatment as well as services integrated in Primary Health Care level. General MH services should be able to provide effective interventions for common MH disorders as depression, PTSD and anxiety. The 'intervention content' is important as it could be delivered in a frame of different type of services.

Trauma-informed perspective: chain of services: Any mental health care model in a conflict-affected setting should be developed with a trauma-informed perspective; all levels of care and support starting from informal care, PHC, etc. should be trauma-informed. Chain of services should be developed and one of the care components in the overall care approach/ spectrum should be trauma-specific treatment, delivered in the frame of any MH service and used to manage complicated, persistent, highly comorbid cases.

Resource- related approach: The services are better to be distributed/established according to the local resources considering both human and infrastructural resources of the regions; different services for different settings – high and low and middle-resource areas – should be developed considering their cost-effectiveness.

Capacity building and task-shifting: MH personnel should be sensitized of trauma sequel and be provided additional trainings in managing common MH disorders. Besides the trainings, on-going performance improvement and evaluation should be put in place to ensure service quality. Training, supervision, staff care and supporting primary health workers in managing common mental health problems should be a priority as well. Task shifting (or task-sharing) that promotes case management approach and multidisciplinary teamwork should be employed.

Combination of different methods: exploiting diverse methods would safeguard the effective and comprehensive approach; programs and strategies designed locally at regional levels are

specific and cost-effective; advocacy vis-à-vis central and local government is important as ensures on-going lobbying and sensitization in overcoming resistance and capitalizing on support and political will for changes; financial support should be guaranteed for developing effective services. Besides these methods, the culturally sensitive interventions are needed to address 'demand side barriers': community awareness on mental health impact, information to correct misapprehensions, campaigns for overcoming stigma, information on health care choices/providers.

Key Policy Messages

Combining evidence derived from the both parts of the study a list of policy recommendations has been drafted. These recommendations might guide the policy-makers and professional communities while considering the reform steps.

Conflict affected groups suffer from high prevalence of common mental disorders as depression, post-traumatic stress disorder and anxiety; these big groups exhibit quite high levels of co-morbidity, with over 40% of respondents with a disorder having more than 1 disorder;

The persistence of mental disorders and their co-morbidity suggests that the treatment gap for mental disorders among conflict-affected populations in Georgia may be large and leading to chronic disability;

There is a need for a scaled-up, comprehensive and trauma informed response to support the mental health of conflict-affected populations in Georgia;

The "mainstream" mental health services should be strengthened and/or developed to address common mental disorders of traumatized communities;

All levels of care and support starting from informal care, PHC, etc. should be trauma-informed. A chain of effective services should be developed and one of the components in the overall care spectrum should be trauma-specific treatment (to treat complicated, persistent and comorbid cases);

Different services around the country should be developed – according to high and low & middle-resources considering cost-effectiveness of services.

Low and middle-resource areas (Gori, Zugdidi, etc.) would benefit from services as such: psychosocial interventions, trauma-informed PHC and informal care in communities; as for the high-resource areas as Tbilisi, Batumi, Kutaisi, etc. the effective services could be (again) psychosocial interventions, but also Crisis intervention teams, Community mental health centres and MH Day treatment centres as well as PHC facilities (with integrated MH care). The rehabilitation services should be considered for complicated cases requiring specific long-term treatment.

Capacity building of MH professionals and PHC personnel and the on-going performance improvement &evaluation should be a priority; training, supervision and supporting primary health workers and task shifting should be considered;

Employing of diversity methods as advocacy and lobbying, awareness raising, financing, local programming, etc. would guarantee the success. The empowerment of service users should be a priority.

Bibliography

Abbey S, M.Charbonneau, C. Tranulis, P. Moss, W. Baici, L. Dabby, M. Gautam, M. Paré. 2011. Stigma and discrimination [position paper] *Can J Psychiatry*; 13(10):1–9.

Ager, Alastair. 1993. *Mental Health Issues in Refugee Populations: a Review*. Project on International Mental and Behavioral Health. Cambridge, MA: Harvard Medical School.

Alston Philip. 1995. *Human Rights and Disabled Persons: Essays and relevant Human Rights Instruments.* Ed. Theresia Degener and Yolan Koster-Dreese. Dodrecht:Martinus Nijhoff Publishers.

Alonso J., M. Codony , V Kovess , MC Angermeyer , SJ Katz , JM Haro , G De Girolamo , R De Graaf , K Demyttenaere , G Vilagut , J Almansa , JP Lépine and TS. Brugha. 2007. Population level of unmet need for mental healthcare in Europe. *Br J Psychiatry.* 190 (April):299-306.

Allden K, L. Jones, I. Weissbecker, M. Wessells, P. Bolton, TS. Betancourt, Z. Hijazi, A. Galappatti, R. Yamout, P. Patel, A. Sumathipala. 2009. Mental health and psychosocial support in crisis and conflict: report of the Mental Health Working Group. *Prehosp Disaster Med.* 24 Suppl 2:s217-s227.

Alonso J, MC. Angermeyer, S. Bernert, R. Bruffaerts, TS. Brugha, H. Bryson, G. de Girolamo, R. Graaf, K. Demyttenaere, I. Gasquet, JM. Haro, SJ. Katz, RC. Kessler, V. Kovess, JP. Lépine, J. Ormel, G. Polidori, LJ. Russo, G. Vilagut, J. Almansa, S. Arbabzadeh-Bouchez, J. Autonell, M. Bernal, MA. Buist-Bouwman, M. Codony, A. Domingo-Salvany, M. Ferrer, SS. Joo, M. Martínez-Alonso, H. Matschinger, F. Mazzi, Z. Morgan, P. Morosini, C. Palacín, B. Romera, N. Taub and WA. Vollebergh. 2004. . Use of mental health services in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. *ActaPsychiatrScand Suppl*; (420):47-54.

American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*. Arlington, VA: American Psychiatric Association.

American Psychiatric Association. 1980. *Diagnostic and Statistical Manual of Mental Disorders (3rd ed., rev.) Washington, DC*: APA

American Psychiatric Association. 2000. *Diagnostic and statistical manual of mental disorders (Revised 4th ed.).* Washington, DC: APA.

Anderson J., D. Dayson and W. Wills. 1993. The TAPS project 13: clinical and social outcomes of long-stay psychiatric patients after one year in the community. *British Journal of Psychiatry*162 (suppl): 45–56.

Andrews G, S. Henderson and W. Hall. 2001. Prevalence, comorbidity, disability and service utilization Overview of the Australian National Mental Health Survey. *Br J Psychiatry*; 178 (February):145-53.

APA. *Anxiety disorders.* http://www.psychiatry.org/anxiety-disorders (Accessed July 25, 2014)

APA. 1994. *Diagnostic and statistical manual of mental disorders* (fourth edition). Washington DC: American Psychiatric Association.

Ayazi, T., L. Lien, A.H. Eide, M.M. Ruom, & E. Hauff. 2012. What are the risk factors for the comorbidity of posttraumatic stress disorder and depression in a war-affected population? A cross-sectional community study in South Sudan. *BMC Psychiatry, 12*, 175. doi: 10.1186/1471-244X-12-175.

Balabanova D, B. Roberts, E. Richardson, C. Haerpfer, M. McKee. 2012. Health care reform in the former Soviet Union: beyond the transition. *Health Serv Res.* 47(2) (April): 840-64.

Bartko, J. J. 1966. The intraclass correlation coefficient as a measure of reliability. *Psychological Reports, 19*, 3-11.

Başoğlu Metin, Maria Livanou, Cvetana Crnobarić, Tanja Frančišković, Enra Suljić, Dijana Đurić and Melin Vranešić. 2005. Psychiatric and Cognitive Effects of War in Former Yugoslavia: Association of Lack of Redress for Trauma and Posttraumatic Stress Reactions. *JAMA*.294(5):580-590. doi:10.1001/jama.294.5.580

Basoglu, M, and M. Paker. 1995. Severity of trauma as predictor of long-term psychological status in survivors of torture. J Anxiety Disord; 9:339–50. doi: 10.1016/0887-6185(95)00014-F.

Bauhoff, S., D.R. Hotchkiss and O. Smith. 2011. The impact of medical insurance for the poor in Georgia: a regression discontinuity approach. H*ealth Economic*s; 20(11); (November):1362-1378.

Bedard, M., J. L. Greif & T. C. Buckley. 2004. International publication trends in the traumatic stress literature. *Journal of Traumatic Stress*,17(2), 97-101. doi:10.1023/B:JOTS.0000022615.03388.78.

Beaglehole R and R. Bonita. 2008. Global public health: a scorecard. *Lancet*. (December) 6;372(9654):1988-96.

Becker T and M Koesters. 2011. *Oxford Textbook of Community Mental Health.* Ed. Thornicroft G, GI. Szmukler, KT. Mueser, RE. Drake.Oxford: Oxford University Press.

Berg B Van Den, L. Grievink, J. Yzermans and E. Lebret. 2005. Medically Unexplained Physical Symptoms in the Aftermath of Disasters. *Epidemiol Rev;* 27(figure 1):92–106.

Bisson, J. I., R. Weltch, S. Maddern & J.P. Shepherd. 2010. Implementing a screening programme for post-traumatic stress disorder following violent crime. *European Journal of Psychotraumatology*, 1, 10.3402/ejpt.v1i0.5541. doi:10.3402/ejpt.v1i0.5541.;

Blanchet, K., & B. Roberts. 2013. *Evidence Review on Research for Health in Humanitarian Crises*. London: The Wellcome Trust/DFID/Elhra.

Blanch Andrea. 2008. *Transcending Violence: Emerging Models for Trauma Healing in Refugee Communities. National Center of Trauma Informed Care*. http://www.annafoundation.org/RefugeeTraumaPaper-Biography-July212008.pdf. (Accessed June 15, 2014).

Blake DD, FW. Weathers, LM. Nagy, DG. Kaloupek, FD Gusman, DS. Charney and TM. Keane. 1995. CAPS: The Development of a Clinician-Administered PTSD Scale. *Journal of Traumatic Stress 8,*75-90.

Brewin, C. R., S. Rose, B. Andrews, J. Green, P. Tata, C. McEvedy, S. Turner & E. B. Foa. 2002. Brief screening instrument for post-traumatic stress disorder. *British Journal of Psychiatry, 181*, 158-162.

Brewin, C. R., N. Fuchkan, Z. Huntley and P. Scragg. 2010. Diagnostic accuracy of the trauma screening questionnaire after the 2005 London bombings. *J. Traum. Stress,* 23: 393–398. doi: 10.1002/jts.20529

Brewin CR. 2005. Systematic review of screening instruments for the detection of posttraumatic stress disorder in adults. *Journal of Traumatic Stress 18;* 53-62.

Brewin CR, B. Andrews and JD. Valentine. 2000. Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology;* 68:748–766.

Bramsen, Ivan and HM. Van der Ploeg. 1999. Fifty years later: the long-term psychological adjustment of ageing World War II survivors. *Acta Psychiatr Scand* 1999;100 (5) 350- 358.

Brundtland Gro Harlem. 2000. Mental health of refugees, internally displaced persons and other populations affected by conflict. *Acta Psychiatr Scand* 102(3):159-161

Brune M, C. Haasen, M. Krausz, O. Yagdiran, E. Bustos and D. Eisenman. 2002. Belief systems as coping factors for traumatized refugees: A pilot study. *Eur Psychiat*. 17:451-458.

Buck, Thomas, Alice Morton, Susan Allen Nan, and Feride Zurikashvili. 2000. *Aftermath: Effects of conflict on internally displaced women in Georgia*. Washington: Center for Development Information and Evaluation.

Burns T. 2001. *Oxford Textbook of Community Psychiatry.* Ed. Graham Thornicroft and , George Szmukler. Oxford: Oxford University Press.

Bush PW, RE. Drake, H. Xie, GJ. McHugo and WR. Haslett. 2009. The long-term impact of employment on mental health service use and costs for persons with severe mental illness. *Psychiatr Serv.* August; 60(8).

Butler, Lisa, D., Filomena, M Critell and Elaine S. Rinfrette. 2011. Trauma-informed care and mental health. *Directions in Psychiatry,* 31:197-210.

Cameron IM, JR. Crawford, K. Lawton, IC. Reid. 2008. Psychometric comparison of PHQ-9 and HADS for measuring depression severity in primary care. *Br J Gen Pract.* Jan; 58(546):32-6. doi: 10.3399/bjgp08X263794.

Caucasus Research Resource Centers. 2010. *Caucasus Barometer Surveys*. Tbilisi: CRRC. http://www.crrccenters.org/caucasusbarometer/ (Accessed Septmber 2014)

CRRC. 2007. *Grants to Support Social Science and Policy- Oriented Research: Final Analytical Report.* Prepared by Makhashvili N. Tbilisi: CRRC. http://www.crrc.ge/uploads/files/publications/archive/Nino_Makhashvili_-Eng.pdf.

Cardozo B.L., A. Vergara, F. Agani and CA. Gotway. 2000. Mental health, social functioning and attitudes of Kosovar Albanians following the war in Kosovo. *JAMA*; 284:569-577.

Cardozo Barbara Lopes, Oleg O. Bilukha, Carol A. Gotway Crawford, Irshad Shaikh, Mitchell I. Wolfem Michael L. Gerber and Mark Anderson. 2004. Mental Health, Social Functioning, and Disability in Postwar Afghanistan. *JAMA;* 292(5):575-584. doi:10.1001/jama.292.5.575.

Carlson JM. 2005. *Mental Health and Health-Related Quality of Life in Tortured Refugees.* Copenhagen: University of Copenhagen.

Centers for Disease Control and Prevention. 2015. *Guidelines for mental health screening during the domestic medical examination for newly arrived refugees*. GA, Atlanta: CDC.

Chikovani Ivdity, Nino Makhashvili, George Gotsadze, Vikram Patel, Martin McKee, Maia Uchaneishvili, Natia Rukhadze, Bayard Roberts. 2015. Health service utilization among conflict-affected population in Georgia. *PLOS ONE.* 10(4):e0122673. doi: 10.1371/journal.pone.0122673.

Chisholm D, AJ. Flisher, C Lund, V. Patel, S. Saxena, G. Thornicroft and M. Tomlison. 2007. Scale up services for mental disorders: a call for action. *Lancet* 6;370 (9594)(October) :1241-52

Cleary M, A. Freeman and G.Walter. 2006. Carer participation in mental health service delivery. [Review*] International Journal of Mental Health Nursing*.;15(3) (September): 189-94

Clipp, EC. and GH Elder. 1996. *Aging and posttraumatic stress disorder.* Eds. PE. Ruskin and JA. Talbott. Washington, DC: American Psychiatric Press.

Curatio International Foundation. 2014. *Mental Health Care in Georgia: Challenges and Possible Solutions. A Policy Brief.* Tbilisi: Curatio International Foundation).

Calhoun, P. S. and J.C. Beckham. 2002. Medical service utilization by veterans seeking help for posttraumatic stress disorder. *Am. J Psychiatry;*159 (12) (December): 2081-6.

Collins Pamela Y, Vikram Patel, Sarah S. Joestl, Dana March, Thomas R. Insel, and Abdallah S. Daar. 2011. Grand challenges in global mental health. *Nature*. 475(7354) (July): 27–30. doi:10.1038/475027a.

Collins S, and A. Long. 2003. Working with the psychological effects of trauma: consequences for mental health- care workers--a literature review. *J Psychiatr Ment Health Nurs.* 10(4):417-424.

Comellas, Ruben Moreno, Nino Makhashvili, Ivdity Chikovani, Martin McKee, Vikram Patel, Jonathan Bisson and Bayard Roberts. 2015. Patterns of somatic distress among conflict-affected persons in the Republic of Georgia. *Journal of Psychosomatic Research;* 78 (5). DOI: http://dx.doi.org/10.1016/j.jpsychores.2015.01.015.

Costello A. and A. Zumla. 2000. Moving to research partnerships in developing countries. *BMJ* (321): 827-829.

Costello EJ, BA. Pescosolido, A. Angold and BJ. Burns.1998. A family network-based model of access to child mental health services. Research in Community and Mental Health*. Social Networks and Mental Illness;* 9:165–190.

Council of Europe. Committee for the Prevention of Torture. 2007. *Report to the Georgian Government on the visit to Georgia carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 21 March to 2 April 2007.*

Council of Europe. Committee for the Prevention of Torture. 2010. *Report to the Georgian Government on the visit to Georgia carried out by the European Committee for the*

Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 5 to 15 February 2010. http://www.unhcr.org/refworld/docid/4c986a0d2.html.

de Jong JT, and IH. Komproe. 2002. Closing the gap between psychiatric epidemiology and mental health in post- conflict situations. *Lancet.* 359(9320):1793-1794.

De Jong, J.T., I.H. Komproe, and M. Van Ommeren. 2003. Common mental disorders in postconflict settings. *Lancet* 361(9375): 2128-30

De Jong, J. T, I. H Komproe, M. Van Ommeren, M. El Masri, M. Araya, N. Khaled & D. Somasundaram. 2001. Lifetime events and posttraumatic stress disorder in 4 post-conflict settings. *JAMA*, 286(5), 555-562. doi:10.1001/jama.286.5.555;

De Man-van Ginkel JM, Gooskens F, Schepers VP, MJ. Schuurmans, E. Lindeman, TB. Hafsteinsdóttir. 2012. Screening for post stroke depression using the patient health questionnaire. *Nurs Res*. 61(5)(September-October):333-41.

Department of Health. 2002. Community Mental Health Teams, Policy Implementation Guidance. London: Department of Health.

Deva MP. 2008. Bringing changes to Asian mental health. *International Review of Psychiatry* 20(5):484-7.

De Waal MWM, I. Arnold, J. Eekhof and AM. van Hemert. 2004. Somatoform disorders in general practice: prevalence, functional impairment and comorbidity with anxiety and depressive disorders. *Br J psychiatry J Ment Sci*. 184;(June):470–6.

Decree of the Government of Georgia N762. December 31, 2014. *Mental Health Reform National Strategy and Action Plan 2015-2020*.

Desjarlais R, L. Eisenberg, B. Good and A. Kleinman. 1995. *World Mental Health.*

Demyttenaere K, Bruffaerts R, Posada Villa, J, Gasquet I, Kovess V, Lepine JP, Angermeyer MC, Bernert S, de Girolamo G, Morosini P, Polidori G, Kikkawa T,Kawakami N, Ono Y, Takeshima T, Uda H, Karam EG, Fayyad JA, Karam AN, Mneimneh ZN, Medina-Mora ME, Borges G, Lara C, de Graaf R, Ormel J, Gureje O, Shen Y, Huang Y, Zhang M, Alonso J, Haro JM, Vilagut G, Bromet EJ, Gluzman S, Webb C, Kessler RC, Merikangas KR, Anthony JC, Von Korff MR, Wang PS, Brugha TS, Aguilar-Gaxiola S, Lee S, Heeringa S, Pennell BE, Zaslavsky AM, Ustun TB, Chatterji S. 2004. *Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys.* JAMA 291:2581– 2590.

Dua Tarun, Corrado Barbui, Nicolas Clark, Alexandra Fleischmann, Vladimir Poznyak, Mark van Ommeren, M Taghi Yasamy, Jose Luis Ayuso-Mateos, Gretchen L Birbeck, Colin Drummond, Melvyn Freeman, Panteleimon Giannakopoulos, Itzhak Levav, Isidore S Obot,

Olayinka Omigbodun, Vikram Patel, Michael Phillips, Martin Prince, Afarin Rahimi-Movaghar, Atif Rahman, Josemir W Sander, John B Saunders, Chiara Servili, Thara Rangaswamy, J Unutzer, Peter Ventevogel, Lakshmi Vijayakumar, Graham Thornicroft, Shekhar Saxena. 2011. Evidence based guidelines for mental, neurological and substance use disorders in low- and middle-income countries: summary of WHO recommendations. *PLoS Medicine* 8:1-11

Edwards VJ, GW. Holden, VJ. Felitti, RF. Anda. 2003. Relationship between multiple forms of childhood maltreatment and adult mental health in community respondents: Results from the Adverse Childhood Experiences Study. *Am J Psychiatry* 160(8):1453_1460

Eisenman David, Stevan Weine, Bonnie Green, Joop de Jong, Nadine Rayburn, Peter Ventevogel, Allen Keller and Ferid Agani. 2006. The ISTSS/RAND guidelines on mental health training of primary care providers for trauma exposed populations in conflict-affected countries. J. Traum. Stress, 19: 5–17. doi: 10.1002/jts.20094.

Engel CC, X. Liu, BD. McCarthy, RF. Miller and R. Ursano. 2000. Relationship of physical symptoms to posttraumatic stress disorder among veterans seeking care for gulf war-related health concerns. *Psychosom Med.* 2000;62(6):739.

European health for all database (HFA-DB). http://data.euro.who.int/hfadb/ (Accessed April 3, 2014).

Eytan, A. and M. Gex-Farby. 2012. Use of healthcare services 8 years after the war in Kosovo: role of post-traumatic stress disorder and depression. *Eur J Public Health*; 22(5)(October):638-43.

Eytan A, L. Toscani, L. Loutan, PA. Bovier. 2006. Posttraumatic stress disorder and the use of general health services in post-war Kosovo. *J Trauma Stress*19: 57–67.

Fairbank JA. MJ. Friedman and J. de Jong. 2003. Trauma interventions in war and peace: prevention, practice, and policy. Eds. Bonnie L. green, Matthew J. Friedman, Joop TVM de Jong, Susan D. Solomon, Terence M. Keane, John A. Fairbank, Brigid Donelan and Ellen Frey-Wouters. New York: Kluwer/Plenum.

Fazel, M., J. Wheeler & J. Danesh. 2005. Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *The Lancet*, 365(9467), 1309-1314. doi:10.1016/S0140-6736(05)61027-6.

Ferrari AJ, FJ. Charlson, RE. Norman, SB. Patten, G. Freedman, CJ. Murray, T. Vos and HA. Whiteford. 2013. Burden of depressive disorders by country, sex, age, and year: findings from the global burden of disease study 2010. *PLoS Med*. November; 10(11):e1001547.

First, Michael B., Robert L. Spitzer, Miriam Gibbon and Janet B.W. Williams. 1996. *Structured Clinical Interview for DSM-IV Axis I Disorders, Clinician Version (SCID-CV*). Washington, D.C.: American Psychiatric Press, Inc.

Foa EB, D. Riggs, C. Dancu & B. Rothbaum. 1993. PSS-SR: Reliability and Validity of a Brief Instrument for Assessing Post-traumatic Stress Disorder. *Journal of Traumatic Stress 6,*459-474.

Ford JD, K. Campbell, D. Storzbach, LM. Binder, WK. Anger, DS. Rohlman. 2001. Posttraumatic stress symptomatology is associated with unexplained illness attributed to Persian Gulf War military service. *Psychosom Med*.63(5):842–9.

Fox P, K. Burns, J. Popovich, and M. Ilg. 2001. Depression among immigrant Mexican women and Southeast Asian refugee women in the U.S. *International Journal of Psychiatric Nursing Research.* 7(1):778-792.

Franciskovic, T., Z. Sukovic, and S. Priebe. 2013. The utilization and perceived usefulness of health care and other support services by people exposed to traumatic events related to the war in the Balkans. .*Acta Med Acad*; 42(1):4-14.

Frančišković Tanja, Zdravko Tovilović, Zoran Šuković, Aleksandra Stevanović, Dean Ajduković, Radojka Kraljević, Marija Bogić, Stefan Priebe. 2008. Health care and community -based interventions for war-traumatized people in Croatia: community-based study of service use and mental health. *Croat Med J.* 49(4)(August): 483-90.

Freud, Anna. 1967*. Psychic Trauma*. Ed. Sydney S. Furst. New York: Basic Books.

Funk, Michelle, Natalie Drew, and Martin Knapp.2012. Mental health, poverty and development*. Journal of Public Mental Health*. 11 (4). ISSN 1746-5729: 166-185.

Funk M., B. Saraceno and N. Drew. 2004. Mental health policy and plans: promoting an optimal mix of services in developing countries*. International Journal of Mental Health*, 33:4–16.

Furedi J, P. Mohr, D. Swingler, I. Bitter, MD. Gheorghe, L. Hotujac, M. Jarema, M. Kocmur, G. I. Koychev, S. N. Mosolov, J. Pecenak, J. Rybakowski, J. Svestka and N. Sartorius. 2006. Psychiatry in selected countries of Central and Eastern Europe: an overview of the current situation. [Review] *Acta Psych Scand* 114(4) (October):223-31.

Gask L. 2005. Overt and covert barriers to the integration of primary and specialist mental health care. *Social Science and Medicine* 61 (8) (October) :1785-94.

GCRT. 2010. Healthcare Needs Assessment in Juvenile Special facility. Tbilisi: GCRT; OSGF.

Georgian Centre for Psychosocial and Medical Rehabilitation of Torture Victims 2014. (http://www.gcrt.ge/node/16

Georgian Society of Psychotrauma. 2008. http://www.psychotrauma.ge/index.php?L=eng

Georgian Mental Health Coalition. 2009. *Mental Health and Psychosocial needs of war-affected Populations of Georgia*. Tbilisi: GMHC.

General Assembly of the United Nations. 1948. *Convention for the Protection of Human Rights and Fundamental Freedoms.* Paris: UN

General Assembly of the United Nations. 1953. *Convention for the Protection of Human Rights and Fundamental Freedoms.* Paris: UN

Ghosh. N, A. Mohit, RS. Murthy. 2004. Mental health promotion in post-conflict countries. *J R Soc Promot Health* 124(6):268-270.

Global initiative on Psychiatry. 2011. *Mental Health Reforms (MHR). Special issue: Mental Health Challenges in Lithuania.* Hilversum: Global Initiative on Psychiatry.

Global Initiative on Psychiatry –Tbilisi. 2007. *Situation appraisal in Mental Health Sector. Statement.* Tbilisi: GIP-Tbilisi.

Global Initiative on Psychiatry – Tbilisi. 2009. *Analytical Report on Needs of People with Mental Disorders and Disabilities in Georgia.* Tbilisi: GIP-Tbilisi.

GIP-Tbilisi. 2009. *Analytical Review of Implementation of Law on Psychiatric Care*. Tbilisi: GIP-Tbilisi.

GIP-Tbilisi. 2011*. Annual Review.* Tbilisi: GIP-Tbilisi. http://www.gip-global.org/files/gip-tbilisi-annual-review-2011.pdf. (Accessed August 9, 2014).

GIP-Tbilisi. 2012*. Annual Review.* Tbilisi: GIP-Tbilisi. http://www.gip-global.org/files/gip-tbilisi-annual-review-2012.pdf. (Accessed August 9, 2014).

GIP-Tbilisi. 2010. *Assessing Mental Health Problems of War Affected Populations*. Tbilisi: GIP-Tbilisi.

GIP-Tbilisi. 2008. *Rapid Assessment of Mental Health Problems after War.* Tbilisi: GIP-Tbilisi.

GIP-Tbilisi and GSP. 2009. *Dynamics of Post-Trauma Symptoms in IDPs*. Tbilisi: Gip-Tbilisi.

Gotsadze G, A. Zoidze, N. Rukhadze, N. Shengelia and N. Chkhaidze. 2015. An Impact Evaluation of Private Health Insurance for Poor in Georgia: Preliminary Results and Policy Implications. *Health Policy Plan.* Mar; 30 Suppl 1:i2-13. doi: 10.1093/heapol/czu095.

Gotsadze G, A. Zoidze and N. Rukhadze. 2009. Household catastrophic health expenditure: evidence from Georgia and its policy implications. *BMC Health Serv Res*. (April)28;9:69.

Green JG, KA. McLaughlin, PA. Berglund, MJ. Gruber, NA. Sampson, AM. Zaslavsky, RC. Kessler. 2010. Childhood adversities and adult psychiatric disorders in the National Comorbidity Survey Replication I: Associations with first onset of DSM_IV disorders. *Arch Gen Psychiatry*. 67(2):113_123.

Green BL. 2003 Trauma interventions in war and peace: prevention, practice, and policy. Eds. Bonnie L. green, Matthew J. Friedman, Joop TVM de Jong, Susan D. Solomon, Terence M. Keane, John A. Fairbank, Brigid Donelan and Ellen Frey-Wouters. New York: Kluwer/Plenum.

Grubaugh AL, HM, Zinzow, L. Paul, L.E. Egede and B.C. Frueh. 2011. Trauma exposure and posttraumatic stress disorder in adults with severe mental illness: a critical review. *Clin Psychol Rev* 31(6):883-899.

Haddad M, P. Walters, R. Phillips, J. Tsakok, P. Williams, A. Mann, A. Tylee. 2013. Detecting depression in patients with coronary heart disease: a diagnostic evaluation of the PHQ-9 and HADS-D in primary care, findings from the UPBEAT-UK study. *PLoS One.* Oct 10;8(10):e78493. doi: 10.1371/journal.pone.0078493.

Harris M, Fallot RD. 2001. *Using Trauma Theory to Design Service*. Eds. M. Harris and RD. Fallot. San Francisco, CA: Jossey-Bass :3-22.

Hermansson A, T. Timpka and M. Thyberg. 2002. The mental health of war-wounded refugees: An 8-year follow-up. *J Nerv Ment Dis*; 190(6):374-380.

Hinkle, D., S. Jurs & W. Wiersma. 1988. *Applied statistics for the behavioral sciences.* Boston: Houghton Mifflin.

Hoge CW, A. Terhakopian, C. Castro C, SC. Messer and CC. Engel. 2007. Association of posttraumatic stress disorder with somatic symptoms, health care visits, and absenteeism among Iraq war veterans. *Am J Psychiatry*;164(1):(January)150–3

Holloway F.and L. Sederer. 2011. Oxford Textbook of Community Mental Health. Ed. Graham Thornicroft, George Szmukler, Kim T. Mueser and Robert E. Drake. Oxford: Oxford University Press.

Hudson, C.G. 2005. Socioeconomic Status and Mental Illness: Tests of the Social Causation and Selection Hypotheses. *American Journal of Orthopsychiatry* 75: 3-18.

Huntington N, DJ. Moses and BM. Veysey. 2005. Developing and Implementing a Comprehensive Approach to Serving Women with Co_Occurring Disorders and Histories of Trauma. *J Community Psychol.* 33(4):395_410.

Husain F, M. Anderson, C. Lopes, K. Becknell, C. Blanton, D. Araki and EK. Vithana. 2011. Prevalence of war-related mental health conditions and association with displacement status in postwar Jaffna District, Sri Lanka. *JAMA.* 3;306(5)(August):522-31. doi: 10.1001/jama.2011.1052.

IASC. 2007*. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Geneva: IASC.

IDMC and NRC. 2009. *Internal Displacement - Global Overview of Trends and Developments.* http://www.internal-displacement.org/global-overview/ (Accesed Sptember 2014)

Internal Displacement Monitoring Centre. 2012. *Quick facts sheet.* http://www.internal-displacement.org/publications/global-overview-quick-facts-2011.pdf . (Accessed Aug 28, 2012)

Internal Displacement Monitoring Centre and Norwegian Refugee Council, Georgia. 2012. *Partial progress towards durable solutions for IDPs*. Tbilisi: IDMC; NRC.

Internal Displacement Monitoring Centre and the Norwegian Refugee Council. 2012*. Global Overview 2011: People internally displaced by conflict and violence*. Prepared by Albuja, S., et al., Geneva: IDMC; NRC.

ITHACA. 2011. The ITHACA Study Group. *The ITHACA Toolkit for Monitoring Human Rights and General Health Care in Mental Health and Social Care Institutions*. London: King's College London. www.ithacastudy.eu.

Jacobson A, and B. Richardson. 1987. Assault experiences of 100 psychiatric inpatients: Evidence of the need for routine inquiry. *Am J Psychiatry* 144(7):908-913

Jennings A. 2008. *Models for developing trauma informed behavioral health systems and trauma specific services: 2008 update*. Abt Associates Inc. National Association of State Mental Health Program Directors and the National Center for Trauma Informed Care. http://www.annafoundation.org/Models%20for%20 Developing%20Traums-Report%201-09-09%20-FINAL-.pdf. (Accessed June 15, 2014).

Johns Hopkins Bloomberg School of Public Health/Institute for Policy Studies. 2012. *Aging in Displacement: Assessing Health Status of Displaced Older Adults in the Republic of Georgia*. JHBSPH/IPS. http://www.jhsph.edu/research/centers-and-institutes/center-for-refugee-and-disaster-

response/publications_tools/GEORGIA%20PRM%20OLDER%20ADULT%20STUDY%2001May2012.pdf

Kahana B. 1992. *Stress and health among the elderly.* Eds. Wykle, May L., Eva Kahana, and Jerome Kowal. New York: Springer Pub. Co

Kalin, W. 2008. Guiding principles on internal displacement: Annotations. *Studies in Transnational Legal Policy*. Washington, DC: The American Society of International Law.

Karam, E. G., Z.N. Mneimneh, A.N. Karam, J.A. Fayyad, S.C. Nasser, S Chatterji & R.C. Kessler. 2006. 12-month prevalence and treatment of mental disorders in Lebanon: A National Epidemiologic Survey. *Lancet, 367*(9515), 1000–1006. doi:10.1016/S0140-6736(06)68427-4.

Karam, E. G., Z.N. Mneimneh, H. Dimassi, J.A. Fayyad, A.N. Karam, S. C. Nasser, R.C. Kessler. 2008. Lifetime Prevalence of Mental Disorders in Lebanon: First Onset, Treatment, and Exposure to War. *PLoS Medicine*, 5(4), e61. doi:10.1371/journal.pmed.0050061.

Kardiner, Abram. 1941. *The traumatic neurosis of war.* New York: Hoeber.

Kartha, A.,V. Brower and R. Saitz. 2008. The impact of trauma exposure and post-traumatic stress disorder on healthcare utilization among primary care patients. M*ed Care*; 46(4) (April):388-93.

Kinga E. Fodor, Johanna Unterhitzenberger, Chia-Ying Chou, Dzenana Kartal, Sarah Leistner, Maja Milosavljevic, Agnes Nocon, Laia Soler, Jenifer White, Seonyoung Yoo, Eva Alisic. 2014. Is traumatic stress research global? A bibliometric analysis. *European Journal of Psychotraumatology* 2014, 5: 23269. http://dx.doi.org/10.3402/ejpt.v5.23269

Kessler, RC, A. Sonnega, E. Bromet, M. Hughes and CB. Nelson. 1995. Posttraumatic-stress-disorder in the national comorbidity survey*. Archives of General Psychiatry.* 52:1048–1060.

Kessler, R.C., Stang, P., Wittchen H-U. 1999. Lifetime co-occurrence of DSM-III-R alcohol abuse and dependence with other psychiatric disorders in the National Comorbidity Survey. *Arch Gen Psychiatry*. 54(4): p. 313-21.

Kessler RC, WT. Chiu, O. Demler, KR. Merikangas and EE. Walters. 2005. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry* . 62(6)(June) :617-27.

Kessler RC, O. Demler, RG. Frank, M. Olfson, HA. Pincus, EE. Walters, P.Wang, KB. Wells, AM. Zaslavsky. 2005. Prevalence and treatment of mental disorders, 1990 to 2003. *N Engl J Med* 16;352(24) (June):2515-23.

Keyes EF. 2000. Mental health status in refugees: An integrated review of current research. *Issues in Mental Health Nursing* 21:397-410.

Knapp, Martin., David McDaid, Elias Mossialos and Graham Thornicroft. (Ed.) 2007. *Mental Health Policy and Practice Across Europe. WHO on behalf of European Observatory on Health Systems and Policies Series*. New York: Open University Press

Knapp M, D. Chisholm, J Astin, P Lelliott and B. Audini. 1997. The cost consequences of changing the hospital-community balance: the mental health residential care study. *Psychol Med* 27(3) (May): 681-92.

Kohn R., S. Saxena, I. Levav and B. Saraceno. 2004. The treatment gap in mental health care. *Bull. World Health Org.* 82(11):858-866.

Kohrt Brandon A, Daniel J. Hruschka, Carol M. Worthman, Richard D. Kunz, Jennifer L. Baldwin, Nawaraj Upadhaya, Nanda Raj Acharya, Suraj Koirala, Suraj B. Thapa, Wietse A. Tol, Mark J. D. Jordans, Navit Robkin, Vidya Dev Sharma, Mahendra K. Nepal. 2012. Political violence and mental health in Nepal: prospective study. *Br J Psychiatry*. (October); 201(4): 268–275. doi: 10.1192/bjp.bp.111.096222 PMCID: PMC3461445.

Koren D, I. Arnon and E. Klein.1999. Acute stress response and posttraumatic stress disorder in traffic accident victims: A one-year prospective, follow-up study. *American Journal of Psychiatry*;156:367–373.

Kroenke, K., R. L Spitzer & J. B Williams. 2001. The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*, 606-613.

Kroenke K, RL. Spitzer, JB. Williams, PO. Monahan, B. Löwe .2007. Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. *Ann Intern Med*.6;146(5)(March):317-25.

Krupuick, J.L & M.J. Horowitz. 1981. Stress response syndromes. *Arch. Gen. Psychiatry*., 38:428-435

Krystal, H. 1978. Trauma and effects. *PSOC,* 33:81-116

Lee, KA, GE. Vaillant, WC. Torrey and GH. Elder. 1995. 50-year prospective study of the psychological sequelae of World War II combat. *Am J Psychiatry*;152 (4) 516- 522.

Lelliott P and S. Bleksley. 2010. Improving the quality of acute inpatient care. Epidemiol Psychiatr Soc Soc.Psych.Psych. Epid 19(4) October):287-290.

Letica-Crepulja, Marina, Ebru Salcioglu, Tanja Frančišković, and Metin Basoglu. 2011. Factors associated with posttraumatic stress disorder and depression in war-survivors displaced in Croatia. *Croat Med J.* Dec; 52(6): 709–717. doi: 10.3325/cmj.2011.52.709.

Levesque Jean-Frederic, Mark F Harrisand and Grant Russell. 2013. Patient-centered access to health care: conceptualizing access at the interface of health systems and populations. *International Journal for Equity in Health* 12:18 doi:10.1186/1475-9276-12-18).

Lopez A.D, CD. Mathers, M. Ezzati, D.T. Jamison and C.J. Murray. 2006. Global and regional burden of disease and risk factors, 2001: systematic analysis of population health data. *Lancet* 367(9524) (May):1747-57

Löwe B1, O. Decker, S. Müller, E. Brähler, D. Schellberg, W. Herzog, PY. Herzberg. 2008. Validation and standardization of the Generalized Anxiety Disorder Screener (GAD-7) in the general population. *Med Care.*46 (3) (March): 266-74. doi: 10.1097/MLR.0b013e318160d093.

Maddern S. 2004. Post_traumatic stress disorder in asylum seekers. *Nursing Standard*. 18(18):36-39.

Makhashvili, Nino, and Robert van Voren. 2013. Balancing Community and Hospital Care: A Case Study of Reforming Mental Health Services in Georgia*". PLoS Med* 10(1): e1001366. doi:10.1371/journal.pmed.1001366. (Accessed June 14, 2014).

Makhashvili, Nino. 2011. *The mental Health Reform in Georgia: brief overview*. Tbilisi: GIP-Tbilisi

Makhashvili Nino, Ivdity Chikovani, Martin McKee, Jonathan Bisson, Vikram Patel, Bayard Roberts. 2015. Mental Disorders and their Association with Disability among Internally Displaced Persons and Returnees in Georgia. *Journal of Traumatic Stress*. Vol. 27, Issue 5, pp. 509–518.

Makhashvili, Nino, Lela Tsiskarishvili and Boris Drozdek. 2010. Door to the unknown: On large-scale public health interventions in post-conflict zones - Experiences from Georgia. *Traumatology* 16(4):63-72.

Makhashvili, Nino & Ketevan Pilauri. 2015. *Mental Health Services for Conflict Affected Populations in Georgia. The Survey Report.* Tbilisi: GIP-Tbilisi

Malone D, G. Newron-Howes, S. Simmonds, S. Marriot and P. Tyrer. 2007. Community mental health teams (CMHTs) for people with severe mental illnesses and disordered personality. Cochrane Database Syst Rev. Jul 18;(3):CD000270.

Mann, CE, and MJ. Himelein. 2004.
Factors associated with stigmatization of persons with mental illness. *Psychiatr Serv*; 55(2)(February):185-7.

McManus Sally, Howard Meltzer, Traolach Brugha, Paul Bebbington and Rachel Jenkins. 2007. *Adult psychiatric morbidity in England, 2007: results of a household survey*. Leeds: The Information Centre for Health and Social Care.

Medeiros E. 2007. Integrating mental health into post-conflict rehabilitation: the case of Sierra Leonean and Liberian 'child soldiers'. *J Health Psychol*; 12(3):498-504.

Mathers, CD. And D. Loncar. 2006. Projections of global mortality and burden of disease from 2002 to 2030. *PLOS Medicine*, 3:2011-2030

Mental Health Policy Council. Decree of the Minister on "Amendment to the Decree on Creation of Consultative Body". 01/53O; February 25, 2015.

Miller, K. E., & Rasmussen, A. 2010. War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks. *Social Science & Medicine, 70, 7-16.* doi: S0277-9536(09)00620-0 [pii]10.1016/j.socscimed.2009.09.029.

Ministry of Corrections of Georgia. Healthcare Development Strategy of Penitentiary System: 2014-2017. 2014. http://www.mcla.gov.ge/cms/site_images/pdf/strategia-2014-2017.pdf (Accessed August 1st, 2014).

Ministry of Labour Health and Social Affairs of Georgia. *Press-release "The Mental Health Sphere Reforms in Georgia"*. November 5, 2010.

Ministry of Labour Health and Social Affairs of Georgia. *State Program on Mental Health Care.* 2011.

Ministry of Labour Health and Social Affairs of Georgia. *Guidelines/Protocols*.2014. http://www.moh.gov.ge/index.php?lang_id=GEO&sec_id=68.

Mollica R, N. Sarajlic, M. Chernoff , J. Lavelle, I. Vukovic, M. Massagli. 2001. Longitudinal study of psychiatric symptoms, disability, mortality, and emigration among Bosnian refugees. *JAMA.* 286(5):546-554.

Mollica R. 2008. *Healing Invisible Wounds: Paths to Hope and Recovery in a Violent World*. Nashville, TN: Vanderbilt University Publishers.

Mollica, R. M., L. Massagli, M. Silove, D. 2004. *Measuring Trauma, Measuring Torture*. Cambridge, MA: Harvard University.

Mollica, R. F., Y. Caspi-Yavin, P. Bollini, T. Pruong, S.Tor & J. Lavelle. 1992. The Harvard Trauma Questionnaire - Validating a Cross-Cultural Instrument for Measuring Torture, Trauma, and Posttraumatic-Stress-Disorder in Indo-Chinese Refugees. *Journal of Nervous and Mental Disease,* 180, 111-116.

Mollica, RF, K. Donelan, S. Tor, J. Lavelle, C. Elias, M. Frankel, D. Benett, RJ. Blendon and R. Bass. 1993. The effect of trauma and confinement on functional health and mental health status of Cambodians living in Thailand-Cambodia border camps. *JAMA.* 270: 581–586.

Molnar BE, SL. Buka & RC. Kessler. 2001. Child sexual abuse and subsequent psychopathology: Results from the National Comorbidity Survey. *Am J Public Health* 91(5):753_760.

Moore Burness E & Bernard D. Fine. 1990. (Eds). *Psychoanalytical Terms and Concepts*. The American Psychoanalytical Association and Yale University Press.

Morina N, JD. Ford, AK. Risch, B. Morina and U. Stangier. 2010. Somatic distress among Kosovar civilian war survivors: relationship to trauma exposure and the mediating role of experiential avoidance. *Soc Psychiatry Psychiatr Epidemiol*; 45(12) (Dec):1167–77.

Morina N, U. von Lersner and HG. Prigerson. 2011. War and bereavement: consequences for mental and physical distress. PLoS One. Jan;6(7):e22140.

Morina, N. and P. Emmelkamp. 2012. Health care utilization, somatic and mental health distress, and well-being among widowed and non-widowed female survivors of war. *;* May 11;12:39.

Nathan P, and J. Gorman. 2002*. A Guide to Treatments that Work. 2nd edition*. Oxford: Oxford University Press.

National Institute for Health and Care Excellence. 2014. *Common Mental Health Disorders: Identification and Pathways to Care*. http://www.nice.org.uk/guidance/cg123. (Accessed June 10, 2014)

National Center for Disease Control and Public Health. 2013*. Statistical Guide*. Tbilisi: NCDC

Neuner Frank and Thomas Elbert. 2007. The mental health disaster in conflict settings: can scientific research help? *BMC Public Health* 7:275.

NICE. 2011. *Common Mental Health Disorders*. London:
NICE. http://www.nice.org.uk/guidance/cg123. (Accessed September 3, 2014).

NICE. 2005. *Guideline on Post-traumatic stress disorder (PTSD).* https://www.nice.org.uk/guidance/cg26/chapter/1-guidance (Accessed May 15, 2014).

NICE. 2009. *Depression in adults with a chronic physical health problem: Treatment and management.* http://www.nice.org.uk/guidance/cg91/resources/guidance-depression-in-adults-with-a-chronic-physical-health-problem-pdf

NICE. 2011. *Clinical Guideline on Generalized Anxiety Disorder and Panic Disorder in Adults*. http://www.nice.org.uk/guidance/cg113 (Accessed July 25 2014).

O'Donnell, M. L., M. Creamer & P. Pattison. 2004. Posttraumatic stress disorder and depression following trauma: understanding comorbidity. *American Journal of Psychiatry, 161*, 1390-1396. doi: 10.1176/appi.ajp.161.8.1390.

Olff, M. & E. Vermetten. 2013. Psychotrauma research in the Netherlands. *European Journal of Psychotraumatology,* 4,20873. doi:10.3402/ejpt.v4i0.20873.

Open Society Georgia Foundation. 2011. *Analysis of Georgian Healthcare related Legislation.* Tbilisi: OSGF.

Ormel J, M. Von Korff, B. Ustun, S. Pini and A. Korten. 1994. *Common mental disorders and disability across cultures. Results from the WHO Collaborative Study on Psychological Problems in General Health Care*. Geneva.WHO. JAMA;272:1741-8.

Ortega AN. And M. Alegría. 2002. Self-reliance, mental health need, and the use of mental healthcare among island Puerto Ricans. *Ment Health Serv Res*; 4(3) (September):131-40.

Oruc Lilijana, Aida Kapetanovic, Naris Pojskic, Kate Miley, Sharon Forstbauer, Richard F. Mollica & David C. Henderson. 2008. Screening for PTSD and depression in Bosnia and Herzegovina: validating the Harvard Trauma Questionnaire and the Hopkins Symptom Checklist. *Int. J of Culture and Mental Health.* Vol.1, Issue 2: 105-116. doi:10.1080/17542860802456620.

Parliament of Georgia. Healthcare and Social Affairs Committee. 2014. *Amendments to the "Law on Psychiatric Care" and to the "Georgian Criminal Justice Process Code*. (07-3/322 03.04.14). Adopted on 26.07.2014.

Parliament of Georgia. 2013. *"State Concept on Mental Health Care".* Adopted in December 2013.

Patel Vikram and Arthur Kleinman . 2003. Poverty and common mental disorders in developing countries. *Bulletin of World Health Organisation*. 81(8):609-15.

Patel V. 2001. *Poverty, Inequality and Health.* Eds. D. Leon, G. Walt. Oxford: Oxford University Press.

Patel, V., & A. Sumathipala. 2001. International representation in psychiatric literature Survey of six leading journals. *The British Journal of Psychiatry*, 178(5), 406-409. doi:10.1192/bjp.178.5.406

Patel, Vikram, R Araia, M. de Lima, A. Ludermir and C. Todd. 1999. Women, poverty and common mental disorders in four restructuring societies. *Social Sciences and Medicine* 49: 1461-1471;

Patel Vikram, AJ Flisher, S Hetrick and P McGorry. 2007. Mental health of young people: a global public health challenge. *The Lancet* 369:1302–13.

Patel, V. 2000. *Unmet need in psychiatry: problems, resources, responses*. Eds. S. Crown & A. Lee. Cambridge: Cambridge University Press.

Patel V, M. Maj, AJ. Flisher, MJ DE Silva, M. Koschorke, M. Prince. 2010. Reducing the treatment gap for mental disorders: a WPA survey. *World Psychiatry* 9(3)(October):16.

Patel V, R. Araya, S. Chatterjee, D. Chisholm, A. Cohen, M. De Silva, C. Hosman, H. McGuire, G. Rojas, M. van Ommeren. 2007. Treatment and prevention of mental disorders in low-income and middle-income countries. *Lancet* 15;370(9591) (September):991-1005.

Patel Vikram and Graham Thornicroft. 2009. Packages of care for mental, neurological, and substance use disorders in low- and middle-income countries: *PLoS Medicine series. PLoS Med* 6: e1000160. doi:10.1371/journal.pmed.1000160.

Petersen I, A. Bhana, A Flisher, L Swartz & L Richter L (Eds). (2010). *Promoting mental health in scarce resource environments: emerging evidence and practice*. Cape Town: Human Sciences Research Council Press.

Pinto-Meza A, A. Serrano-Blanco,MT. Penarrubia, E. Blanco, JM. Haro. 2005. Assessing depression in primary care with the PHQ-9: can it be carried out over the telephone? *J Gen Intern Med;* 20(8)(August):738-42.

Port, CL, B. Engdahl and P. Frazier. 2001. A longitudinal and retrospective study of PTSD among older prisoners of war. *American Journal of Psychiatry*; 158:1474–1479

Pol, J.L.V. 1999. Stable instability of displaced people in Western Georgia: A food-security and gender survey after five years. *Journal of Refugee Studies*; 12(4):149-366

Porter, M. and N. Haslam. 2005. Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: a meta-analysis. JAMA 294(5): p. 602-12.

Posner J, J. Eilenberg, JH. Friedman and MJ. Fullilove. 2008. Quality and use of trauma histories obtained from psychiatric outpatients: A ten-year follow-up. *Psychiatr Serv* 59(3):318-321.

Priebe Stefan, Marija Bogic, Dean Ajdukovic, Tanja Franciskovic, Gian Maria Galeazzi, Abdulah Kucukalic, Dusica Lecic-Tosevski, Nexhmedin Morina, Mihajlo Popovski, Duolao Wang, Matthias Schützwohl. 2010. Mental Disorders Following War in the Balkans: A Study in 5 Countries. *Arch Gen Psychiatry.* 67 (5): 518-528. doi:10.1001/archgenpsychiatry.2010.37.

Prince M, V. Patel, S. Saxena, M. Maj, J. Maselko, MR. Phillips, A. Rahman. 2007. No health without mental health. *Lancet*. 8;370(9590) (September):859-77.

Prins Marijn, Graham Meadows, Irene Bobevski, Annette Graham, Peter Verhaak, Klaas van der Meer, Brenda Penninx, and Jozien Bensing. 2011. Perceived need for

mental health care and barriers to care in the Netherlands and Australia. *Soc Psychiatry PsychiatrEpidemiol;* 46(10) (October):1033-44.

Public Defender's office. 2007-2010. *Special and Parliamentary reports.* http://www.ombudsman.ge/index.php?page=22&lang=1.

Pumariega AJ, E. Rothe and JB. Pumariega. 2005. Mental health of immigrants and refugees. *Community Ment Hlt J.*;41(5):581-597.

Quirk A and P. Lelliott. 2001. What do we know about life on acute psychiatric wards in the UK? A review of the research evidence. *Soc Sci Med* 53(12) (December): 1565-74.

Rappaport, E. A. 1968. Beyond traumatic neurosis. *IJP*. 49:719-731.

Rao H, H. Mahadevappa, P. Pillay, M. Sessay, A. Abraham, J. Luty. 2009. A study of stigmatized attitudes towards people with mental health problems among health professionals. *PsychiatrMent Health Nurs*; 16(3)(April): 279-84.

Rice Dorothy P, Sander Kelman and Leonard S. Miller. 1990. *The economic costs of alcohol and drug abuse and mental illness: 1985*. Rockville, MD: National Institute on Drug Abuse. (DHHS, No. 90-1694).

Riggs DS, BO. Rothbaum and EB. Foa. 1995. A prospective examination of symptoms of posttraumatic-stress-disorder in victims of nonsexual assault. *Journal of Interpersonal Violence*;10:201–214.

Roberts B, and J. Browne. 2011. A systematic review of factors influencing the psychological health of conflict- affected populations in low- and middle-income countries. *Glob Public Health* 6(8):814-829.

Bayard Roberts, Ivdity Chikovani, Nino Makhashvili, Martin McKee, Vikram Patel. 2014. Individual and community level risk-factors for alcohol use disorder among conflict-affected persons in Georgia. *Journal PLOS ONE*. DOI: 10.1371/journal.pone.0098299

Rosen A and K. Barfoot. 2001. Textbook of Community Psychiatry .Ed. Graham Thornicroft, George Szmukler, Kim T. Mueser and Robert E. Drake Oxford: Oxford University Press.

Rosenthal Eric & Leonard S. Rubenstein. 1993. International Human Rights Advocacy under the "Principles for the Protection of Persons with Mental Illness 16 *INT'L J. L. & PSYCHIATRY;* 257.

Roth Anthony and Peter Fonagy. 2005. *What Works for Whom? A Critical Review of Psychotherapy Research*. New York: Guildford Press.

Rothbaum BO, EB. Foa, DS. Riggs, T. Murdock and W. Walsh. 1992. A prospective examination of posttraumatic-stress-disorder in rape victims. *Journal of Traumatic Stress*; 5:455–475.

Rousseau C, and T. Measham. 2007. Understanding Trauma: Integrating Biological, Clinical and Cultural Perspectives. Eds. LJ. Kirmayer, R. Lemelson and M. Barad. New York: Cambridge University Press.

Rüsch N, SE. Evans-Lacko, C. Henderson, C. Flach and G. Thornicroft. 2011. Knowledge and attitudes as predictors of intentions to seek help for, and disclose, a mental illness. *PsychiatrServ* 62: 675–678.

Sabes-Figuera Ramon, Paul McCrone, Marija Bogic, Dean Ajdukovic, Tanja Franciskovic, Niccolò Colombini, Abdulah Kucukalic, Dusica Lecic-Tosevski, Nexhmedin Morina, Mihajlo Popovski, Matthias
Schützwohl and Stefan Priebe. 2012. Long-Term Impact of War on Healthcare Costs: An Eight-Country Study. *PLoS One.* 7(1):e29603. doi: 10.1371/journal.pone.0029603.

Sabin Miriam, Barbara Lopes Cardozo, Larry Nackerud, Reinhard Kaiser and Luis Varese. 2003. Factors Associated With Poor Mental Health Among Guatemalan Refugees Living in Mexico 20 Years After Civil Conflict

SAMHSA. 2014. http://www.samhsa.gov/nctic

Saraceno Benedetto. June 2014. Some comments on the National Action Plan of Mental Health of GEORGIA. Personal communication. Official letter.

Saraceno B, M. Freeman and M. Funk. 2011. *Public Mental Health*. Oxford: Oxford University Press.

Saraceno B, M. van Ommeren, R. Batniji, A. Cohen, O. Gureje, J Mahoney, D. Sridhar and C. Underhill. 2007. Barriers to improvement of mental health services in low-income and middle-income countries. *Lancet* 370:1164–1174.

Saxena S, G. Thornicroft, M. Knapp and H. Whiteford. 2007. Resources for mental health: scarcity, inequity, and inefficiency. *Lancet* 8;370(9590) (September):878-89.

Saxena, S., A. Lora, J. Morris, A. Berrino, P. Esparza, T. Barrett, & B. Saraceno, 2011. Focus on global mental health: mental health services in 42 low-and middle-income countries: A WHO-AIMS Cross-National Analysis. *Psychiatric Services*, 62(2), 123-125. doi:10.1176/appi.ps.62.2.123

Schnurr, Paula P, Matthew J. Friedman, Anjana Sengupta, M.Kay Jankowski and Tamara Holmes. 2008.

PTSD and utilization of medical treatment services among male Vietnam veterans. *J Nerv Ment Dis*; 188(8)(August):496-504.

Schnyder, Ulrich 2013. Trauma is a global issue. *European Journal of Psychotraumatology,* **4**, 20419. doi:10.3402/ejpt.v4i0.20419

Sharan Pratap, Itzhak Levav, Sylvie Olifson, Andrés de Francisco and Shekhar Saxena. 2007. Eds. *Research capacity for mental health in low- and middle-income countries: Results of a mapping project.* Geneva: World Health Organization & Global Forum for Health Research. http://www.who.int/mental_health/MHRC_FullText.pdf (Accessed June 21, 2013).

Sederer LI. 2010. Inpatient psychiatry: why do we need it? Soc.Psych.Psych. Epid. 19(4) (October):291-295.

Semrau M, EA Barley, A. Law and G.Thornicroft. 2011. Lessons learned in developing community mental health care in Europe. *World Psychiatry*10(3)(October):217-25

Sharashidze, M., G Naneishvili, T. Silagadze, A Begiashvili and Z. Beria. 2004. Georgia mental health country profile. *International Review of Psychiatry*, 16(1–2): 107–116).

Shepherd G, and R. MacPherson. 2011. *Oxford Textbook of Community Psychiatry.* Ed.Graham Thornicroft, George Szmukler, Kim T. Mueser and Robert E. Drake. Oxford: Oxford University Press.

Shepherd Geoff. 1990. *Theory and Practice of Psychiatric Rehabilitation.* Chichester: Wiley.

Shlosberg, A. and RD Strous. 2005. Long-term follow-up (32 years) of PTSD in Israeli Yom Kippur War veterans. *J Nerv Ment Dis*; 193 (10) 693- 696.

Silove Derrick. 2004. The challenges facing mental health programs for post-conflict and refugee communities. *Prehosp Disaster Med* 19(1):90-96.

Silove D, I. Sinnerbrink, A. Field, V. Manicavasagar, Z. Steel. 1997. Anxiety, depression and PTSD in asylum-seekers: Associations with pre-migration trauma and post-migration stressors. *Br J Psychiat.*170:351-357.

Simon, G. E. and M. VonKorff. 1995. Recall of psychiatric history in cross-sectional surveys: implications for epidemiologic research. *Epidemiologic Reviews,* 17, 221-227.

Simmonds S, J. Coid, P. Joseph, S. Marriott and P. Tyrer. 2001. Community mental health team management in severe mental illness: a systematic review. *Br J Psychiatry* 178 (June):497-502.

Siriwardhana Chesmal, Anushka Adikari, Gayani Pannala, Sisira Siribaddana, Melanie Abas, Athula Sumathipala,and Robert Stewart. 2013. Prolonged Internal Displacement and

Common Mental Disorders in Sri Lanka: The COMRAID Study. *PLoS One.* 8(5): e64742. doi: 10.1371/journal.pone.0064742 PMCID: PMC3661540

Short Warwick-Edinburgh Mental Well-being Scale. 2007. NHS Health Scotland, University of Warwick and University of Edinburgh. http://www.healthscotland.com/uploads/documents/14092-SWEMWBSSept2007.pdf .

Slade M. 2009. *Personal recovery and mental illness. A guide for mental health professionals.* Cambridge: Cambridge University Press.

Smith, H. 2003. Needs assessment in mental health services: the DISC Framework, *Journal of Public Health Medicine*, vol.20, No.2:154-160

Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & van Ommeren, M. 2009. Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. *JAMA, 302*, 537-549. doi: 302/5/537 [pii] 10.1001/jama.2009.1132

Solomon Z. and M. Mikulincer. 2006. Trajectories of PTSD: A 20-year longitudinal study. American Journal of Psychiatry. 163:659–666.

Stein, B.D. and T.L. Tanielian. 2006. Building and translating evidence into smart policy: continuing research needs for informing post-war mental health policy. *World Psychiatry,* 5(1), 34–35.

Spitzer, R. L., K. Kroenke, J.B. Williams & B. Lowe. 2006. A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine, 166*, 1092-1097. doi: 10.1001/archinte.166.10.1092.

Swinson RP. 2006. The GAD-7 scale was accurate for diagnosing generalized anxiety disorder. *Evid Based Med.*11(6)(December):184

Switzer GE, MA. Dew, K. Thompson, JM. Goycoolea, T. Derricott and SD. Mullins. 1999. Posttraumatic stress disorder and service utilization among urban mental health center clients. *J Trauma Stress* 12(1):25-39.

Ten Have M, R. de Graaf, G. Vilagut, V. Kovess, and J. Alonso. 2010. Are attitudes towards mental health help-seeking associated with service use? Results from the European Study of Epidemiology of Mental Disorders. *Soc Psychiatry PsychiatrEpidemiol* 45: 153–163.

The Center for Victims of Torture. 2005. *Helping Refugee Trauma Survivors in the Primary Care Setting*. Prepared by David R. Johnson. http://www.cvt.org/files/pg74/ Helping_Refugee_Trauma_Survivors_Primary_Care.pdf. (Accessed June 15, 2011).

The ITHACA Study Group. The ITHACA Toolkit for Monitoring Human Rights and General Health Care in Mental Health and Social Care Institutions. London: King's College London: www.ithacastudy.eu; 2011

Thornicroft Graham. June 2014. Support to Mental Health Reform in Georgia by Developing a National Action Plan. Personal communication. Official letter.

Thornicroft, Graham and Michele Tansella. 2004. Components of a modern mental health service: a pragmatic balance of community and hospital care. *The British Journal of Psychiatry*. 185: 283-290. doi: 10.1192/bjp.185.4.283.

Thornicroft, Graham and Michele Tansella. 2009. *Better Mental Health Care*. New York: Cambridge University Press.

Thornicroft, Graham. 2014. Comments and Recommendations on the National Action Plan following the meeting with international consultants on June 12, 2014. Personal communication. Official letter.

Thornicroft Graham and Michele Tansella. 2013. The Balanced Care Model: the case for both hospital and community-based mental health care. *The British Journal of Psychiatry* 202: 246–248. doi: 10.1192/bjp.bp.112.111377.

Thornicroft G, T. Becker, F. Holloway, S. Johnson, M. Leese, P. McCrone,G. Szmukler, R. Taylor and T. Wykes. 1999. Community mental health teams: evidence or belief? *Br J Psychiatry*175(December):508-13.

Thornicroft G, T. Wykes, F. Holloway, S. Johnson and G. Szmukler. 1998. From efficacy to effectiveness in community mental health services. PRiSM Psychosis Study. *Br J Psychiatry* 173(November):423-7.

Thornicroft Graham. 2007. Most people with mental illness are not treated. *Lancet.* 8;370(9590)(September):807-808.

Thornicroft Graham and Michele Tansella. 1999. *The Mental Health Matrix: a Manual to Improve Services*. Cambridge: Cambridge University Press.

Thornicroft, G. 2006. *Shunned: Discrimination against People with Mental Illness.* Oxford: Oxford University Press.

Thornicroft, Graham. 2008. Stigma and discrimination limit access to mental health care. *Epidemiol. Psychiatr. Soc*. (17).

Thornicroft G. D. Ros, A. Kassam & N. Sartorius. 2007. Sigma: ignorance, prejudice or discrimination? *Br. J. Psychiatry* 190: 192-193

Tomov, T., D. Puras, R. Keukens, and R. Van Voren. 2007. Mental health policy in former Eastern Bloc countries; Ed. Knapp, Martin., David McDaid, Elias Mossialos and Graham Thornicroft. New York: McGraw/Hill.

Tyrer S, J. Coid, S. Simmonds, P. Joseph and S. Marriott. 2003. *Community mental health teams (CMHTs) for people with severe mental illnesses and disordered personality* (Cochrane Review). Oxford: Update Software.

Totman J, F. Mann and S. Johnson. 2010. Is locating acute wards in the general hospital an essential element in psychiatric reform? The U.K. experience. *Epidemiol Psychiatr Soc* 19(4) (October):282-6.

Tomov T. 2001. *The Mental Health Matrix. A Manual to Improve Services*.Ed. Graham Thornicroft and Michele Tansella. Cambridge: Cambridge University Press.

United Nations. 2006. *Convention on the Rights of Persons with Disabilities.* New York: UN. http://www.un.org/disabilities/documents/convention/convoptprote.Pdf. (Accessed July 19, 2013).

United Nations High Commissioner for Refugees. 2009. *2008 Global Trends: Refugees, Asylum Seekers, Returnees, Internally Displaced and Stateless Persons.* New York: UNHCR, United Nations.

UN. 1948. *United Nations Convention on the Rights of the Child.* New York: UN

UN. 1987. Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. New York: UN.

UN. 1991. *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (the MI Principles).* (G.A. Res. 46/119, 46. GAOR Supp. (No. 49) Annex at 188-192, U.N. Doc. A/46/49).

UN. 2006. *United Nations Convention on the Rights of Persons with Disabilities*. New York: UN. http://www.un.org/disabilities/default.asp?id=150.(Accessed September 3, 2014)

United Nations Department of Economic and Social Affairs, Population Division. 2013. *World Population Prospects: The 2012 Revision, Highlights and Advance Tables. Working Paper No. ESA/WP .228*. (Accessed August 29 2013).

UNHCR. 2013. *Operational Guidance Mental Health and Psychosocial Support Programming in Refugee Operations*. Geneva: UNHCR http://www.unhcr.org/525f94479.html (Accessed September 2014)

UNICEF, USAID & HSSP. 2011. *Survey of Barriers to Access to Social Services in Georgia in 2010: why not all poor families get social benefits and services? Survey Report.* www.unicef.org/georgia/BASS_final-eng.pdf.(Accessed 13 November 2013).

UNICEF. 1986. *Children in Situations of Armed Conflict*. New York: UNICEF. UN document E/ICEF.CRP.2.

Ursano Robert J, Carl Bell, Spencer Eth, Matthew Friedman, Ann Norwood, Betty Pfefferbaum, Robert S. Pynoos, Douglas F. Zatzick and David M. Benedek. 2004. Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. *Am J Psychiatry;* 161(Suppl.):3–31.

Üstün, T. B., N. Kostanjsek, S. Chatterji & J. Rehm. 2010. *Measuring Health and Disability. Manual for WHO Disability Assessment Schedule (WHODAS 2.0*). Geneva: WHO.

Üstün, T. B., S. Chatterji, N. Kostanjsek, J. Rehm, C. Kennedy, J. Epping-Jordan, S. Saxena, M. von Korff & C. Pull. 2010. *Developing the World Health Organization Disability Assessment Schedule 2.0*. Bulletin of the World Health Organization. 88, 815-823. doi: 10.2471/BLT.09.067231.

Van Griensven F, ML. Chakkraband, W. Thienkrua, W. Pengjuntr, CB. Lopes, P. Tantipiwatanaskul and JW. Tappero. 2006. Mental health problems among adults in tsunami-affected areas in southern Thailand. *Journal of the American Medical Association;* 296:537–548.

Van der Kolk Bessel A and Alexander C. McFarlane. 1996. Traumatic Stress. Ed. Bessel A. van der Kolk, Alexander C. McFarlane & Lars Weisaeth. New York: The Guilford Press.

Van der Kolk Bessel A, Lars Weisaeth & Onno van der Hart. 1996. Traumatic Stress. Eds. Bessel A. van der Kolk, Alexander C. McFarlane & Lars Weisaeth. New York: The Guilford Press.

Van Voren, Robert. 2014. Is there a resumption of political psychiatry in the former Soviet-Union? *Intern. Psychiatry* 11/3.

Van Ommeren, M., B. Sharma, S. Thapa, R. Makaju, D. Prasain, R. Bhattarai & J. De Jong. 1999. Preparing instruments for transcultural research: Use of the translation monitoring form with Nepali-speaking Bhutanese refugees. *Transcultural Psychiatry*, 36: 285-301.

Van Ommeren, M, J. de Jong, B. Sharma, I. Komproe, S. Thapa and E. Cardeña. 2001. Psychiatric disorders among tortured Bhutanese refugees in Nepal. *Arch Gen Psychiatry*.58: 475–482.

Wang P.S., S Aguilar-Gaxiola., Alonso J., Angermeyer MC, Borges G, Bromet EJ, Bruffaerts R, de Girolamo G, de Graaf R, Gureje O, Haro JM, Karam EG, Kessler RC, Kovess V, Lane

MC, Lee S, Levinson D, Ono Y, Petukhova M, Posada-Villa J, Seedat S, Wells JE. 2007. Use of Mental Health Services for Anxiety, Mood, and Substance Disorders in 17 countries in the WHO World Mental Health Surveys. *Lancet*. 370 (9590):841-850

Walters, J.T.R., J.I. Bisson & J.P. Shepherd. 2007. Predicting post-traumatic stress disorder: Validation of the Trauma Screening Questionnaire in victims of assault. *Psychological Medicine, 37,* 143-150.

WHO. 1994. *International Classification of Diseases (ICD), 10th revision*. Geneva: WHO

WHO. 2001. *The World Health Report, Mental Health: New Understanding, New Hope*. Geneva, WHO

WHO. 2003*. Organization of Services for Mental Health.* Geneva: WHO.

WHO. 2003. *Advocacy for Mental Health*. Geneva: WHO.

WHO.2004. *Mental health policy, plans and programmes*. Geneva: WHO.

WHO. 2004. *The Role of International Human Rights in National Mental Health Legislation*. Prepared by Eric Rosenthal & Clerence Sundram. Geneva: WHO

WHO. 2005. *WHO Resource Book on Mental Health, Human Rights and Legislation. Geneva:* WHO.

WHO. 2005. *Mental Health Atlas - Revised Edition*. Geneva: WHO.

WHO. 2005. *The Optimal Mix of Services for Mental Health: WHO Pyramid Framework*. Geneva: WHO.

WHO. 2005. *Mental Health Declaration for Europe Facing the Challenges, Building Solutions*. Helsinki: WHO.

WHO. 2005. *Developing a mental health policy.* Geneva: WHO.

WHO. 2005. *Mental Health Declaration for Europe: Facing the Challenges, Building Solutions*. Copenhagen: WHO. http://www.euro.who.int/__data/assets/pdf_file/0008/88595/E85445.pdf. (Accessed March 21, 2014).

WHO. 2007. *Task Shifting: Global Recommendations and Guidelines*. Geneva: WHO.

WHO. 2007. SUPRE - *the WHO worldwide initiative for the prevention of suicide.* Geneva: WHO. http://www.who.int/mental health/prevention/suicide/suicideprevent/en/ (Accessed June 18, 2012).

WHO. 2008. *The Global Burden of Disease: 2004 Update*. Geneva: WHO.

WHO. 2009. *Improving health systems and services for mental health (Mental health policy and service guidance package).* Geneva: WHO Press.

WHO. 2009*. Improving Health Systems and Services for Mental Health*. Geneva: WHO. http://whqlibdoc.who.int/publications/2009/9789241598774_eng.pdf.

WHO. 2010. *The world health report: health systems financing: the path to universal coverage.* Geneva: WHO).

WHO. 2010. *Mental health and development: Targeting people with mental health conditions as a vulnerable group.* Geneva: WHO

Press. http://www.who.int/mental_health/policy/development/en/index.html. (Accessed August 26, 2014).

WHO. 2011. *Mental Health Atlas. Department of Mental Health and Substance Abuse.* Geneva:
WHO. http://www.who.int/mental_health/evidence/atlas/profiles/geo_mh_profile.pdf. (Accessed June 16, 2014).

WHO. 2011. *Global status report on alcohol and health*. Geneva: World Health Organization

WHO. 2013. *Mental Health Action Plan 2013-2020*. Geneva:
WHO. http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf (Accessed September 9th, 2014).

WHO. 2013. *The European Mental Health Action Plan*. Izmir:
WHO. http://www.euro.who.int/__data/assets/pdf_file/0004/194107/63wd11e_MentalHealth-3.pdf (Accessed September 9th, 2014).

WHO. 2014. *World Health Organization and the Gulbenkian Global Health Platform. Innovation in deinstitutionalization: a WHO expert survey*. Geneva: WHO.

WHO & Children of Georgia. 2009. *An assessment of the mental health and psychosocial support needs of the conflict-affected populations*. Tbilisi: WHO; Children of Georgia

WHO. 2010. *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: mental health Gap Action Programme (mhGAP)*. Geneva: WHO.

WHO. 2010. *mhGAP Intervention Guide*. Geneva: WHO.
http://who.int/mental_health/publications/mhGAP_intervention_guide/en/ (Accessed September 2014)

WHO. 2013. *mhGAP module Assessment Management of Conditions Specifically Related to Stress.* Geneva: WHO.

WHO. 2013. *Guidelines for the management of conditions specifically related to stress*. Geneva: WHO.

WHO. 2008. *Training for Mid-level Managers Module 7: The EPI Coverage Survey*. Geneva: WHO.

WHO. 2001. *International Classification of Functioning, Disability and Health.* Geneva: WHO. http://www.who.int/classifications/icf/en/. (Accessed September 2014)

WHO. 2013. *BUILDING BACK BETTER: Sustainable mental health care after emergencies*. Geneva: WHO.

WHO. Equality and Human Rights Commission. 2006*. Improving health systems and services for mental health.Equal treatment: closing the gap–A formal investigation into physical health inequalities experienced by people with learning disabilities and/or mental health problems*. Geneva. WHO.

Wittchen HU, F. Jacobi, J. Rehm, A. Gustavsson, M. Svensson and B. Jonsson. J. Olesen, C. Allgulander, J. Alonso, C. Faravelli, L. Fratiglioni, P. Jennum, R. Lieb, A. Maercker , J. van Os, M. Preisig, L. Salvador-Carulla, R. Simon, HC Steinhausen. 2011. The size and burden of mental disorders and other disorders of the brain in Europe 2010. Eur Neuropsychopharmacol 21(9) (September):655-79.

Wittchen HU, and F. Jacobi. 2005. Size and burden of mental disorders in Europe--a critical review and appraisal of 27 studies. *Eur Neuropsychopharmacol*; 15(4) (August):357-76.

World Bank. 2010. *World Bank List of Economies*. Washington DC: World Bank. http://data.worldbank.org/about/country-classifications/

Wu KK, and MWL. Cheung. 2006. Posttraumatic stress after a motor vehicle accident: A six-month follow-up study utilizing latent growth modelling. *Journal of Traumatic Stress;* 19:923–936.

Zoidze A, N. Rukhadze, K. Chkhatarashvili, and G. Gotsadze. 2013. Promoting universal financial protection: health insurance for the poor in Georgia – a case study. *Health Research Policy and Systems* 11:45.

Annexes

ANNEX I.1

Questionnaire on mental health problems of conflict-affected populations *(Eng. version)*

SECTION A: BACKGROUND INFORMATION

(Background section to be filled in by the interviewer or regional representative prior to interview)

Questionnaire Number |_____|_____|_____|____|

Code for primary sampling unit |_____|_____|_____|

Interviewer's number |_____|_____|

Interview date|_____|_____|_____|____|

Day month

Local time of the interview start. |_____|_____|_____|____|

hour minute

Name of the region of country:

6.1 Name of the district:

6.2 Name of the community: _____

Living location area:

1 = Capital of the country
2 = Regional centre
3 = Rayon centre
4= Village

Type of dwelling:

1= New IDP settlements (cottage)
2 = Apartment block/government building/collective centre (specifically inhabited by IDPs)
3= Individual house in home village (returnees)
4 = Other (specify)_____

INTRODUCTION

Hello! How do you do? You have randomly been chosen to participate in our survey on people who have been affected by war or displacement from their homes because insecurity and conflict. We are very thankful to you for your help in our survey and for your sincere answers.

[Interviewer, please read out information sheet (and leave with respondent) and complete consent form].

SECTION B: DEMOGRAPHIC CHARACTERISTICS

Respondents gender

1 = Male	2 = Female

What is your age?

_____ Years 98 refusal	

What is your marital status?

1 = Single, have never been married	5 = Widow/Widower – within last year
2 = Married/co-habiting	6 = Widow/Widower – for more than 1 year
3 = Divorced/separated – within last year	
4 = Divorced/separated – for more than 1 year	98 = Refused to answer

What is your highest level of education?

1 = Primary or without education	4 = Non-finished higher education
2 = Incomplete secondary	5 = Completed higher education
3 = Completed secondary education (including vocational)	98 = Refused to answer

SECTION C: DISPLACEMENT

Have you ever been displaced from your home community (village, town) because of war or armed violence?

1=Yes, I am still displaced	98 = Refused
2=Yes, and I have returned to my community	
3=No, I have not been displaced →[SKIP TO 17]	

When were you first displaced?

_____ Year	98 = Refused
	99 = Don't know

How many times have you been displaced by war or by government (excluding personal reasons such as marriage or family reasons)?

	a.How many times	b.When last displaced (year)
i)By war		
ii)By the Georgian government		
98 – refused to answer		

Do you currently have IDPs Status?

1 = Yes	98 = Refuse to answer
2 = No	99 = Don't know

SECTION D: HOUSEHOLD CHARACTERISTICS

How many people currently live in this household (including all babies and children)?

	98 =Refused to answer
_____ people	99 = Don't know

Approximately, how many square metres of living space is there in your household?

_____ square metres	98 =Refused to answer
	99 = Don't know

What is your position in relation to the head of the household?

1=Head of household	8 = Son in law
2=Spouse or partner	9 = Grandchild
3=Parent	10 = Other type of relative
4=Brother or sister	
5=Daughter	11= Friend
6=Son	12 = Other (specify) _____
7=Daughter in law	98 =Refused to answer

Who owns this accommodation?

1= The government	
2= Ourselves	98 = Refused to answer
3 = Our relatives/friends (we stay here for free)	99 = Don't know
4 = Our relatives/friends (we pay to stay here either cash or in kind (e.g. food)	
5 = Private landlord (we rent)	

Do you have the following, and how satisfied are you with them:

	21. a.		21.b							
	Yes	No	Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied	Refused to answer	Don'tknow	NA
a=the conditions			1	2	3	4	5	98	99	

of the community in which you live										
b= Electricity supply	1	2	1	2	3	4	5	98	99	
c=Gas supply	1	2	1	2	3	4	5	98	99	
d=Water supply (domestic use)	1	2	1	2	3	4	5	98	99	
e=water supply (agricultural use)	1	2	1	2	3	4	5	98	99	97
f=your general living conditions			1	2	3	4	5	98	99	

SECTION E: SOCIAL CAPITAL AND SAFETY

What is the degree to which you agree with the statement that a majority of people can be trusted?

1 = Agree	98 = Refused to answer
2 = Quite agree	99 = Don't know
3 = Rather disagree	
4 = Disagree	

We now have questions on people in your life who can provide you with help or support (*for interviewer: questions a to g include family members as well)*.

		Yes	No	Refused	Don't know
	Is there anyone who you can really count on	1	2	98	99

	to listen to you if you were feeling very sad/depressed?				
	Is there anyone with whom you can discuss intimate and personal matters?	1	2	98	99
	Is there anyone who you can really count on to listen to you when you need to talk?	1	2	98	99
	Is there anyone who you can really count on to help you out in a crisis?	1	2	98	99
	Is there anyone who you can totally be yourself with?	1	2	98	99
	Is there anyone who you feel really appreciates you as a person?	1	2	98	99
	Is there anyone who you can really count on to comfort you when you are very upset?	1	2	98	99
	Outside of the household, is there anyone who you could borrow money from to cover your usual expenses for 2 weeks (without expecting compensation/interest)?	1	2	98	99
	Outside of the household, is there someone who could look after you if you were ill (without expecting compensation)?	1	2	98	99

Are you a member of a party, organisation, association, or church?

(Prompt: e.g. neighbourhood good, youth group, women's organisation, church, arts/education, trade union, political party etc.)

1 = Yes	98 = Refuse to answer [go to 26]
2 = No [go to 26]	

Are you an active member of an organisation?

1 = Yes	98 = Refuse to answer

2 = No	

How often do you attend religious service?

1 = Several time a day	98 = Refused to answer
2 = Daily	
3 = Several times each week	
4 = Once weekly	
5 = Monthly	
6 = Only on religious days or particular occasions	
7 = Rarely	
8 = Never	

In your neighbourhood…

	Strongly agree	Slightly agree	Slightly disagree	Strongly disagree	Refused	Don't know
People around here are willing to help neighbours	1	2	3	4	98	99
b. People around here get along with each other	1	2	3	4	98	99
c. People in the neighbourhood can be trusted	1	2	3	4	98	99
d.Neighbours would help you if you needed it	1	2	3	4	98	99

In your neighbourhood…

	Always	Mostly	Some-times	Rarely	Never	Refused	Don't

							know
a. Do you feel safe during the day?	1	2	3	4	5	98	99
b. Do you feel safe during the night?	1	2	3	4	5	98	99

During the past 12 months, have you been worried about any of the following things in this town/village/settlement?

	Not worried	Little bit worried	Quite worried	Very Worried	Refused	Don't know
Having things stolen from your home	1	2	3	4	98	99
Being harassed or threatened on the street	1	2	3	4	98	99
Being abused because you were displaced from another area in Georgia	1	2	3	4	98	99
Being robbed on the street	1	2	3	4	98	99
Being physically attacked	1	2	3	4	98	99
Being sexually harassed, molested or attacked	1	2	3	4	98	99

During the past 2 years, have any of the following events happened to you, a family member, or someone else you know in this settlement?

	To you	To a family member	To someone in the settlement	No	Refused	Don't know

Having things stolen from home	1	2	3	4	98	99
Being harassed or threatened on the street	1	2	3	4	98	99
Being abused because you were displaced from another area in Georgia	1	2	3	4	98	99
Being robbed on the street	1	2	3	4	98	99
Being physically attacked	1	2	3	4	98	99
Being sexually harassed, molested or attacked	1	2	3	4	98	99

Over the past 1 month, how afraid have you felt that your community could be attacked again in an armed conflict?

1 = Very afraid	98 = Refused
2 = Quite afraid	99 = Don't know/difficult to answer
3 = Not very afraid	
4 = Not at all afraid	

SECTION F: HEALTH

In general, would you say your health is....

(for interviewer: please read questions and response options exactly as written)

1 = Very good	98 = Refused to answer
2 = Good	99 = Don't know
3 = Fair	
4 = Poor	
5 = Very poor	

Please think about the time you spent walking in the last 7 days. This includes at work and at home, walking to travel from place to place, and any other walking that you might do solely for recreation, sport, exercise, or leisure.

During the last 7 days, on how many days did you walk for at least 10 minutes at a time?

_____ days per week

98 = Refusal

99= Don't know

Last week, on a typical day, how much time did you spend walking in total?

_____ hours _____ minutes, per day

98 = Refusal

99= Don't know

During the last 4 weeks, how much have you been bothered by any of the following problems?

PHQ-15 somatic symptoms

	Not bothered	Bothered a little	Bothered a lot
Stomach pain	1	2	3
Back pain	1	2	3
Pain in your arms, legs, or joints (knees, hips, etc.)	1	2	3
[WOMEN ONLY]: Menstrual cramps or other problems with your periods	1	2	3
Pain or problems during sexual intercourse	1	2	3
Headaches	1	2	3
Chest pain	1	2	3
Dizziness	1	2	3
Fainting spells	1	2	3
Feeling your heart pound or race	1	2	3
Shortness of breath	1	2	3
Constipation, loose bowels, or diarrhoea	1	2	3
Nausea, gas, or indigestion	1	2	3
Feeling tired or having low energy	1	2	3

Trouble sleeping	1	2	3

Do you have any long term illness, health problem or handicap which limits your daily activities or the work you can do?

1 = Yes	98 = Refused to answer
2 = No	

Below are some statements about feelings and thoughts. Please say which response best describes your experience of each statement over the last 2 weeks.

[Short Warwick-Edinburgh Mental Well-being Scale:].

(for interviewer: please read questions and response options exactly as written)

	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?

[PHQ-9]

[Interviewer: Please read out the questions and response options exactly as they are written. Read out all response options for each question until respondent clear what response options are.]

	Not at	Several	More	Nearly

	all	days	than half the days	every day
Little interest or pleasure in doing things.	1	2	3	4
Feeling down, depressed, or hopeless.	1	2	3	4
Trouble falling or staying asleep, or sleeping too much.	1	2	3	4
Feeling tired or having little energy.	1	2	3	4
Poor appetite or overeating.	1	2	3	4
Feeling bad about yourself — or that you are a failure or have let yourself or your family down.	1	2	3	4
Trouble concentrating on things, such as reading the newspaper or watching television.	1	2	3	4
Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	1	2	3	4
Thoughts that you would be better off dead or of hurting yourself in some way.	1	2	3	4
Interviewer note: If any individual questions score answer of 2 ('several days or more') or above, please ask the following question:				
	Not difficult at all	Somewhat difficult	difficult	Very difficult
How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	1	2	3	4

How often during the past 2 weeks have you felt bothered by:

[Interviewer: Please read out the questions and response options exactly as they are written. Read out all response options for each question until respondent clear what response options are.]

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge?	1	2	3	4
Not being able to stop or control worrying?	1	2	3	4
Worrying too much about different things?	1	2	3	4
Trouble relaxing?	1	2	3	4
Being so restless that it is hard to sit still?	1	2	3	4
Becoming easily annoyed or irritable?	1	2	3	4
Feeling afraid as if something awful might happen?	1	2	3	4
Interviewer note: If any individual questions score answer of 2 ('several days or more') or above, please ask the following question:				
	Not difficult at all	Somewhat difficult	difficult	Very difficult
How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	1	2	3	4

In the last <u>30 days</u> how much difficulty did you have in:

WHO Disability questionnaire (WHO-DAS -12):

[Interviewer: Please read out the questions and response options exactly as they are written]

	None	Mild	Moderate	Severe	Extreme or	Not applic	Refusal	Don't know

					Cannot Do	able		
Standing for long periods such as 30 minutes?	1	2	3	4	5	97	98	99
Taking care of your household responsibilities?	1	2	3	4	5	97	98	99
Learning a new task, for example, learning how to get to a new place?	1	2	3	4	5	97	98	99
How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	1	2	3	4	5	97	98	99
How much have you been emotionally affected by your health problems?	1	2	3	4	5	97	98	99

IF ANY OF the individual responses from 102 to 106 have been 2 or above then please continue to Q107. If not, then please → [SKIP TO Q114]

In the last 30 days how much difficulty did you have in:

[Interviewer: Please read out the response options exactly as they are written. Read out all response options for each question until respondent clear what response options are.]

	None	Mild	Moderate	Severe	Extreme or Cannot Do
Concentrating on doing something for ten minutes?	1	2	3	4	5
Walking a long distance such as a kilometre [or equivalent]?	1	2	3	4	5

Washing your whole body?	1	2	3	4	5
Getting dressed?	1	2	3	4	5
Dealing with people you do not know?	1	2	3	4	5
Maintaining a friendship?	1	2	3	4	5
Your day to day work?	1	2	3	4	5

SECTION G: EXPOSURE TO TRAUMATIC EVENTS

Prompt: I would like to ask you about your life in the past. Some of the questions may make you feel distress. If this happens, feel free not to answer them. I would also like to remind you that all your answers will be kept confidential. Have you experienced any of the following situations in your life?

Read out exact response options for each question until respondent clear what response options are. If event happen, specify when. More than one option is possible.

	Experienced ?		when experienced				
	Yes	Never	Before conflict / displacement	During the conflict/ fighting	During displacement	After conflict / displacement	Refused
Have you ever experienced having to sleep out in the open because of a lack of housing/shelter?	1	2	1	2	3	4	98
Have you ever experienced serious injury?	1	2	1	2	3	4	98
Have you ever directly	1	2	1	2	3	4	98

experienced a combat situation?							
Have you ever experienced physical abuse from your partner or other family member?	1	2	1	2	3	4	
Have you experiencedsexual abuse or being forced to have sex when you did not want to? This could include a partner, family member, someone that you know, or a stranger.	1	2	1	2	3	4	98
Have you ever experienced being abducted?	1	2	1	2	3	4	98
Have you ever been tortured?	1	2	1	2	3	4	98
Have you ever experienced the murder, torture or other violent act against a family member or friend?	1	2	1	2	3	4	98
Have you ever witnessed the murder, torture or other violent act against a stranger or strangers?	1	2	1	2	3	4	98
Have you experienced the death of family member or close friend during the conflict (eg.lack of shelter/exposure to cold, killed in fighting, bombs, landmines)?	1	2	1	2	3	4	98
Have you ever experienced the unexpected death of a family member/ close friend due to causes not related to the war that	1	2	1	2	3	4	98

was very traumatic to you? (e.g. from car accident, illness, suicide etc)							

Prompt: Please indicate (Yes or No) whether or not you have experienced any of the following at least twice in the past one week.

[Interviewer: Please read out the questions exactly as they are written]

	Yes	No	Refusal	Don't know
Upsetting thoughts or memories about the event that have come into your mind against your will.	1	2	98	99
Upsetting dreams about the event.	1	2	98	99
Acting or feeling as though the event were happening again.	1	2	98	99
Feeling upset by reminders of the event.	1	2	98	99
Bodily reactions (such as fast heartbeat, stomach churning, sweatiness, dizziness) when reminded of the event.	1	2	98	99
Difficulty falling or staying asleep.	1	2	98	99
Irritability or outbursts of anger.	1	2	98	99
Difficulty concentrating.	1	2	98	99
Heightened awareness of potential dangers to yourself and others.	1	2	98	99
Being jumpy or being startled by something unexpected.	1	2	98	99

SECTION H: HEALTH CARE COVERAGE AND SERVICES

Do you have health insurance coverage?

1= Yes, state insurance for vulnerable groups	6 =Yes, individual private insurance

2= Yes, teachers' programme	7 = Yes, other specify_____
3 = Yes, military / police programme	8= No insurance
4 =Yes, other employer programme, paid by employer	98 = Refused to answer
5 =Yes, other employer programme paid by employee	99 = Don't know

In the past1 year, have you ever felt feelings such as anxiety, nervousness, depression, insomnia or any other emotional or behavioural problems for which you sought health care?

= Yes→ [SKIP TO 139]	98 = Refuse to answer → [SKIP TO 140]
2 = Did not have the feelings mentioned [SKIP TO 140]	99 = Don't know → [SKIP TO 140]
3 = Had feelings/problems but did not seek health care	

If had feeling but did not seek health care services, what was the reason for not using health care services?

[interviewer: multiple responses allowed]

1 = I thought I would get better by using the drugs I had or other self-treatment	8 = Remote location of the health care facility
2 = I could not afford to pay for the health services	9 = I had no health insurance
3 = I could not afford to pay for the drugs	10 = Other, please specify_____
4 = No time/ I cannot take time off work	
5 = I did not know where I could get help	
6 = Health care services were of poor quality	98 = Refuse to answer
7 = I didn't trust the health care providers	99 = Don't know

[Interviewer, after you have completed the above question for patients who did not use health services, → SKIP TO 140]

If Yes, what sources care did you use?

[interviewer: multiple responses allowed]

Source	Drugs	Counselling	psychotherapy/ psychosocial support
Pharmacy	1	2	
GP office /ambulatory / policlinic services	1	2	3
Outreach/mobile services	1	2	3
Neurologist at Polyclinic	1	2	3
Psychiatric dispensary	1	2	3
Specialist mental health /psychosocial centre	1	2	3
Private mental health specialist	1	2	3
Therapist/ Neurologist at Hospital	1	2	3
Psychiatric hospital	1	2	3
Alternative/traditional health provider	1	2	
Other (*specify)*	1	2	3
98 = Refuse to answer			
99 = Don't know			

SECTION I: ALCOHOL AND TOBACCO USE

I am now going to ask you a series of questions regarding your drinking of alcohol. These questions are about the past year, unless otherwise specified.

Surrogates are mentioned in the following questions. These are substances not intended for drinking, including eau de colognes and medicinal tinctures as well as other things. They may be found in shops, chemists and kiosks.

How long, in minutes, does it take to get to the nearest place where one can obtain alcohol, (regardless of whether you drink alcohol or not)?

1 = No time (mainly drink home-made alcohol)	5 = more than 30 minutes

2 = less than 5 minutes	98 = refuse to answer
3 = 5-10 minutes	99 = Don't know
4 = 10-30 minutes	

How easy it for you to obtain an alcoholic drink (regardless of whether you drink alcohol or not)?

1 = very easy	98 = refuse to answer
2 = quite easy	99 = Don't know
3 = quite difficult	
= very difficult	

Are you currently drinking more than, less than, or about the same as you were before you were displaced/affected by the armed conflict?

1= more than before displacement	5= do not consume alcohol If 5 → [SKIP TO 162]
2= about the same as before displacement	6 = started after displacement
3 = less than before displacement	98 = refuse to answer
4 = Stopped drinking altogether If 4 → [SKIP TO 162]	99 = don't know

Prompt: For each type of drink listed in the left hand column, please indicate how often each is usually drunk

	Everyday	4 or more times a week	2-3 times per week	2-4 times a month	Once a month	Once in 2-3 months	Less often	Never	Refuse to answer	Don't know
Alcohol (any	1	2	3	4	5	6	7	8	98	99

type)										
If 8 ('Never') → [SKIP TO 162]										
Wine	1	2	3	4	5	6	7	8	98	99
Vodka (and other spirits)	1	2	3	4	5	6	7	8	98	99
Beer	1	2	3	4	5	6	7	8	98	99

Prompt: During the past year, what was your frequency of drinking and how much did you typically drink on one occasion? (read out all responses)

Wine a. 1=Never → [SKIP TO 148] 2=Less than monthly 3=Monthly 4=Weekly 5=Daily = Refused = Don't know	b. Wine _____ litres
Beer a. 1=Never → [SKIP TO 149] 2=Less than monthly 3=Monthly 4=Weekly 5=Daily 98 = refused 99 = Don't know	b. Beer _____ litres
Vodka (spirits)	

a. 1=Never → [SKIP TO 150] 2=Less than monthly 3=Monthly 4=Weekly 5=Daily 98 = refused 99 = Don't know	b. Vodka (spirits) _____ grammes

How often do you drink alcohol alone?

1 = Often
2 = Sometimes
3 = Never
98 = difficult to answer
99 = refuse to answer

In the <u>last one</u> year, have you had an episode of zapoi?

(zapoi refers to a period of continuous drunkenness of more than 2 days during which the person does not work and is withdrawn from normal life)

1 = Yes
2 = No
98 = difficult to answer
99 = refuse to answer

Do you <u>mainly</u> obtain alcohol from?

[interviewer, please read out options available]

1 = I/we make at home	98 = refuse to answer
2= home-made from someone else (without money, gift, in kind)	
3 = purchase home-made from someone else, market, shop, kiosk,	99 = don't know
4 = purchase manufactured from a bar/café, market, shop, kiosk	
5= other	

Prompt: This section has some questions about drinking alcohol over the past 1 year. These are drinks like beer,"A drink" means 1 glass of strong alcohol, 1 glass of wine, 1 small glass of strong beer, 1 big glass of mild beer.

[Interviewer: Please read out the questions exactly as they are written, and also read out response options.]

	How many drinks do you take on a particular day when you are drinking? (read out all responses)	0=0 1=1 or 2 2=3 or 4 3=5 or 6 4=7,8 or 9 5=More than 10
	How often do you take 6 or more drinks of alcohol at one sitting? (read out all responses)	1=Never 2=Less than monthly 3=Monthly 4=Weekly 5=Daily
	Over the last one year, how many times did you find it hard to stop drinking once you had started drinking? (read out all responses)	1=Never 2=Less than monthly 3=Monthly 4=Weekly 5=Daily
	During the last one year, how often did you fail to do what you were meant to do because of drinking? (read out all responses)	1=Never 2=Less than monthly 3=Monthly 4=Weekly 5=Daily
	During the last year, how many times did you have to take a drink in the morning before	1=Never 2=Less than monthly

	you are able to feel and work normally following a heavy drinking occasion the previous day? (read out all responses)	3=Monthly 4=Weekly 5=Daily
	During the last one year, how often did you feel guilty or embarrassed after drinking? (read out all responses)	1=Never 2=Less than monthly 3=Monthly 4=Weekly 5=Daily
	During the last year, how often did you find it difficult to remember what happened the previous night because of drinking alcohol? (read out all responses)	1=Never 2=Less than monthly 3=Monthly 4=Weekly 5=Daily
	Have you or someone else been injured because of your drinking alcohol? (read out all responses)	1=Never 2=Yes, but not during the last year 3=Yes, during the last year
	Has a friend, relative, health worker or someone ever complained to you about your drinking and advised you to stop or reduce drinking? (read out all responses)	1=Never 2=Yes, but not during the last year 3=Yes, during the last year

Tobacco: Based upon the fagerstrom test for nicotine dependency

Do you smoke at least one cigarette per day (1 papirossi, 1 pipe, cigar etc.)

1 = Yes 99 = Refusal → [SKIP TO 169]

2 = No → [SKIP TO 169]

About how many cigarettes (papirossi, cigars, pipes) a day do you smoke?

_____cigarettes 98 = Don't know

= Refusal

How soon after you wake up do you smoke your first cigarette?

1= Within the first 5 minutes

2 = between 5 minutes and 30 minutes after getting up in the morning

3 = During the first hour after getting up in the morning

= Before midday

5= After midday or in the evening

98 = Don't Know

99 = Refused

Do you find it difficult to refrain from smoking in places where smoking is not allowed (e.g. transport, hospitals, government offices, cinemas, libraries etc)?

1 = Yes

2 = No

98 = Don't know

99= Refused

Do you usually smoke more during the first hours after waking than during the rest of the day?

1 = Yes

2 = No

98 = Don't know

99 = Refused

Which cigarette would you be the most unwilling to give up?

1 = First in the morning

2 = Any of the others

98 = Don't know

99 = Refused

Do you smoke even when you are very ill?

1 = Yes

2 = No

98 = Don't know

99 = Refused

SECTION K: ECONOMIC SITUATION

Please tell me about your work situation. Are you…

1 = Unemployed, seeking work	8 = Subsistence farmer
2 = Not employed and not seeking work	9 = Full time student
3 = In regular paid work	10 = Retired due to age
4 = In irregular paid work	11 = Retired due to invalidity
5 = Self-employed	12 = Other:
6 = Housewife	_____
7 = On maternity leave	98 = Refused to answer

How would you describe your household's current economic situation?

1 = Very good	98 = Refused to answer
2 = Good	99 = Don't know
3= Average	
4= Bad	
5= Very bad	

Which of the following things in working condition does this household own?

(inteviewer, multiple responses are permitted. Please circle all numbers that apply)

1 = Fridge	8=Generator
2 = Colour TV with remote control	9= Water heater
3 = Automatic Washing machine	10= Gas room heater
4 = Mobile telephone	11 = None of the above
5 = Computer/laptop	98 = Refuse to answer
6 = Car	99 = Don't know
7 = DVD player	

And now, please imagine a ten-step ladder for Georgia where on the bottom, the first step, stand the poorest people, and on the highest step, the tenth, stand the rich. On which step of the ten steps are you personally standing today?

										98	99
Poorest									*people*	Refused	Don't know
Richest people											

In the past twelve months did your household have to do without things that you really need, such as:

	Constantly	Sometimes	Never	Do not use it	Refused to answer	Don't know
Basic foods (bread, sugar, milk)	1	2	3	4	98	99
Heating	1	2	3	4	98	99
Clothes/ shoes that are really necessary	1	2	3	4	98	99
Electricity	1	2	3	4	98	99
Transportation/fuel for car	1	2	3	4	98	99
Medical care	1	2	3	4	98	99
Essential school books	1	2	3	4	98	99
Medical drugs	1	2	3	4	98	99
Home repairs	1	2	3	4	98	99

THANK YOU VERY MUCH FOR YOUR COOPERATION!

Interview conducted in privacy, with only respondent present?

1 = Yes, only with respondent present

2 = No, other people were present

Local time of the interview finish.

/_____/_____//_____/_____/

hour minute

INTERVIEWER'S GUARANTEE:

I guarantee that the questionnaire has been conducted by me in accordance with the instruction, by the method of personal interview with the selected accordingly to the instruction respondent.

*Signature*_____

*Name& Surname.*_____

ANNEX 1.2 (ქართული ვერსია).

კითხვარი: იძულებით გადაადგილება და ჯანმრთელობა საქართველოში

სექცია ა: ძირითადი მონაცემები

(ძირითადი მონაცემების სექცია ივსება ინტერვიუერის ან რეგიონული წარმომადგენლის მიერ ინტერვიუს დაწყებამდე)

კითხვარის ნომერი |_____|_____|_____|____|

პირველადი შერჩევის ერთეულის კოდი |_____|_____|_____|

ინტერვიუერის კოდი |_____|_____|

ინტერვიუს თარიღი|_____|_____|_____|____|

დღე თვე

ინტერვიუს დაწყების დრო |_____|_____|_____|____|

საათი წუთი

რეგიონის დასახელება: _____

6.1 რაიონის დასახელება: _____

6.2 სოფლის დასახელება: _____

საცხოვრებელი არეალი:

1 = თბილისი
2 = რეგიონული ცენტრი
3 = რაიონული ცენტრი
4= სოფელი

დასახლების ტიპი:

1= ახალი დევნილების დასახლება (კოტეჯები)
2 = კორპუსი/ სახელმწიფოს საკუთრებაში მყოფი შენობა/კოლექტიური ცენტრი (დევნილებით დასახლებული)
3= საკუთარი სახლი მშობლიურ სოფელში (დაბრუნებული)
4 = სხვა (დააკონკრეტეთ) _____

შესავალი

გამარჯობა! როგორ ბრძანდებით? შემთხვევითი შერჩევის პრინციპით თქვენ აღმოჩნდით მათ შორის, ვინც ჩვენს კვლევაშია ჩართული.კვლევა ეხება იმ ადამიანებს, ვისაც შეეხო ომი ან იძულებით მოუწია საკუთარი სახლის დატოვება კონფლიქტის გამო.წინასწარ გიხდით მადლობას კვლევაში მონაწილეობისთვის და გულწრფელი პასუხებისთვის.

[ინტერვიუერს! გთხოვთ წაიკითხოთ საინფორმაციო ფურცელი (და დაუტოვოთ იგი რესპონდენტს) და შეავსოთ თანხმობის ფორმა)

სექცია ბ: დემოგრაფიული მახასიათებლები

რესპონდენტის სქესი

1 = მამრობითი	2 = მდედრობითი

თქვენი ასაკი?

_____ წელი	98= უარი პასუხზე

თქვენი ოჯახური მდგომარეობა?

1 = არასოდეს ვყოფილვარ ქორწინებაში	5 = ქვრივი - ბოლო ერთი წელია
2 = დაქორწინებული/თანამცხოვრები	6 = ქვრივი - წელიწადზე მეტია
3=განქორწინებული/ გაშორებული ბოლო ერთი წლის განმავლობაში	98 = უარი პასუხზე
4= განქორწინებული/ გაშორებული-	

წელიწადზე მეტი ხნის განმავლობაში	

თქვენი განათლების უმაღლესი საფეხური

1 = საწყისი განათლება ან განათლების გარეშე	4 = არასრული უმაღლესი განათლება
2 = არასრული საშუალო	5 = სრული უმაღლესი განათლება
3 = სრული საშუალო განათლება (პროფესიული განთლების ჩათვლით)	98 = უარი პასუხზე

სექცია გ: იძულებით გადაადგილება

ოდესმე თუ დაგიტოვებიათ თქვენი დასახლება (სოფელი, ქალაქი) ომის ან შეიარაღებული კონფლიქტის გამო?

1=დიახ, ახლაც დატოვებული მაქვს	98 = უარი პასუხზე
2=დიახ, მაგრამ დავუბრუნდი დასახლებას	
3=არა, არ დამიტოვებია→ [გადადით 0-ზე]	

როდის მოგიწიათ საცხოვრებელი ადგილის დატოვება პირველად?

_____ წელი	98 = უარი პასუხზე
	99 = არ ვიცი

რამდენჯერ მოგიწიათ საცხოვრებელი ადგილის შეცვლა ომის ან საქართველოს მთავრობის გადაწყვეტილების გამო? *(არ იგულისხმება პირადი მიზეზები, მაგ. ქორწინება, ოჯახური მდგომარეობა)*

მიზეზი	a.რაოდენობა	b. აღნიშნეთ ბოლო *(მიუთითეთ წელი)*
1 = ომის გამო		
2 = საქართველოს მთავრობის გამო		
98 = უარი პასუხზე		

გაქვთ თუ არა ახლა დევნილის სტატუსი?

1 = დიახ	98 = უარი პასუხზე
2 = არა	99 = არ ვიცი

სექცია დ: შინამეურნეობის მახასიათებლები

რამდენი ადამიანი ცხოვრობთ ამჟამად ოჯახში? (ჩვილი ბავშვებისა და მოზარდების ჩათვლით)?

	98 =უარი პასუხზე
_____ *ადამიანი*	99 = არ ვიცი

დაახლოებით რამდენი კვ.მ -ია თქვენი ოჯახის საცხოვრებელი ფართი?

	98 =უარი პასუხზე
_____ *კვ.მ*	99 = არ ვიცი

ვინ ხართ თქვენ ამ ოჯახისთვის (მიმართება ოჯახის უფროსთან)?

1=ოჯახის უფროსი	8 = სიძე
2=მეუღლე ან პარტნიორი	9 = შვილიშვილი
3=მშობელი	10 = სხვა ნათესავი
4=ძმა ან და	11 = მეგობარი
5= ქალიშვილი	12 = სხვა (დააკონკრეტეთ) _____
6= ვაჟი	
7 = რძალი	98 =უარი პასუხზე

ვის მფლობელობაშია ეს საცხოვრებელი ფართი?

1= სახელმწიფოს	
2= ჩვენი საკუთრებაა	98 = უარი პასუხზე
3 = ჩვენი ნათესავების/მეგობრების (დაგვითმეს საზღაურის გარეშე)	99 = არ ვიცი
4 = ჩვენი ნათესავების/მეგობრების (ვუხდით ქირას ან ვანაზღაურებთ ნატურით (მაგ: პროდუქტით)	
5 = კერძო მფლობელის (ვქირაობთ)	

გაქვთ თუ არა და რამდენად კმაყოფილი ხართ:

	21 a)		21.b)							
	კი	არა	ძალიან უკმაყოფილო	უკმაყოფილო	არც უკმაყოფილო არც კმაყოფილი	კმაყოფილი	ძალიან კმაყოფილი	უარი პასუხზე	არ ვიცი	შეუსაბამოა
1. საცხოვრებელი პირობებით იმ არეალში სადაც ცხოვრობთ			1	2	3	4	5	98	99	
2.ელექტრომომარაგებით	1	2	1	2	3	4	5	98	99	
3.ბუნებრივი აირის მიწოდებით	1	2	1	2	3	4	5	98	99	
4. წყალმომარაგებით (საშინაო მოხმარებისთვის)	1	2	1	2	3	4	5	98	99	
5. წყალმომარაგებით (სასოფლო-სამეურნეო დანიშნულების თვის)	1	2	1	2	3	4	5	98	99	97
6.პირადად			1	2	3	4	5	98	99	

თქვენი საცხოვრებელი პირობებით										

სექცია ე: სოციალური კაპიტალი და დაცულობა

რამდენად ეთანხმებით დებულებას, რომ შეიძლება ადამიანების უმეტესობის ნდობა?

1 = სრულიად ვეთანხმები	98 = უარი პასუხზე
2 = ვეთანხმები	99 = არ ვიცი
3 = არ ვეთანხმები	
4 = სრულიად არ ვეთანხმები	

ჩვენი მომდევნო შეკითხვა ეხება იმ ადამიანებს, ვისაც შეუძლიათ გარკვეული სახის დახმარება გაგიწიონ ან მხარდაჭერა აღმოგიჩინონ (*ინტერვიუერს: 1-7 ეხება ოჯახის წევრების ჩათვლით)*

		დიახ	არა	უარი	არ ვიცი
	გეგულებათ ისეთი ადამიანი, რომელიც უეჭველად მოგისმენთ, თუკი ძალიან ნაღვლიანად ან დეპრესიულად იგრძნობთ თავს?	1	2	98	99
	გეგულებათ ისეთი ადამიანი, რომელთანაც შეგიძლიათ განიხილოთ ინტიმური და პირადი საკითხები?	1	2	98	99
	არის ვინმე ისეთი, ვინც გეიმედებათ მსმენელად, როცა თქვენ საუბარი გჭირდებათ?	1	2	98	99
	არსებობს ადამიანი, რომელიც ნამდვილად დაგეხმარებათ კრიზისიდან/ მძიმე შინაგანი მდგომარეობიდან გამოსვლაში?	1	2	98	99
	არსებობს ადამიანი, რომელთან ყოფნისას	1	2	98	99

	ბოლომდე შეგიძლიათ იყოთ ისეთი, როგორიც ხართ?				
	არსებობს ადამიანი, რომელიც ნამდვილად გაფასებთ, როგორც პიროვნებას?	1	2	98	99
	გეგულებათ ადამიანი რომელიც უეჭველად დაგამშვიდებთ როდესაც ძალიან შეწუხებული ხართ	1	2	98	99
	არსებობს ოჯახის გარეთ ისეთი ადამიანი, ვინც უანგაროდ და ყოველგვარი სარგებლის გარეშე გასესხებთ ფულს ორი კვირის განმავლობაში ყოველდღიური ხარჯების დასაფარად?	1	2	98	99
	არსებობს ოჯახის გარეთ ისეთი ადამიანი, რომელიც უანგაროდ მოგივლით ავადმყოფობის დროს?	1	2	98	99

ხართ თუ არა რომელიმე პარტიის, ორგანიზაციის, გაერთიანების, ასოციაციის წევრი, ან ეკლესიის მრევლი?

(*წაუკითხეთ საჭიროების შემთხვევაში.* მაგ: სათემო კავშირი, ახალგაზრდული ორგანიზაცია, ქალთა ორგანიზაცია, ხელოვნება/განათლება, სავაჭრო კავშირი, პოლიტიკური პარტია (და ა.შ.)

1 = დიახ	98 = უარი პასუხზე [გადადით 0-ზე]
2 = არა [გადადით 0-ზე]	

ხართ თუ არა ორგანიზაციის აქტიური წევრი?

1 = დიახ	98 = უარი პასუხზე
2 = არა	

რამდენად ხშირად ესწრებით რელიგიურ მსახურებას?

1= დღეში რამდენჯერმე	98 = უარი პასუხზე

2= ყოველდღე	
3 = კვირაში რამდენჯერმე	
4 =კვირაში ერთხელ	
5 = ყოველთვიურად	
6 = მხოლოდ რელიგიურ დღესასწაულებზე ან განსაკუთრებულ შემთხვევებში	
7 =იშვიათად	
8 = არასოდეს	

რამდენად ეთანხმებით ქვემოჩამოთვლილ დებულებებს: თქვენს დასახლებაში ...

	სავსებით ვეთანხმები	უფრო ვეთანხმები	უფრო არ ვეთანხმები	სავსებით არ ვეთანხმები	უარი	არ ვიცი
ადამიანებს აქვთ სურვილი დაეხმარონ ერთმანეთს	1	2	3	4	98	99
ადამიანები ერთმანეთს კარგად ეწყობიან	1	2	3	4	98	99
აქ მცხოვრებ ადამიანებს შეიძლება ენდო	1	2	3	4	98	99
მეზობლები დაგეხმარებიან საჭიროების შემთხვევაში	1	2	3	4	98	99

თქვენს დასახლებაში…

	ყოველთვის	უმეტესად	ხანკი ხან არა	იშვიათად	არასოდეს	უარი	არ ვიცი
გრძნობთ თუ არა თავს დაცულად დღისით?	1	2	3	4	5	98	99
გრძნობთ თუ არა თავს	1	2	3	4	5	98	99

დაცულად ღამით?							

რომ ავიღოთ ბოლო 12 თვე და თქვენი დასახლება გქონიათ თუ არა შფოთვა, წუხილი რომელიმე ქვემოთ ჩამოთვლილი პრობლემის გამო ?

	არ მაწუხებს	ცოტა მაწუხებს	საკმაოდ მაწუხებს	ძალიან მაწუხებს	უარი	არ ვიცი
ნივთების მოპარვა სახლიდან	1	2	3	4	98	99
დამცირება, დამუქრება ქუჩაში	1	2	3	4	98	99
შეურაცხყოფა საქართველოს სხვა რეგიონიდან გადმოსახლების გამო	1	2	3	4	98	99
გაძარცვა ქუჩაში	1	2	3	4	98	99
ფიზიკური შეურაცხყოფა	1	2	3	4	98	99
დამცირება, ან სექსუალური ძალადობა	1	2	3	4	98	99

ბოლო 2 წლის განმავლობაში თქვენს დასახლებაში თქვენ, თქვენს ოჯახის წევრს, ან ვინმეს თქვენი დასახლებიდან ხომ არ შეემთხვა რომელიმე ქვემოთ ჩამოთვლილი მოვლენა?

	თქვენ	თქვენს ოჯახის წევრს	სხვა თქვეს დასახლებაში	არა	უარი	არ ვიცი
ნივთების მოპარვა სახლიდან	1	2	3	4	98	99
დამცირება, დამუქრება ქუჩაში	1	2	3	4	98	99
შეურაცხყოფა საქართველოს სხვა რეგიონიდან გადმოსახლების გამო	1	2	3	4	98	99

გაძარცვა ქუჩაში	1	2	3	4	98	99
ფიზიკური შეურაცხყოფა	1	2	3	4	98	99
სექსუალური ზეწოლა ან ძალადობა	1	2	3	4	98	99

<u>ბოლო 1 თვის განმავლობაში</u> ხომ არ შეუშინებიხართ იმ აზრს, რომ თქვენს დასახლებაზე კვლავ მოხდება თავდასხმა შეიარაღებული კონფლიქტის გამო?

1 = ძალიან შემაშინა	98 = უარი პასუხზე
2 =საკმაოდ შემაშინა	99 = არ ვიცი
3 = ძალიანაც არ შევუშინებივარ	
4 = სულაც არ შევუშინებივარ	

სექცია ვ: ჯანმრთელობის მდგომარეობა

ზოგადად, შეგიძლიათ თქვათ, რომ თქვენი ჯანმრთელობის მდგომარეობა არის ....

(*ინტერვიუერს: წაიკითხეთ შეკითხვები ზუსტად როგორც წერია)*

1 = ძალიან კარგი	98 = უარი პასუხზე
2 = კარგი	99 = არ ვიცი
3 = საშუალო	
4 = ცუდი	
5 = ძალიან ცუდი	

(*შეკითხვებისთვის0-0)* დაფიქრდით რამდენი ხანი <u>იარეთ ფეხით ბოლო 7 დღის განმავლობაში.</u>ამაში იგულისხმება როგორც სახლში ისე სამსახურში გადაადგილება ერთი ადგილიდან მეორეზე, ასევე განტვირთვა, სპორტი, ვარჯიში და დასვენება.

ბოლო 7 დღის განმავლობაში რამდენი დღე იარეთ ფეხით ერთ ჯერზე მინიმუმ 10 წუთის განმავლობაში?

_____ დღე კვირაში

98 = უარი პასუხზე

99= არ ვიცი

გასული კვირის რომელიმე ჩვეულებრივ დღეს საშუალოდ რამდენი ხანი იარეთ ფეხით ჯამურად?

_____ საათი _____ წუთი <u>დღის განმავლობაში</u>

98 = უარი პასუხზე

99= არ ვიცი

ბოლო 4 კვირის განმავლობაში, რამდენად შეგაწუხათ ქვემოთ ჩამოთვლილმა პრობლემებმა?

	არ შემაწუხა	შემაწუხა	ძლიერ შემაწუხა
კუჭის ტკივილი	1	2	3
წელის ტკივილი	1	2	3
კიდურების, სახსრების ტკივილი (მუხლები, მენჯი სახსარი)	1	2	3
[მხოლოდ ქალებისთვის]: მენსტრუალური ტკივილები	1	2	3
ტკივილი ან პრობლემები სქესობრივი აქტის დროს	1	2	3
თავის ტკივილი	1	2	3
გულმკერდის ტკივილი	1	2	3
თავბრუსხვევა	1	2	3
გულის წასვლა	1	2	3
გაძლიერებული ან აჩქარებული გულის ცემის შეგრძნება	1	2	3
სუნთქვის გაძნელება	1	2	3
შეკრულობა, ან ფაღარათი	1	2	3
გულისრევა, შებერილობა, მონელების დარღვევა	1	2	3
დაღლილობა, ენერგიის ნაკლებობა	1	2	3
ძილის დარღვევა	1	2	3

გაქვთ თუ არა ისეთი ხანგრძლივი/ქრონიკული დაავადება, ჯანმრთელობის პრობლემა ან უნარშეზღუდულობა, რაც ხელს გიშლით ყოველდღიურ საქმიანობაში ან სამუშაოში რასაც ასრულებთ?

1= დიახ	98 = უარი პასუხზე
2= არა	

ქვემოთ მოტანილი დებულებები გრძნობებსა და აზრებს ეხება. თუ შეიძლება გვითხარით, თითოეულ დებულებასთან დაკავშირებული რომელი პასუხი გამოხატავს ყველაზე უკეთ თქვენს განცდებს, რომლებიც ბოლო 2 კვირის მანძილზე გქონიათ

	არც ერთხელ	იშვიათად	ხანდახან	ხშირად	ყოველთვის
ოპტიმისტურადვიყავიგანწყობილიმომავლისმიმართ	1	2	3	4	5
სასარგებლო ადამიანად ვგრძნობდი თავს	1	2	3	4	5
მშვიდად ვგრძნობდი თავს	1	2	3	4	5
პრობლემებს კარგად ვუმკლავდებოდი	1	2	3	4	5
საღად ვაზროვნებდი	1	2	3	4	5
სიახლოვეს განვიცდიდი სხვა ადამიანებთან	1	2	3	4	5
შემეძლო მიმეღო გადაწყვეტილება სხვადასხვა საკითხის შესახებ და საკუთარი აზრი მქონოდა	1	2	3	4	5

<u>ბოლო 2 კვირის განმავლობაში</u> რამდენად ხშირად გქონიათ ქვემოთ ჩამოთვლილი უსიამოვნო მოვლენები?

[ინტერვიუერს: გთხოვთ ზუსტად ისე წაიკითხოთ კითხვები როგორც წერია. წაუკითხეთ ყველა შესაძლო პასუხი თითოეული შეკითხვისთვის ვიდრე რესპონდენტი არ გაერკვევა შესაძლო ვარიანტებში]

	საერთოდ არა	ზოგიერთ დღეებში	უმეტესი დღის განმავლობაში	თითქმის ყოველდღე
ინტერესის/ სიამოვნების ნაკლებობა რაიმეს კეთებისას	1	2	3	4
ცუდ გუნებაზე, დეპრესიულად, უიმედოდ ყოფნა	1	2	3	4
ჩაძინების პრობლემები, ცუდი ძილი ან ძილიანობა	1	2	3	4
დაღლილობის შეგრძნება ან ენერგიის ნაკლებობა	1	2	3	4
უმადობა ან გაძლიერებული მადა	1	2	3	4
განცდა იმისა, რომ ხართ წარუმატებელი, ან რომ ცხოვრებაში ვერაფერი მოახერხეთ, ან ვერ გაამართლეთ ოჯახის იმედები	1	2	3	4
კონცენტრაციის გაძნელება, მაგალითად გაზეთის კითხვის ან ტელევიზორის ყურების დროს	1	2	3	4
ნელა საუბარი ან მოძრაობა, რომ ეს სხვებისთვის შეიძლება შესამჩნევი გამხდარიყო, ან ისეთი მოუსვენრობა, რომ ჩვეულებრივზე მეტად მოძრაობთ	1	2	3	4

	საერთოდ არა	ზოგიერთ დღეებში	უმეტესი დღის განმავლობაში	თითქმის ყოველდღე
ფიქრი იმაზე, რომ ასეთ ყოფნასსიკვდილი სჯობს ან ფიქრისაკუთარი თავის დაზიანების შესახებ	1	2	3	4
ინტერვიუერის შენიშვნა: თუ რომელიმე კითხვა ფასდება „2“ ან მეტი ქულით, ჰკითხეთ:				
	სრულებით არ გაართულა	ერთგვარად გაართულა	გაართულა	ძალიან გაართულა
რამდენად გაართულა ამ პრობლემებმა სამუშაოს შესრულება, საშინაო საქმის კეთება ან სხვებთან ურთიერთობა?	1	2	3	4

ბოლო2 კვირის განმავლობაში რამდენად ხშირად შეგაწუხათ ქვემოთ ჩამოთვლილმა პრობლემებმა:

[ინტერვიუერს: გთხოვთ ზუსტად ისე წაიკითხოთ კითხვები როგორც წერია. წაუკითხეთ ყველა შესაძლო პასუხი თითოეული შეკითხვისთვის ვიდრე რესპონდენტი არ გაერკვევა შესაძლო ვარიანტებში]

	საერთოდ არა	ზოგიერთ დღეებში	უმეტესი დღის განმავლობაში	თითქმის ყოველდღე
ნერვიულობა, შფოთვა, განცდა იმისა, რომ უკიდურესობამდე ხართ მისული - „წკიპზე ხართ“	1	2	3	4
უუნარობა შეგეწყვიტათ ან გეკონტროლებინათ შფოთვა	1	2	3	4
ზედმეტი ნერვიულობა სხვადასხვა საკითხებზე	1	2	3	4
განტვირთვის/სიმშვიდის მოპოვების სირთულე	1	2	3	4
ისეთი მოუსვენრობა რომ ჭირს ერთ ადგილას ჯდომა	1	2	3	4
ადვილად წყენა ან გაღიზიანებადობა	1	2	3	4
შიში იმისა, რომ რაიმე საშინელება შეიძლება მოხდეს	1	2	3	4
ინტერვიუერის შენიშვნა: თუ რომელიმე კითხვა ფასდება „2“ ან მეტი ქულით, შეეკითხეთ:				
	სრულებით არ გაართულა	ერთგვარად გაართულა	გაართულა	ძალიან გაართულა
რამდენად გაართულა ამ პრობლემებმა სამუშაოს შესრულება, საშინაო საქმის კეთება ან სხვა ადამიანებთან შეწყობა?	1	2	3	4

ქვემოთ მოყვანილია ის რისი გაკეთებაც თქვენ რთულად გამოგდით სხვა ადამიანებთან მიმართებაში.

რთულია . . . *[ინტერვიუერს: გთხოვთ კითხვები ზუსტად ისე წაიკითხოთ როგორც წერია)*

		საერთოდ არ არის რთული	მცირე სირთულეს წარმოადგენს	გარკვეულწილად რთულია	საკმაოდ რთულია	უკიდურესად რთულია
	ნებისმიერ ფორმალურ თუ არაფორმალურ ჯგუფებში გაერთიანება	1	2	3	4	5
	პირადი საკითხების დამალვა სხვა ადამიანებისგან	1	2	3	4	5
	ადამიანისთვის იმის თქმა, რომ იგი შემაწუხებელია	1	2	3	4	5
	საკუთარი თავის წარდგენა ახალი ადამიანებისთვის	1	2	3	4	5
	ადამიანებისთვის წინააღმდეგობის გაწევა პრობლემურ სიტუაციებში	1	2	3	4	5
	იყო თვითდაჯერებული სხვა ადამიანებთან	1	2	3	4	5
	ვაგრძნობინო სხვებს თუ როდის ვარ გაბრაზებული	1	2	3	4	5
	სოციალურად აქტიური ვიყო სხვა ადამიანებთან ერთად	1	2	3	4	5

	გამოვხატო სიახლოვე სხვა ადამიანების მიმართ	1	2	3	4	5
	გავიზიარო სხვა ადამიანის აზრი	1	2	3	4	5
	ვიყო მტკიცე, როდესაც ეს საჭიროა	1	2	3	4	5
	განვიცადო სიყვარულის გრძნობა სხვა ადამიანის მიმართ	1	2	3	4	5
	მხარი დავუჭირო სხვა ადამიანის ცხოვრებისეულ მიზნებს	1	2	3	4	5
	ვიგრძნო სიახლოვე სხვა ადამიანებისგან	1	2	3	4	5
	გავიხარო სხვა ადამიანის ბედნიერებით	1	2	3	4	5
	ვთხოვო სხვა ადამიანებს დრო გაატარონ ჩემთან ერთად	1	2	3	4	5
	ვიზრუნო ჩემს საკუთარ კეთილდღეობაზე, როდესაც სხვას უჭირს	1	2	3	4	5
	ვიყო პირდაპირი და არ ვიდარდო რომ ჩემი ქცევა სხვა ადამიანს გულს ატკენს	1	2	3	4	5

ქვემოთ მოყვანილია ის, რასაც თქვენ შესაძლოა ზომაზე მეტად აკეთებდეთ

[ინტერვიუერს: გთხოვთ კითხვები ზუსტად ისე წაიკითხოთ როგორც წერია)

		სრულიად არა	მცირედ	მეტ-ნაკლებად	საკმაოდ	ზედმეტად
	ძალიან ადვილად ვექცევი სხვა ადამიანების გავლენის ქვეშ	1	2	3	4	5
	ზომაზე მეტად გახსნილი ვარ ადამიანებთან	1	2	3	4	5
	ზომაზე მეტად აგრესიული ვარ ადამიანებთან მიმართებაში	1	2	3	4	5
	ზომაზე მეტად ვცდილობ ვასიამოვნო სხვა ადამიანებს	1	2	3	4	5
	ძალიან მინდა რომ ყველა მამჩნევდეს	1	2	3	4	5
	ზომაზე მეტად ვცდილობ სხვა ადამიანების გაკონტროლებას	1	2	3	4	5
	ზომაზე მეტად ვაყენებ სხვა ადამიანების საჭიროებებს საკუთარზე წინ	1	2	3	4	5
	ზედმეტად ეჭვიანი ვარ სხვა ადამიანების მიმართ	1	2	3	4	5
	ჩემს პირადულს ზომაზე მეტად ვუყვები სხვა ადამიანებს	1	2	3	4	5
	ზედმეტად ვკამათობ სხვა ადამიანებთან	1	2	3	4	5
	ზომაზე მეტად დისტანციური ვარ	1	2	3	4	5
	სხვა ადამიანებს ზომაზე მეტად ვაძლევ უფლებას ჩემით ისარგებლონ	1	2	3	4	5

		სრულიად არა	მცირედ	მეტ-ნაკლებად	საკმაოდ	ზედმეტად
	სხვა ადამიანის წუხილი ჩემზე ზომაზე მეტად მოქმედებს	1	2	3	4	5
	გამძაფრებული მაქვს შურისძიების გრძნობა	1	2	3	4	5

<u>ბოლო 30 დღის განმავლობაში</u> რამდენად გაგიჭირდათ:

[ინტერვიუერს: გთხოვთ კითხვები და შესაძლო პასუხები ზუსტად ისე წაიკითხოთ ისე როგორც წერია)

		არა	მსუბუქად	ზომიერად	ძლიერ	უკიდურესად / ვერ შევძელი	შეუსაბამოა	უარი	არ ვიცი
	30 წუთზე მეტი ხნის განმავლობაში ფეხზე დგომა (უწყვეტად)	1	2	3	4	5	97	98	99
	საშინაო საქმეებზე ზრუნვა	1	2	3	4	5	97	98	99
	სიახლეების ათვისება, როგორიცაა საყოფაცხოვრებო სიახლეები, ან ახალ ადგილზე მისვლა	1	2	3	4	5	97	98	99
	ჩართულიყავით სხვების მსგავსად სათემო აქტივობებში (მაგ. თავყრილობა,	1	2	3	4	5	97	98	99

	რელიგიური ან სხვა სახის ღონისძიებები)								
	ემოციურად რამდენად აგაფორიაქათ თქვენი ჯანმრთელობის პრობლემებმა?	1	2	3	4	5	97	98	99

თუ რომელიმე შეკითხვაზე პასუხი შეკითხვამდე იყო 2 ან მეტი, მაშინ გააგრძელეთ 0 - *შეკითხვიდან, თუ არა, მაშინ → [გადადით* 0*-ზე] x*

<u>ბოლო 30 დღის განმავლობაში</u> რამდენად გაგიჭირდათ ქვემოთ ჩამოთვლილი:

[ინტერვიუერს: გთხოვთ კითხვები და შესაძლო პასუხები ზუსტად ისე წაიკითხოთ

		არა	მსუბუქად	ზომიერად	ძლიერ	უკიდურესად ან ვერ შევძელი
	კონცენტრაცია ან რამის კეთება 10 წუთზე მეტი ხნის განმავლობაში (უწყვეტად)	1	2	3	4	5
	დიდი მანძილის ფეხით გავლა, მაგალითად კილომეტრი	1	2	3	4	5
	ბანაობა	1	2	3	4	5
	ჩაცმა	1	2	3	4	5
	უცნობ ადამიანებთან ურთიერთობა	1	2	3	4	5
	მეგობრებთან ურთიერთობა	1	2	3	4	5

ისე როგორც წერია)

	ყოველდღიური საქმიანობის შესრულება	1	2	3	4	5

სექცია ზ: ტრავმულ მოვლენებთან შეხება

ინსტრუქცია: ახლა თქვენი წარსული ცხოვრების შესახებ მინდა გკითხოთ, ზოგიერთი შეკითხვა შესაძლოა მტკივნეული იყოს. თუ ასე მოხდა, შეგიძლიათ არ უპასუხოთ.ასევე, მინდა შეგახსენოთ, რომ დაცული იქნება თქვენს მიერ გაცემული პასუხების კონფიდენციალობა.ოდესმე თუ აღმოჩენილხართ რომელიმე ქვემოთ ჩამოთვლილ სიტუაციაში?

წაუკითხეთ ისე როგორც წერია ყველა შესაძლო პასუხი თითოეულ შეკითხვაზე, ვიდრე რესპონდენტი არ გაერკვევა რა ვარიანტებია შეთავაზებული.თუ ადგილი ჰქონდა შემთხვევას, დააზუსტეთ როდის. შესაძლებელია ერთზე მეტი პასუხი

	a) გამოცდილება		b) როდის				
	კი	არა	იძულებით გადაადგილება მდე / კონფლიქტამდე	კონფლიქტის/ ბრძოლის დროს	იძულებით გადაადგილების შემდეგ	იძულებით გადაადგილების / კონფლიქტის შემდეგ	უარი
ოდესმე გძინებიათ თუ არა გარეთ იმის გამო, რომ არ გქონიათ სახლი/ თავშესაფარი?	1	2	1	2	3	4	98
მიგიღიათ ოდესმე სერიოზული დაზიანება?	1	2	1	2	3	4	98

	a) გამოცდილება		b) როდის				
	კი	არა	იძულებით გადაადგილება მდე / კონფლიქტამდე	კონფლიქტის/ბრძოლის დროს	იძულებით გადაადგილების შემდეგ	იძულებით გადაადგილების / კონფლიქტის შემდეგ	უარი
უშუალოდ აღმოჩენილხართ საომარ ვითარებაში?	1	2	1	2	3	4	98
გამოგიცდიათ ფიზიკური შეურაცხყოფა პარტნიორისგან ან ოჯახის წევრისგან?	1	2	1	2	3	4	98
ხომ არ გქონიათ სექსუალური ძალადობის შემთხვევა? ან ვინმეს ხომ არ უცდია თქვენთან სქესობრივი კავშირის დამყარება თქვენი ნების წინააღმდეგ? ეს შეიძლება ყოფილიყო პარტნიორი, ოჯახის წევრი, ნაცნობი ან უცხო	1	2	1	2	3	4	98

	a) გამოცდილება		b) როდის				
	კი	არა	იძულებით გადაადგილება მდე / კონფლიქტამდე	კონფლიქტის/ ბრძოლის დროს	იძულებით გადაადგილების შემდეგ	იძულებით გადაადგილების / კონფლიქტის შემდეგ	უარი
პირი.							
გაუტაციხართ ოდესმე?	1	2	1	2	3	4	98
უწამებიხართ ოდესმე?	1	2	1	2	3	4	98
ხომ არ მოუკლავთ ან უწამებიათ თქვენი ოჯახის წევრი ან მეგობარი, ან ხომ არ განხორციელებულა ფიზიკური ძალადობა მათ მიმართ?	1	2	1	2	3	4	98
ხომ არ შესწრებიხართ უცხო ადამიან(ებ)ის მკვლელობას, წამებას, ან მათ მიმართ ძალადობის გამოყენებას?	1	2	1	2	3	4	98
კონფლიქტის დროს ხომ არ გარდაგცვლიათ ოჯახის წევრი, ახლო მეგობარი (მაგ.	1	2	1	2	3	4	98

	a) გამოცდილება		b) როდის				
	კი	არა	იძულებით გადაადგილება მდე / კონფლიქტამდე	კონფლიქტის/ბრძოლის დროს	იძულებით გადაადგილების დროს	იძულებით გადაადგილების / კონფლიქტის შემდეგ	უარი
თავშესაფრის არქონის, სიცივეში ყოფნის გამო, საომარი მოქმედების, დაბომბვის ან ნაღმის აფეთქების შედეგად)?							
კონფლიქტის შემდეგ ხომ გარდაგცვლიათ ოჯახის წევრი, ახლო მეგობარი, რომელთა გარდაცვალების მიზეზს უკავშირებთ კონფლიქტს?	1	2	1	2	3	4	98
მოულოდნელად ხომ არ გარდაგცვლიათ ოჯახის წევრი ან ახლობელი რაიმე ისეთი მიზეზით, რომელიც ომთან არ ყოფილა დაკავშირებული, რამაც	1	2	1	2	3	4	98

	a) გამოცდილება		b) როდის				
	კი	არა	იძულებით გადაადგილება მდე / კონფლიქტამდე	კონფლიქტის/ბრძოლის დროს	იძულებით გადაადგილების შემდეგ	იძულებით გადაადგილების / კონფლიქტის შემდეგ	უარი
მძიმე დარტყმა მოგაყენათ (მაგ. ავტოკატასტროფა, ავადმყოფობა, თვითმკვლელობა, სხვ)?							

თუ შეიძლება მითხარით სულ მცირე ორჯერ თუ გქონიათ მსგავსი გამოცდილება <u>ბოლო 1 კვირის მანძილზე?</u>

წაუკითხეთ თითოეული დებულება ისე როგორც წერია

	დიახ	არა	უარი	არ ვიცი
უსიამოვნო აზრები ან მოგონებები მძიმე მოვლენის შესახებ, რომლებიც ჩნდებიან თქვენი ნების საწინააღმდეგოდ	1	2	98	99
უსიამოვნო სიზმრები მძიმე მოვლენის შესახებ	1	2	98	99
ისე იქცევით ან ისეთივე განცდა გეუფლებათ, როგორც წარსულის მძიმე მოვლენის დროს	1	2	98	99
გაწუხებთ ნებისმიერი რამ, რაც მომხდარს	1	2	98	99

მოგაგონებთ				
სხეულებრივი რეაქციები (აჩქარებული გულის ცემა, მუცლის გვრემა, ოფლიანობა, თავბრუსხვევა) მომხდარის გახსენებისას	1	2	98	99
დაძინების პრობლემა ან ცუდი ძილი	1	2	98	99
ადვილი გაღიზიანებადობა, ბრაზის ვერ შეკავება	1	2	98	99
ყურადღების კონცენტრაციის სირთულე	1	2	98	99
გამძაფრებული საფრთხის შეგრძნება საკუთარი თავის და გარშემო მყოფთა მიმართ	1	2	98	99
მოულოდნელობისაგან შეკრთომა, ან შეხტომა	1	2	98	99

სექცია თ: სამედიცინო მომსახურება და მოცვა

გაქვთ თუ არა ჯანმრთელობის დაზღვევა, თუ კი რა ტიპის?

1= უმწეოთა (სიღარიბის ზღვარს ქვემოთ) სამედიცინო დაზღვევის სახელმწიფო პროგრამა	6 = კერძო ინდივიდუალური დაზღვევა
2= პედაგოგთა სამედიცინო დაზღვევის პროგრამა	7 = სხვა*დააკონკრეტეთ*:
3 = სამხედრო მოსამსახურეთა/პოლიციელთა სამედიცინო დაზღვევის პროგრამა	8 = არ აქვს დაზღვევა
4 = კერძო კორპორატიული სამედიცინო დაზღვევა (ანაზღაურებული დამსაქმებლის მიერ)	98 = უარი პასუხზე
5 = კერძო კორპორატიული სამედიცინო დაზღვევა (ანაზღაურებული დაზღვეულის მიერ)	99 = არ ვიცი

<u>ბოლო 1 წლის განმავლობაში</u> გქონიათ თუ არა შფოთვა, მოუსვენრობა, დეპრესია, უძილობა ან სხვა ემოციური ან ქცევითი პრობლემები, რის გამოც მიმართეთ სამედიცინო დახმარებას?

= დიახ→ [გადადით0-ზე]	98 = უარი პასუხზე → [გადადით 0-ზე]
2 = არ მქონდა პრობლემები [გადადით 0-ზე]	99 = არ ვიცი → [გადადით 0-ზე]
3 = მქონდა შეგრძნებები /პრობლემები, მაგრამ არ მიმიმართავს	

თუ გქონდათ პრობლემები, მაგრამ არ მიგიმართავთ სამედიცინო მომსახურებისთვის რა იყო ამის მიზეზი?*[ინტერვიუერს: შესაძლებელია რამდენიმე პასუხი]*

1 = ვფიქრობდი რომ უკეთესად გავხდებოდი იმ წამლებით რაც გამაჩნდა ან	8 = სამედიცინო დაწესებულების სიშორის გამო

სხვა სახის თვითმკურნალობით	
2 = არ მქონდა საშუალება გადამეხადა სამედიცინო მომსახურებისთვის	9 = არ მაქვს ჯანმრთელობის დაზღვევა
3 = არ მქონდა საშუალება შემეძინა წამლები	10 =სხვა, *დააკონკრეტეთ*_____
4 = დროის უქონლობა/სამუშაოს გამო ვერ გამოვძებნე დრო	
5 = არ ვიცოდი სად შეიძლება მიმეღო დახმარება	
6 = სამედიცინო მომსახურების დაბალი ხარისხის გამო	98 = უარი პასუხზე
7 = არ ვენდობი ჯანდაცვის პერსონალს	99 = არ ვიცი

[ინტერვიუერს, როდესაც დაასრულებთ ზედა შეკითხვას რესპონდენტებს, რომლებსაც არ მიუმართია სამედიცინო მომსახურებისთვის, → გადადით 0-ზე]

თუ დიახ, რა ტიპის მომსახურება გამოიყენეთ? *[ინტერვიუერს: შესაძლებელია რამდენიმე პასუხი, შემოხაზეთ]*

წყარო	წამლები	კონსულტირება	ფსიქოთერაპია / ფსიქოსოციალური დახმარება
აფთიაქი	1	2	
ოჯახის ექიმის კაბინეტი/ ამბულატორია / პოლიკლინიკაში	1	2	3
მობილური მომსახურება	1	2	3
ნევროლოგი პოლიკლინიკაში	1	2	3
ფსიქიატრიული დისპანსერი	1	2	3
ფსიქიკური ჯანმრთელობის სპეციალისტი /ფსიქოსოციალური ცენტრი	1	2	3

წყარო	წამლები	კონსულტირება	ფსიქოთერაპია / ფსიქოსოციალური დახმარება
კერძო ფსიქიატრი (ბინაზე, კაბინეტში)	1	2	3
თერაპევტი/ ნევროლოგი საავადმყოფოში	1	2	3
ფსიქიატრიული საავადმყოფო	1	2	3
ალტერნატიული/ ტრადიციული მედიცინა	1	2	
სხვა (განმარტეთ:)	1	2	3
98 = უარი პასუხზე			
99 = არ ვიცი			

სექცია ი: ალკოჰოლისა და თამბაქოს მოხმარება

ახლა დაგისვამთ მთელ რიგ შეითვხებს ალკოჰოლის მიღებასთან დაკავშირებით. ეს შეკითხვები ეხება ბოლო 1 წელიწადს, თუ სხვაგვარად არ არის მითითებული სუროგატები ნახსენებია ქვემოთ მოყვანილ შეკითხვებში. ეს არის ნივთიერებები, რომლებიც არ გამოიყენება დასალევად, როგორიცაა ოდეკოლონი, სამედიცინო სპირტი და ა.შ. ისინი შესაძლოა იშოვებოდეს მაღაზიებში, ჯიხურებში ან აფთიაქში.

რამდენიწუთიგჭირდებათუახლოესადგილამდე,

სადაცშეგიძლიათალკოჰოლურისასმელიიშოვნოთ,

მიუხედავადიმისამოიხმართთუარა?

1 = ძირითადად მოვიხმარ(თ) სახლში დამზადებულ სასმელს	5 = 30 წუთზე მეტი
2 = 5 წუთზე ნაკლები	98 = უარი პასუხზე
3 = -5-10 წუთი	99 = არ ვიცი
4 = 10-30 წუთი	

რამდენად ადვილად შეგიძლიათ იშოვოთ ალკოჰოლური სასმელი, მიუხედავად იმისა მოიხმართ თუ არა ალკოჰოლურ სასმელს?

1 = ძალიან ადვილად	98 = უარი პასუხზე
2 = საკმაოდ ადვილად	99 = არ ვიცი
3 = საკმაოდ რთულად	
4 = ძალიან რთულად	

იძულებით გადაადგილებამდე / კონფლიქტამდე რამდენსაც სვამდით, იმდენივეს სვამთ ამჟამად? თუ უფრო მეტს ან უფრო ნაკლებს?

1= მეტს ვიდრე იძულებით გადაადგილებამდე	5 = არასდროს მოვიხმარ ალკოჰოლურ სასმელს → {გადადით 0-ზე]
2= იგივე რაოდენობას, რასაც იძულებით გადაადგილებამდე	6 = დავიწყე იძულებთ გადაადგილების შემდეგ
3 = ნაკლებს, ვიდრე იძულებით გადაადგილებამდე	98 = უარი პასუხზე
4 = შევწყვიტე სმა → [გადადით 0-ზე]	99 = არ ვიცი

ჩამოთვლილი თითოეული ტიპის სასმელისთვის მიუთითეთ რამდენად ხშირად სვამთ

	ყოველდღე	4 და მეტჯერ კვირაში	2-3 ჯერ კვირაში	2-4 ჯერ თვეში	თვეში ერთხელ	2-3 თვეში ერთხელ	უფრო ნაკლებ სიხშირით	არასოდეს	უარი	არ ვიცი
ალკოჰოლი (ნებისმიერი სახის)	1	2	3	4	5	6	7	8	98	99
თუ 8 (‘არასოდეს) → [გადადით 0-ზე]										
ღვინო	1	2	3	4	5	6	7	8	98	99

არაყი (და სხვასპირტიანი სასმელები)	1	2	3	4	5	6	7	8	98	99
ლუდი	1	2	3	4	5	6	7	8	98	99

გასული 1 წლის განმავლობაში ჩამოთვლილი თითოეული ტიპის სასმელისთვის მიუთითეთ რა სიხშირით სვამდით და ჩვეულებრივ, რამდენს სვამთ ხოლმე ერთ ჯერზე? *(წაუკითხეთ ყველა პასუხი)*

a. ღვინო 1=არასოდეს → [გადადით 0-ზე] 2= რამდენიმე თვეში ერთხელ 3=ყოველთვიურად 4=ყოველკვირეულად 5=ყოველდღიურად- 98 = უარი პასუხზე 99 = არ ვიცი	b. ღვინო _____ ლიტრი
a. ლუდი 1=არასოდეს → [გადადით 0-ზე] 2= რამდენიმე თვეში ერთხელ 3=ყოველთვიურად 4=ყოველკვირეულად 5=ყოველდღიურად 98 = უარი პასუხზე 99 = არ ვიცი	b. ლუდი _____ ლიტრი
a. არაყი (სპირტიანი სასმელები) 1=არასოდეს → [გადადით 0-ზე] 2= რამდენიმე თვეში ერთხელ 3=ყოველთვიურად 4=ყოველკვირეულად	b. არაყი (სპირტიანი სასმელები) _____ გრამი

5=ყოველდღიურად 98 = უარი პასუხზე 99 = არ ვიცი	

რამდენად ხშირად სვამთ ალკოჰოლს მარტო?

1 = ხშირად	98 = არ ვიცი
2 = ხანდახან	99 =უარი პასუხზე
3 = არასდროს	

<u>ბოლო 1 წლის განმავლობაში</u> გქონიათ „ზაპოის“ ეპიზოდი?

(*განუმარტეთ:* „ზაპოი“ ნიშნავს უწყვეტ სმას 2 დღეზე მეტი ხნის განმავლობაში, რომლის დროსაც ადამიანი არ მუშაობს და ამოვარდნილია ცხოვრების ნორმალური რიტმიდან, არ ვგულისხმობთ დღესასწაულებს)

1 = დიახ	98 = არ ვიცი
2 = არა	99 = უარი პასუხზე

სად შოულობთ ალკოჰოლს ძირითადად?

[ინტერვიუერს, წაუკითხეთ ყველა პასუხი]

1 = სახლში ვამზადებთ	5 = სხვა *(მიუთითეთ)*
2= სხვისგან სახლში დამზადებულს (ფულის გარეშე, საჩუქარი, ნატურით)	
3 = ვყიდულობ სახლში დამზადებულს (ბაზარში, მაღაზიაში, ჯიხურში, ბარში, კაფეში)	98 = უარი პასუხზე
4 = ვყიდულობ ქარხნულს (ბაზარში, მაღაზიაში, ჯიხურში, ბარში/კაფეში)	99 = არ ვიცი

ეს სექცია მოიცავს შეკითხვებს ალკოჰოლის (მათ შორის მსუბუქი სასმელი მაგ. ლუდი) მიღებასთან დაკავშირებით ბოლო <u>1 წლის განმავლობაში</u>. სასმელის დოზა

ნიშნავს 1 ჭიქა მაგარ სპირტიან სასმელს, 1 ჭიქა ღვინოს, 1 საშუალო კათხა მაღალი ალკოჰოლის შემცველ ლუდს, 1 დიდ კათხა დაბალი ალკოჰოლის შემცველ ლუდს. *[ინტერვიუერს: წაუკითხეთ შეკითხვები ისე, როგორც წერია, ასევე წაუკითხეთ შესაძლო პასუხები]*

	რა რაოდენობით ალკოჰოლური სასმელის დოზას იღებთ <u>1 კონკრეტული დღის</u> განმავლობაში, როდესაც სვამთ? ”. *(წაუკითხეთ ყველა პასუხი)*	0=0 1=1 ან 2 2=3 ან 4 3=5 ან 6 4=7,8 ან 9 5= 10 და მეტი
	<u>ერთ ჯერზე</u> რამდენად ხშირად იღებთ ალკოჰოლური სასმელის 6 დოზას*? (წაუკითხეთ ყველა პასუხი)*	1=არასოდეს 2= რამდენიმე თვეში ერთხელ 3=ყოველთვიურად 4=ყოველკვირეულად 5=ყოველდღიურად
	<u>ბოლო 1 წლის განმავლობაში</u> რამდენჯერ მოხდა ისე, რომ გაგიჭირდათ სმის შეწყვეტა, მას შემდეგ რაც დაიწყეთ სმა? *(წაუკითხეთ ყველა პასუხი)*	1=არასოდეს 2=რამდენიმე თვეში ერთხელ 3=ყოველთვიურად 4=ყოველკვირეულად 5=ყოველდღიურად
	<u>ბოლო 1 წლის განმავლობაში</u> რამდენჯერ მოხდა ისე, რომ ვერ შესძელით იმის გაკეთება რაც უნდა გაგეკეთებინათ ალკოჰოლის მიღების გამო? *(წაუკითხეთ ყველა პასუხი)*	1=არასოდეს 2=რამდენიმე თვეში ერთხელ 3=ყოველთვიურად 4=ყოველკვირეულად 5=ყოველდღიურად
	<u>ბოლო 1 წლის</u> განმავლობაში წინა დღის მძიმე სმის შემდეგ რამდენჯერ	1=არასოდეს 2=რამდენიმე თვეში ერთხელ

	დაგილევიათ დილით ნაბახუსევზე რათა აღგედგინათ ფიზიკური მდგომარება და შრომისუნარიანობა? *(წაუკითხეთ ყველა პასუხი)*	3=ყოველთვიურად 4=ყოველკვირეულად 5=ყოველდღიურად
	<u>ბოლო 1 წლის</u> განმავლობაში, რამდენჯერ გიგრძნიათ თავი დამნაშავედ ან უხერხულად ალკოჰოლის მიღების შემდეგ? *(წაუკითხეთ ყველა პასუხი)*	1=არასოდეს 2=რამდენიმე თვეში ერთხელ 3=ყოველთვიურად 4=ყოველკვირეულად 5=ყოველდღიურად
	ალკოჰოლის მიღების გამო, <u>ბოლო 1 წლის</u> განმავლობაში რამდენჯერ ვერ გაგიხსენებიათ რა მოხდა წინა დღეს? *(წაუკითხეთ ყველა პასუხი)*	1=არასოდეს 2=რამდენიმე თვეში ერთხელ 3=ყოველთვიურად 4=ყოველკვირეულად 5=ყოველდღიურად
	თქვენი სმის გამო ხომ არ დაშავებულხართ ან დაგიზიანებიათ ვინმე? *(წაუკითხეთ ყველა პასუხი)*	1=არასოდეს 2=დიახ, მაგრამ არა ბოლო ერთი წლის განმავლობაში 3=დიახ, ბოლო ერთი წლის განმავლობაში
	თქვენი ოჯახის წევრი, მეგობარი, ნათესავი, ექიმი ან სხვა ვინმე ხომ არ შეწუხებულა თქვენი სმის გამო და მოუცია რჩევა შეგეწყვიტათ ან შეგემცირებინათ სმა? *(წაუკითხეთ ყველა პასუხი)*	1=არასოდეს 2= დიახ, მაგრამ არა ბოლო 1 წლის განმავლობაში 3=დიახ, ბოლო 1 წლის განმავლობაში

ეწევით თუ არა დღეში სულ მცირე ერთ ღერს სიგარეტს (პაპიროსი, ჩიბუხი, სიგარა და სხვ)

1 = დიახ 99 = უარი პასუხზე → [გადადით **Error! Reference source not found.**-ზე]

2 = არა → [გადადით **Error! Reference source not found.**-ზე]

დღეში რამდენ ღერ სიგარეტს ეწევით (პაპიროსი, სიგარა, ჩიბუხი)?

_____სიგარეტი

98 = არ ვიცი

= უარი პასუხზე

გაღვიძებიდან რამდენ ხანში ეწევით პირველ ღერს?

1= გაღვიძებისთანავე, პირველი 5 წუთის განმავლობაში	98 = არ ვიცი
2 = გაღვიძებიდან 5- 30 წუთის ინტერვალში	99= უარი პასუხზე
3 = გაღვიძებიდან ერთი საათის განმავლობაში	
4 = შუადღემდე	
5= შუადღის შემდეგ ან საღამოს	

გიჭირთ თავი შეიკავოთ მოწევისგან ისეთ ადგილებში, სადაც მოწევა არ შეიძლება (მაგ. ტრანსპორტი, საავადმყოფო, დაწესებულება, კინო, და ა.შ.)

1 = დიახ 98 = არ ვიცი

2 = არა 99= უარი პასუხზე

ჩვეულებრივ გაღვიძებიდან პირველ საათებში უფრო მეტს ეწევით ვიდრე დღის სხვა მონაკვეთში?

1 = დიახ 98 = არ ვიცი

2 = არა 99 = უარი პასუხზე

დღის რომელ მონაკვეთში იქნებოდა ყველაზე რთული მოწევაზე უარის თქმა?

1 = დილით (პირველი ღერი) 98 = არ ვიცი

2 = ნებისმერდროს 99 = უარი პასუხზე

ეწევით როდესაც ძლიერ ავად ხართ?

1 = დაიხ 98 = არ ვიცი

2 = არა 99 = უარი პასუხზე

სექცია ლ: ეკონომიკური მდგომარეობა

მითხარით თქვენი სამუშაოს შესახებ. თქვენ ხართ...

1 = უმუშევარი, ვეძებ სამსახურს	8 = ფერმერი (სოფლის მეურნეობა)
2 = უმუშევარი, არ ვეძებ სამსახურს	9 = სტუდენტი
3 = რეგულარული, ანაზღაურებადი სამსახური	10 = პენსიონერი
4 = არარეგულარული / სეზონური, ანაზღაურებადი სამსახური	11 = უმუშევარი შეზღუდული შესაძლებლობის გამო
5 = თვითდასაქმებული	
6 = დიასახლისი	12 = სხვა*(დააკონკრეტეთ)*:
7 = დეკრეტულ შვებულებაში მყოფი	98 = უარი პასუხზე

როგორ დაახასიათებდით თქვენი ოჯახის ამჟამინდელ ეკონომიკურ მდგომარეობას?

1 = ძალიან კარგი	98 = უარი პასუხზე
2 = კარგი	99 = არ ვიცი
3= საშუალო	
4= ცუდი	
5= ძალიან ცუდი	

ქვემოთჩამოთვლილთაგან რომელს ფლობს ოჯახი მუშა მდგომარეობაში?

(ინტერვუერს, შესაძლებელია რამდენიმე პასუხი)

1 = მაცივარი	8=გენერატორი
2 = ფერადი ტელევიზორი პულტზე	9= წყლის გამათბობელი
3 = ავტომატური სარეცხი მანქანა	10= ოთახის გამათბობელი გაზზე
4 = მობილური ტელეფონი	11 = არც ერთი ზემოთ ჩამოთვლილთაგანი
5 = პერს.კომპიუტერი / ლეპტოპი	98 = უარი პასუხზე
6 = ავტომობილი	99 = არ ვიცი
7 = დი-ვი-დი პლეიერი	

ახლა წარმოიდგინეთ ათსაფეხურიანი კიბე საქართველოსთვის, სადაც ქვედა საფეხურზე ყველაზე ღარიბი ხალხია, ყველაზე მაღალ, მეათე საფეხურზე კი ყველაზე მდიდარი. პირადად თქვენ რომელ საფეხურზე დგახართ დღეს?

										98	99
უკიდურესად ღარიბიძალიან მდიდარი										უარი	არ ვიცი

<u>ბოლო 12 თვის განმავლობაში</u> თქვენს ოჯახს მოუწია ისეთი საჭიროებების გარეშე ყოფნა, როგორიცაა:

	მუდმივად	ხანდახან	არასოდეს	შეუსაბამოა/ არ იყენებს	უარი	არ ვიცი
1 = ძირითადი საკვები (პური, შაქარი, რძე)	1	2	3	77	98	99
2 = გათბობა	1	2	3	77	98	99
3 = ტანსაცმელი/ ფეხსაცმელი რომელიც რეალურად საჭირო იყო	1	2	3	77	98	99
4 = ელექტროენერგია	1	2	3	77	98	99
5 = ტრანსპორტი/ საწვავი მანქანისთვის	1	2	3	77	98	99
6 = სამედიცინო მომსახურება	1	2	3	77	98	99
7 = ძირითადი სასკოლო წიგნები	1	2	3	77	98	99
8 = მედიკამენტები	1	2	3	77	98	99
9 = სახლის შეკეთება	1	2	3	77	98	99

დიდი მადლობა თანამშრომლობისთვის!

ინტერვიუ ჩატარდა პრივატულ გარემოში მხოლოდ რესპონდენტის თანდასწრებით?

1 = დიახ, ესწრებოდა მხოლოდ რესპონდენტი

2 = არა, რესპონდენტის გარდა სხვაც ესწრებოდა

ინტერვიუს დასრულების დრო

/_____/_____//_____/_____/

საათი წუთი

ინტერვიუერის დასტური:

ვადასტურებ, ინტერვიუ ავიღე ინსტრუქციის შესაბამისად, პირისპირ ინტერვიუს მეთოდით ინსტრუქციის მიხედვით შერჩეულ რესპონდენტთან.

*ხელმოწერა*_____ *სახელი და გვარი*

_____

ANNEX 2

EXPERTS SURVEY (English and Georgian versions)

Questionnaireon Mental Health services for war-affected populations in Georgia

Dear colleague,

The presented questionnaire explores experts' opinions regarding those mental health (MH) services/methods that address the needs of traumatized people, specifically of war-affected populations in Georgia. Experts with substantial knowledge of MH policies, systems and problems and needs of conflict-affected groups are invited to complete this questionnaire.

Please rate the closed-ended questions on a scale ranging from '1' meaning *not at all useful* to '5' meaning *very useful*. In case a specific service or method has not been used in your experience, please mark the *not applicable* option. For open-ended questions please feel free to provide your opinions and experiences.

To explain the context and clarify possible questions, the general situation of war-affected populations in Georgia and their use of mental health services are introduced in the annex 1. The list of services is provided in the annex 2.

QUESTIONNAIRE

Demographics

Gender ❒Male❒Female

Professional background: ----------

Experience in the field (years) ----------

Country: ----------

Affiliation: ❒Government ❒Local NGO ❒International Organization
❒International NGO ❒Academia
❒IDPs organization or Local CBO/community-based organization
❒Other:

Age: ❒25-35❒36-50❒51-65 ❒>65

Q.1. Please read the short descriptions of each type of service as provided below and rate them according to their usefulness for working with war-affected populations from your experience. Add your comments if you have any.

1=not at all useful 2= not useful 3=neutral 4=useful 5=very useful

1.1. Community-based mental health inpatient unit/ acute department within general hospitals

1 2 3 4 5 Not applicable

Your comment:

1.2. Community residential health facility

1 2 3 4 5 Not applicable

Your comment:

1.3. Crisis Intervention/crisis resolution teams

1 2 3 4 5 Not applicable

Your comment:

1.4. Community Mental health centres/Mental health outpatient facility/Ambulatories

1 2 3 4 5 Not applicable

Your comment:

1.5.Mobile groups/Outreach teams/Home treatment

1 2 3 4 5 Not applicable

Your comment:

1.6. Psychosocial interventions

1 2 3 4 5 Not applicable

Your comment:

1.7. Rehabilitation services

1 2 3 4 5 Not applicable

Your comment:

1.8. Mental health day treatment facility

1 2 3 4 5 Not applicable

Your comment:

1.9. Mental hospital

1 2 3 4 5 Not applicable

Your comment:

1.10. Primary Healthcare Facilities/Policlinics

1 2 3 4 5 Not applicable

Your comment:

1.11. Other specialists

1 2 3 4 5 Not applicable

Your comment (please explain what kind of specialist do you have in mind):

1.12.Informal care

1 2 3 4 5 Not applicable

Your comment:

Q.2. Which services do you find effective/useful to address mental health needs of war-affected population in low & middle resource and in higher resource areas? *Please tick the three most important in each column.*

	low and middle resource area	higher resource area
Informal care in communities		
Primary Healthcare Facilities/Policlinics		
Care delivered by other specialists (e.g. neurologists) at secondary level		
Inpatient care/acute MH departments within general hospitals		
Crisis Intervention/crisis resolution centers		

Community Mental health centers		
Mobile groups/Outreach teams		
Psychosocial interventions (among them community mobilization)		
Rehabilitation services		
Mental health day treatment facility		
Community residential health facility		
Mental Hospital		

Q.3 Please comment on the resource-related service development approach for Georgia[1]

Q.4. Please indicate how useful are the following additional methods in addressing the needs of war-affected populations?

Early screening for trauma histories and assessment	1	2	3	4	5	Not applicable
Training, supervision and supporting primary health workers	1	2	3	4	5	Not applicable
Capacity building of professionals	1	2	3	4	5	Not applicable
Awareness rising on MH issues	1	2	3	4	5	Not applicable
Advocacy via-a-vis Central and local government	1	2	3	4	5	Not applicable

1We refer here to the Balanced Care Model (BCM) framework, proposed by Thornicroft and Tansella for MH service planning based on three 'levels of resources' – low-, medium- and high-resource settings (Thornicroft G, Tansella M. (2004) Components of modern mental health service: a pragmatic balance of community and hospital care: overview of systemic evidence. British Journal of Psychiatry 185: 283-290)

Programs and strategies at regional levels/municipalities	1	2	3	4	5	Not applicable
Employment and vocation training	1	2	3	4	5	Not applicable
Finances	1	2	3	4	5	Not applicable
Evidence-based and emerging best practices	1	2	3	4	5	Not applicable
On-going performance improvement and evaluation	1	2	3	4	5	Not applicable
Research	1	2	3	4	5	Not applicable

Q.5. Please comment and/or indicate any other useful method you know for effective service development

_____

_____

Q.6. Could you please share your understanding of

a) trauma-informed care and

b) trauma-specific services[2] and

c) their interaction?

_____

_____

Q.7.* for Georgian experts only) Please specify essential MH services that would meet the needs of war-affected populations in relatively low and middle resource areas (Gori, Zugdidi, etc.)

[2] *please see the explanation of termins in the annex B*

Q.8.* (for Georgian experts only) Please specify essential MH services that would meet the needs of war-affected populations in relatively high resource areas (Tbilisi, Batumi, etc.)

Thank you for your time!

ANNEX A

BACKGROUND

The Republic of Georgia has experienced two main phases of conflict in recent years, each involving secessionist movements. The first was in the early 1990s, when fighting between the regions of Abkhazia and South Ossetia lead to the forced displacement of 300,000 people. Approximately 200,000 of these still live as internally displaced persons (IDP). The second phase was in August 2008, when conflict broke out between Georgia and the Russian Federation concerning South Ossetia, leading to at least 128,000 Georgians being displaced, of which around 100,000 have now returned to their home areas in the border region ('Returnees'). The majority of current internally displaced persons live in congested government-established IDP settlements/villages, while some remain in improvised settlements in former hotels, schools, factories and hospitals. Governmental, non-governmental, and United Nations agencies have provided different kinds of assistance to internally displaced persons. However, their communities are characterized by poor living conditions, high unemployment, poverty, and limited integration to local communities and low access to mental health care.

A recent study (Makhashvili et al. 2015) identified high prevalence of common mental disorders among these war-affected populations, such as 23.3% suffering from post-traumatic stress disorder (PTSD), 14.0% from depression, and 10.4% from anxiety. Nearly a third (of the combined sample) reported at least one condition and 12.4% reported more than one disorder. The mental disorders all showed significant associations with worse functional disability.

As for service utilization among these groups (Chikovani et al. 2015) it was found that a quarter (24.8%) of all respondents had used some type of formal health care service for mental or emotional problems during the last 12-month. For respondents who met the criteria of a mental disorder, 39.7% utilized some type of health service. A significantly higher proportion of individuals with depression used services compared to those with PTSD. When more than one disorder was present the utilization rate was 47.5%.

Interestingly, more than one quarter (27.4%) of individuals who met the criteria of at least one mental disorder, did not report any problem that would prompt them to seek medical attention during the last 12 months. About one-third (33.1%) of respondents who met the clinical criteria of disorder and self-reported problems, did not seek care. This proportion is similar among those with PTSD, depression, anxiety and having more than one disorder.

The majority (app. 70%) of people used pharmacy services. Among individuals with mental disorders 13.8% used only pharmacy service without consulting other formal health care provider. Approximately half used general practitioners (GP) service at a primary care facility. Those who used only GP service without referring to other specialists reach 29%. Overall, around half consulted a neurologist at a hospital or outpatient clinic and use of outreach services was low (ranging from 4.0% to 7.0%). A small minority of those with mental disorder (2.3%) consulted psychiatric dispensaries/policlinics and the same proportion used private mental health specialist or psychosocial center service. Very few (1.2%) have attended a psychiatric hospital during the last 12 months.

ANNEX B

List of services

Community-based mental health inpatient unit/ acute department within general hospitals: A psychiatric unit that provides inpatient care for the management of mental disorders within a community-based facility. These units are usually located within general hospitals but sometimes some beds are provided as part of Community mental health services. They provide care to users with acute problems, and the period of stay is usually short (weeks to months).

Community residential health facility: A non-hospital, community-based mental health facility that provides overnight residence for people with mental ill health. Usually these facilities serve users with relatively stable mental and psychosocial disabilities not requiring intensive medical interventions.

Includes: Supervised housing; therapeutic communities.

Crisis Intervention/crisis resolution teams: Crisis refers to brief, acute breakdowns in which an individual's usual coping strategies are temporarily overwhelmed. The intervention offers resources for urgent and intensive care to obviate the need for admission to mental facility. Involves 24 h access, or at least extended hours, access to professionals by phone. Might have overnight or day beds. Early approaches tried to restrict crisis to disorders lasting days (typically 72 hours) but now generally stretches up to several weeks. Crisis care is characterized by the rapid provision of support (e.g. counselling, respite admission) while arousal and distress settle and more long-term care is planned. Contact is often very frequent, sometimes more than once a day.

Community Mental health centres/Mental health outpatient facility/Ambulatories: A facility that focuses on the management of mental disorders and the clinical and social problems related to it on an outpatient basis.

Includes: outpatient services for specific mental disorders or for specialized treatments; mental health outpatient departments in general hospitals; mental health policlinics; specialized NGO clinics that have mental health staff and provide mental health outpatient care (e.g. for rape survivors or homeless people).

Mobile groups/Outreach teams/Home treatment: Treatments (psychological, pharmacological and social) provided in the patient's home or neighbourhood when it is safe to do so. Often implies Multidisciplinary Team (MDT) approach and may involve frequent contacts (usually between daily and weekly).

Psychosocial interventions: An intervention using primarily psychological or social methods for the treatment and/or rehabilitation of a mental disorder or substantial reduction of psychosocial distress.

Includes: Psychotherapy; counseling; activities with families; psycho-educational treatments; the provision of social support; rehabilitation activities (e.g. leisure and socializing activities,

interpersonal and social skills training, occupational activities, vocational training, sheltered employment activities); also includes broader ps support activities, as First Psychological Aid, community mobilization, etc.

Rehabilitation services: Treatment and support for patients with severe, established mental health problems. Their main focus is on limiting and reducing disabilities. Increasingly they serve patients with complex illnesses who, despite best treatment, are unable to survive independently outside institutions without their intensive support.

Mental health day treatment facility: A facility that typically provides care for users during the day. The facilities are generally: (1) available to groups of users at the same time (rather than delivering services to individuals one at a time), (2) expect users to stay at the facilities beyond the periods during which they have face-to-face contact with staff (i.e. the service is not simply based on users coming for appointments with staff and then leaving immediately after the appointment) and (3) involve attendances that last half or one full day.

Includes:Day centers; sheltered workshops; club houses; employment/rehabilitation workshops; social enterprises.

Mental hospital: A specialized hospital-based facility that provides inpatient care and long-stay residential services for people with mental disorders.

Primary Healthcare Facilities/Policlinics - MH care provided within general primary care services

Other specialists - MH care provided by other specialists at outpatients or inpatient units of general hospitals; e.g. neurologists are general hospitals

Informal care: provided by families and community networks, as well as via self-care and peer-support, including Alcoholics Anonymous –AA.

“Trauma-informed” services and “trauma-specific” services are not the same.Trauma-informed services are informed about, and sensitive to, the potential for trauma-related issues to be present in patients, regardless of whether the issues are directly or obviously related to the presenting complaint or condition. Moreover, trauma-informed services are notdesigned to treat the sequelae of physical and sexualabuse or other traumatic experience.

Trauma-specificservices, in contrast, are designed expressly to treat thesymptoms and syndromes related to current or pasttrauma" (Butler et al. 2010, 197-210).

Annex 2.2.

კითხვარი ფსიქიკური ჯანმრთელობის სამსახურების შესახებ ომის შედეგად დაზარალებული მოსახლეობისათვის საქართველოში

ძვირფასო კოლეგებო,

წარმოდგენილი კითხვარი იკვლევს ექსპერტთა მოსაზრებებს ფსიქიკური ჯანმრთელობის (ფჯ) იმ სამსახურებთან / მეთოდებთან დაკავშირებით, რომელიც ითვალისწინებს ტრავმირებული ადამიანების, კერძოდ კი საქართველოში ომის შედეგად დაზარალებული მოსახლეობის საჭიროებებს. მოცემული კითხვარის შევსებას ვთავაზობთ ომით დაზარალებული ჯგუფების და ფსიქიკური ჯანმრთელობის პოლიტიკის, სისტემების, პრობლემებისა და საჭიროებების შესახებ არსებითი ცოდნით აღჭურვილ ექსპერტებს.

გთხოვთ, შეაფასოთ ერთი შესაძლო პასუხის მქონე დახურული კითხვები „1" -დან (მნიშვნელობით *სრულიად არ არის სასარგებლო*) '5'-მდე (მნიშვნელობით *ძალიან სასარგებლოა*)შკალით. იმ შემთხვევაში, თუკი თქვენი გამოცდილებით რომელიმე კონკრეტული მომსახურების ან მეთოდის გამოყენება არ მომხდარა, გთხოვთ, მონიშნოთ ვარიანტი*ამგვარი გამოცდილება არ არსებობს.*ხოლო ღია კითხვებისათვის,გთხოვთ,თავისუფლად წარმოადგინოთ თქვენი მოსაზრებები და გაგვიზიაროთ თქვენი გამოცდილება.

კონტექსტის განმარტებისა და შესაძლო კითხვების დაზუსტების მიზნით, საქართველოში ომით დაზარალებული მოსახლეობის ზოგადი მდგომარეობა და მათ

მიერ ფსიქიკური ჯანმრთელობის სამსახურების გამოყენების მონაცემები მოცემულია დანართ 1-ში. მომსახურების ჩამონათვალი კი წარმოდგენილია დანართი 2 სახით.

კითხვარი

დემოგრაფიული მონაცემები და სტატისტიკა

სქესი ❒მამრობითი❒მდედრობითი

პროფესიული გამოცდილება: ---

მოცემულ სფეროში მუშაობის გამოცდილება (წლები) ---

ქვეყანა: ---

აფილაცია: ❒სამთავრობო სტრუქტურა❒ადგილობრივი არასამთავრობო ორგანიზაცია ❒საერთაშორისო ორგანიზაცია

❒საერთაშორისო არასამთავრობო ორგანიზაცია

❒აკადემიური საზოგადოება

❒დევნილთა ორგანიზაცია ან ადგილობრივი თემზე დაფუძნებული ორგანიზაცია

❒სხვა:

ასაკი: ❒25-35❒36-50❒51-65 ❒>65

კ.1. გთხოვთ, წაიკითხოთ თითოეული ტიპის მომსახურების მოკლე აღწერა, როგორც ეს წარმოადგენილია ქვემოთ, და თქვენი გამოცდილების გათვალისწინებით,შეაფასოთ ისინი მათი სარგებლიანობის მიხედვით ომით დაზარალებულ მოსახლეობასთან მუშაობის თვალსაზრისით. დაამატეთ თქვენი კომენტარი, ასეთის არსებობის შემთხვევაში.

1=სრულიად არ არის სასარგებლო 2= არ არის სასარგებლო 3=ნეიტრალურია 4=სასარგებლოა 5=ძალიან სასარგებლოა

1.1.თემზე დაფუძნებული ფსიქიკური ჯანმრთელობის სტაციონარული განყოფილება / მწვავე განყოფილება ზოგადი პროფილის საავადმყოფოებში

1	2	3	4	5	ამგვარი გამოცდილება არ არსებობს

თქვენი კომენტარი:

1.2. თემზე დაფუძნებული საცხოვრისი

1	2	3	4	5	ამგვარი გამოცდილება არ არსებობს

თქვენი კომენტარი:

1.3. კრიზისული ინტერვენციის ჯგუფები / კრიზისული მდგომარეობების მართვის გუნდები

1	2	3	4	5	ამგვარი გამოცდილება არ არსებობს

თქვენი კომენტარი:

1.4. თემზე დაფუძნებული ფსიქიკური ჯანმრთელობის ცენტრები / ფსიქიკური ჯანმრთელობის ამბულატორული დაწესებულებები / ამბულატორიები

1	2	3	4	5	ამგვარი გამოცდილება არ არსებობს

თქვენი კომენტარი:

1.5.მობილური ჯგუფები /გამსვლელი გუნდები / შინზრუნვა - სახლის პირობებში მკურნალობა

1	2	3	4	5	ამგვარი გამოცდილება არსებობს	არ

თქვენი კომენტარი:

1.6. ფსიქოსოციალური ინტერვენციები

1	2	3	4	5	ამგვარი გამოცდილება არსებობს	არ

თქვენი კომენტარი:

1.7.სარეაბილიტაციო სამსახურები

1	2	3	4	5	ამგვარი გამოცდილება არსებობს	არ

თქვენი კომენტარი:

1.8. ფსიქიკური ჯანმრთელობის დღის ცენტრები

1	2	3	4	5	ამგვარი გამოცდილება არსებობს	არ

თქვენი კომენტარი:

1.9. ფსიქიატრიული საავადმყოფოები

					ამგვარი
1	2	3	4	5	გამოცდილება არ
					არსებობს

თქვენი კომენტარი:

1.10. პირველადი ჯანდაცვის დაწესებულებები / პოლიკლინიკები

					ამგვარი
1	2	3	4	5	გამოცდილება არ
					არსებობს

თქვენი კომენტარი:

1.11. სხვა სპეციალისტები

					ამგვარი
1	2	3	4	5	გამოცდილება არ
					არსებობს

თქვენი კომენტარი (გთხოვთ, განმარტოთ, რა სახის სპეციალისტი გყავთ მხედველობაში):

1.12.არაფორმალური მოვლა/დახმარება

					ამგვარი
1	2	3	4	5	გამოცდილება არ
					არსებობს

თქვენი კომენტარი:

კ.2. რომელი სამსახური/ მომსახურება მიგაჩნიათ ეფექტურად ომით დაზარალებული მოსახლეობის ფსიქიკური ჯანმრთელობის საჭიროებების დასაკმაყოფილებლად დაბალი და საშუალო, და მაღალი რესურსების მქონე ზონებში?*გთხოვთ, მონიშნოთ სამი ყველაზე მნიშვნელოვანი პასუხი თითოეულ სვეტში.*

	დაბალი და საშუალო რესურსების მქონე ზონა	მაღალი რესურსების მქონე ზონა
არაფორმალური მოვლა-დახმარებასაზოგადოებაში		
პირველადი ჯანდაცვის დაწესებულებები / პოლიკლინიკები		
სხვა სპეციალისტების მიერ გაწეული დახმარება (მაგ. ნევროლოგის) მეორად დონეზე		
სტაციონარული დახმარება / მწვავე ფსიქიკური ჯანმრთელობის განყოფილებები ზოგადი პროფილის საავადმყოფოებში		
კრიზისული ინტერვენციის /კრიზისული მდგომარეობების მართვის ცენტრები		
თემზე დაფუძნებული ფსიქიკური ჯანმრთელობის ცენტრები		
მობილური ჯგუფები / გამსვლელი გუნდები		
ფსიქოსოციალური ინტერვენციები (მათ შორის საზოგადოების მობილიზაცია)		
სარეაბილიტაციო სამსახურები		
ფსიქიკური ჯანმრთელობის დღის		

ცენტრები		
თემზე დაფუძნებული საცხოვრისიდაწესებულება		
ფსიქიატრიული საავადმყოფოები		

კ.3გთხოვთ, კომენტარი დაურთოთ რესურსებთან დაკავშირებული სამსახურების განვითარების მიდგომის კონცეფციას საქართველოსთვის[3]

_____

_____

კ.4.გთხოვთ, მიუთითოთ, რამდენად სასაგებლოა ომით დაზარალებული მოსახლეობის საჭიროებების დაკმაყოფილების პროცესში შემდეგი, ქვემოთ ჩამოთვლილი დამატებითი მეთოდები?

ტრავმის შეფასების ადრეული სკრინინგი	1	2	3	4	5	ამგვარი გამოცდილება არ არსებობს
გადამზადება (ტრეინინგი), ზედამხედველობა-სუპერვიზირება და პირველადი ჯანდაცვის რგოლის მუშაკების მხარდაჭერა	1	2	3	4	5	ამგვარი გამოცდილება არ არსებობს
პროფესიონალების უნარ-	1	2	3	4	5	ამგვარი

[3]აქ ჩვენ ვგულისხმობთ ფსიქიკური ჯანმრთელობის სამსახურების დაგეგმვისათვის თორნიკროფტისა და ტანზელას მიერ შემოთავაზებულ დაბალანსებული დახმარების მოდელის სტრუქტურას, რომელიც ეფუძნება „რესურსთა სამ დონეს“ - ანუ, დაბალ, საშუალოსა და მაღალი დონის რესურსების მქონე გარემოს(ჯ. თორნიკროფტი და მ. ტანზელა (2004).თანამედროვე ფსიქიკური ჯანმრთელობის სამსახურების კომპონენტები: სათემო და სტაციონარული დახმარებისპრაგმატული ბალანსი: სისტემური მტკიცებულებებისმიმოხილვა. ფსიქიატრიის ბრიტანული ჟურნალი 185, გვ. 283-290)

შესაძლებლობების გაზრდა და პოტენციალის განვითარება						გამოცდილება არ არსებობს
გათვითცნობიერებისა და ინფორმირებულობის გაზრდა ფსიქიკური ჯანმრთელობის საკითხების შესახებ	1	2	3	4	5	ამგვარი გამოცდილება არ არსებობს
ადვოკატირება და ლობირება ცენტრალური და ადგილობრივი მთავრობების საშუალებით	1	2	3	4	5	ამგვარი გამოცდილება არ არსებობს
პროგრამები და სტრატეგიები რეგიონალურ / მუნიციპალიტეტების დონეებზე	1	2	3	4	5	ამგვარი გამოცდილება არ არსებობს
დასაქმება და პროფესიული მომზადება	1	2	3	4	5	ამგვარი გამოცდილება არ არსებობს
ფინანსები	1	2	3	4	5	ამგვარი გამოცდილება არ არსებობს
მტკიცებულებაზე დაფუძნებული და განვითარების ეტაპზე მყოფი საუკეთესო პრაქტიკები	1	2	3	4	5	ამგვარი გამოცდილება არ არსებობს
მიმდინარე მომსახურების ეფექტურობის გაუმჯობესება-დახვეწა და შეფასება	1	2	3	4	5	ამგვარი გამოცდილება არ არსებობს
კვლევა	1	2	3	4	5	ამგვარი

გამოცდილება

არ არსებობს

კ.5. გთხოვთ, კომენტარი დაურთეთ და/ ან მიუთითეთ სამსახურების ეფექტური განვითარების ნებისმიერი სხვა სასარგებლო თქვენთვის ცნობილიმეთოდები

_____

_____

კ.6. გთხოვთ, გაგვიზიაროთ ქვემოთ შემოთავაზებული ცნებების შესახებ თქვენი მოსაზრებები:

ა) ტრავმით ინფორმირებული დახმარება (ტრავმის შესახებ ცოდნით ინფორმირებული სერვისი/trauma-informed care), და

ბ) უშუალოდ ტრავმაზე ორიენტირებული სპეციფიკური სამსახური (trauma-specific care)[4],და

გ) მათი ურთიერთქმედება?

_____

_____

კ.7.* (მხოლოდ ქართველი ექსპერტებისათვის). გთხოვთ, დააკონკრეტოთ ფსიქიკური ჯანმრთელობის ის აუცილებელი სამსახურები, რომლებიც დააკმაყოფილებდა ომის შედეგად დაზარალებული მოსახლეობის საჭიროებებს შედარებით დაბალი და საშუალო რესურსების არსებობის ზონაში (გორი, ზუგდიდი და სხვ.)

_____

_____

კ.8.* (მხოლოდ ქართველი ექსპერტებისათვის).) გთხოვთ, განსაზღვროთ ფსიქიკური ჯანმრთელობის ის აუცილებელი სამსახურები, რომლებიც დააკმაყოფილებდა ომის შედეგად დაზარალებული მოსახლეობის საჭიროებებს შედარებით მაღალი რესურსების არსებობის ზონაში (თბილისი, ბათუმი და სხვ.

[4] *გთხოვთ, გაეცნოთ ტერმინების განმარტებებს დანართ ბ-ში*

მადლობას გიხდით ჩვენთვის გამონახული დროისათვის!

დანართი ა

ზოგადი მიმოხილვა

ბოლო წლებში საქართველოს რესპუბლიკამ გადაიტანა სეპარატისტულ მოძრაობის მომცველი კონფლიქტის ორი ძირითადი ეტაპი. პირველი ფაზა დაიწყო ადრეულ 1990-იან წლებში, როდესაც ბრძოლებმა აფხაზეთისა და სამხრეთ ოსეთის რეგიონებში გამოიწვია 300,000 ადამიანისიძულებითი გადაადგილება.დაახლოებით 200,000 მათგანი დღესაც ცხოვრობს იძულებით ადგილნაცვალ პირთა სტატუსით (IDP). მეორე ფაზა განხორციელდა 2008 წლის აგვისტოში, როდესაც კონფლიქტი დაიწყო საქართველოსა და რუსეთის ფედერაციიას შორის სამხრეთ ოსეთის ირგვლივ, რამაც მიგვიყვანა მინიმუმ 128,000 ქართველის იძულებით გადაადგილებამდე, რომელთაგანაც 100,000 ამჟამად დაუბრუნდა მშობლიურ მიწა-წყალს მოსაზღვრე რეგიონში (‘დაბრუნებულები’). დღესდღეობით იძულებით ადგილნაცვალ პირთა უდიდესი უმრავლესობა ცხოვრობს იძულებით გადაადგილებულ პირთათვის სახელმწიფოს მიერ აშენებულ მჭიდრო და გადატვირთულ დასახლებებში/ სოფლებში, ხოლო ზოგიერთი კი რჩება იმპროვიზირებულ დასახლებებში, რომელიც წარმოადგენს სასტუმროების, სკოლების, ქარხნებისა და საავადმყოფოების ყოფილ შენობებს. სამთავრობო სტრუქტურებმა, არასამთავრობო ორგანიზაციებმა და გაეროს შესაბამისმა ორგანოებმასხვადასხვა სახის დახმარება გაუწიეს იძულებით გადაადგილებულ პირებს. თუმცა, მათი თემები ხასიათდება უკიდურესად მწირი საცხოვრებელი პირობებით, უმუშევრობის მაღალიმაჩვენებლით, სიღარიბით, ადგილობრივ თემებში ინტეგრაციის შეზღუდული შესაძლებლობებითა და ფსიქიკური ჯანმრთელობის დახმარების სფეროში მოქმედი სამსახურების დაბალი ხელმისაწვდომობით.

ბოლოდროინდელმა კვლევამ (მახაშვილი და სხვები, 2015) განსაზღვრა ფართოდგავრცელებული ფსიქიკური დარღვევების მაღალი განვრცობადობა ომით

დაზარალებულ მოსახლეობაში, მაგალითად, 23.3%-საღენიშნებოდა პოსტ-ტრავმული სტრესული აშლილობა (PTSD), 14.0%-ს- დეპრესია,ხოლო 10.4% -ს - შფოთვა. მონაცემების თანახმად, თითქმის მესამედს(საერთო რაოდენობიდან)აღენიშნებოდა მინიმუმ ერთი მდგომარეობა და 12.4%-ს ჰქონდა ერთზე მეტი აშლილობა. ყველა ფსიქიკური აშლილობა მნიშვნელოვანწილად ასოციაცირდებოდა უარეს ფუნქციონალურ დარღვევებთან.

რაც შეეხება მომსახურების გამოყენებას ზემოაღნიშნულ ჯგუფებში (ჩიქოვანი და სხვები, 2015), აღმოჩნდა, რომ ყველა რესპონდენტთა მეოთხედს (24.8%) მიუმართავს ამა თუ იმ ტიპის ჯანდაცვის ფორმალური სამსახურებისათის ფსიქიკური ან ემოციური პრობლემების გამო უკანასკვნელი 12 თვის განმავლობაში. იმ რესპონდენტთაგან, რომლებიც აკმაყოფილებდნენ ფსიქიკური აშლილობის კრიტერიუმებს, 39.7% იყენებდარომელიმე ტიპის ჯანმრთელობის სამსახურებს. დეპრესიის მქონე ადამიანთა მნიშვნელოვანად უფრო მაღალი პროცენტული რაოდენობამიმართავდა ჯანმრთელობის სამსახურებს, იმ პირებთანშედარებით, რომელთაც აღენიშნებოდათPTSD. ერთზე მეტი აშლილობის არსებობის პირობებში, სამსახურების გამოყენების მაჩვენებელი შეადგენდა 47.5%-ს.

საინტერესოა, რომ იმ ადამიანთა მეოთხედზე მეტი (27.4%), რომლებიც მინიმუმ ერთი ფსიქიკური აშლილობის კრიტერიუმებს აკმაყოფილებდა, არ აღნიშნავდა იმ პრობლემების არსებობას, რომელნიც აიძულებდათ მათ, სამედიცინო დახმარებისათვის მიემართათუკანასკვნელი 12 თვის მანძილზე. რესპონდენტებისდაახლოებით ერთ მესამედს(33.1%), რომლებიც აკმაყოფილებდნენ აშლილობებისა და თვით-აღიარებული პრობლემების კლინიკურ კრიტერიუმებს, არ მიუმართავთ დახმარებისათვის. ეს მაჩვენებლები PTSD-ს, დეპრესიის, შფოთვისა და ერთზე მეტი აშლილობის მქონე პირთა თანაფარდობის ანალოგიურია. ადამიანთა უმრავლესობამ (დაახლ. 70%) ისარგებლა სააფთიაქო მომსახურებით. ფსიქიკური აშლილობების მქონე ადამიანთა შორის 13.8%-მაგამოიყენა სააფთიაქო მომსახურება ჯანდაცვის სხვა ფორმალური სამსახურების მიმწოდებლებთან კონსულტაციის გარეშე. ამ ადამიანთა დაახლოებით ნახევარი სარგებლობდა თერაპევტის მომსახურებით პირველადი დახმარების დაწესებულებებში. იმ ადამიანთა

რაოდენობა, რომელიც მიმართავდა მხოლოდ თერაპევტის მომსახურებას სხვა სპეციალისტებთან კონსულტაციის გარეშე, აღწევს 29%-ს. საერთო ჯამში, დაახლოებით ნახევარმა მიმართა საკონსულტაციოდ ნევროლოგს საავადმყოფოებსა ან ამბულატორულ კლინიკებში, ხოლო ინდივიდუალური მხარდაჭერის სამსახურებისათვის მიმართვის დონე დაბალი იყო (მერყეობდა 4.0%-დან 7.0%-მდე). ფსიქიკური ჯანმრთელობის მქონე პირთა უმნიშვნელო რაოდენობა (2.3%) საკონსულტაციოდ მიმართავდა ფსიქიატრიულ დისპანსერებს / პოლიკლინიკებს და ადამიანთა იგივე რაოდენობა გამოიყენებდა ფსიქიკური ჯანმრთელობის კერძო სპეციალისტთა მომსახურებას ან ფსიქოსოციალური ცენტრების სამსახურს. დაზარალებული მოსახლეობის ძალიან მცირე რაოდენობამ(1.2%) მიმართა ფსიქიატრიულ საავადმყოფოებს უკანასკვნელი 12 თვისმანძილზე.

დანართი ბ

სამსახურების ჩამონათვალი

ფსიქიკური ჯანმრთელობის თემზე დაფუძნებული სტაციონარული განყოფილება/ მწვავე განყოფილება ზოგადი პროფილის საავადმყოფოებში: ფსიქიატრიული განყოფილება, რომელიც უზრუნველყოფს სტაციონარულ დახმარებას ფსიქიკური აშლილობების მართვის მიზნით თემზე დაფუძნებული დაწესებულებების ფარგლებში. ეს განყოფილებები, როგორც წესი, მდებარეობს ზოგადი პროფილის საავადმყოფოებში, მაგრამ ზოგჯერ საწოლთა გარკვეული რაოდენობა წარმოადგენილია ფსიქიკური ჯანმრთელობის თემზე დაფუძნებული სამსახურების ნაწილის სახით. ისინი უზრუნველყოფენ მწვავე პრობლემების მქონე იუზერების დახმარებას, ამ განყოფილებაში დარჩენის პერიოდი, ჩვეულებრივ, მცირეა (რამდენიმე კვირიდან რამდენიმე თვემდე).

თემზე დაფუძნებული საცხოვრისი დაწესებულება: არა საავადმყოფოს ტიპის, თემზე დაფუძნებული ფსიქიკური ჯანმრთელობის დაწესებულება, რომელიც უზრუნველყოფსღამით საცხოვრებელს ფსიქიკური ჯანმრთელობის პრობლემების მქონე ადამიანთათვის. როგორც წესი, ამგვარი დაწესებულებები ემსახურება შედარებით სტაბილური ფსიქიკური და ფსიქოსოციალური პრობლემების მქონე

შეზღუდული შესაძლებლობების იმ იუზერებს, რომელნიც არ საჭიროებენ ინტენსიურ სამედიცინო ჩარევას (ინტერვენციას).
მოიცავს: საცხოვრებელი გარემოს ზედამხედველობა-კონტროლირებას; არაფორმალურ თერაპიულ გარემოს.

კრიზისული ინტერვენციის/ კრიზისული მდგომარეობების მართვის ჯგუფები:კრიზისი გულისხმობს ჯანმრთელობის მდგომარეობის მოკლევადიან, მწვავემოშლას, რომლის დროსაც ადამიანის გამკლავების ჩვეული სტრატეგიები დროებით ითრგუნება. ინტერვენცია გვთავაზობს რესურსებს გადაუდებელი და ინტენსიური დახმარებისათვის ფსიქიკური ჯანმრთელობის დაწესებულებაში მოხვედრის საჭიროების თავიდან აცილების მიზნით. მოიცავს: ხელმისაწვდომობას 24 საათის განმავლობაში, ან უზრუნველყოფსმომსახურებას გახანგრძლივებული დროით, ყველა პროფესიონალის მიწვდომა შესაძლებელია ტელეფონით. შესაძლოა ჰქონდეს ღამის ან დღის საწოლ-ადგილები. ადრეულ სტადიაზე ჩარევის მიდგომა უზრუნველყოფს კრიზისული მდგომარეობის მხოლოდ რამდენიმე დღის განმავლობაში (ჩვეულებრივ 72 საათის განმავლობაში) გაგრძელებად აშლილობამდე შეზღუდვის მცდელობას; თუმცა ამჟამად ამგვარი კრიზისული მდგომარეობა ზოგადად იჭიმება რამდენიმე კვირის განმავლობაში. კრიზისული დახმარება ხასიათდება მხარდაჭერის სწრაფი უზრუნველყოფით (მაგ. კონსულტირებით, ჰოსპიტალიზაციის დროებითი გადადებით), რომლის დროსაც ხდება აღგზნებადობისა და დისტრესისდარეგულირება, უფრო გრძელვადიანი დახმარების დაგეგმვამდე. კონტაქტი, ჩვეულებრივ, ძალზე ხშირია, ზოგჯერ ერთჯერზე მეტი დღეში.

ფსიქიკური ჯანმრთელობის თემზე დაფუძნებული ცენტრები / ფსიქიკური ჯანმრთელობის ამბულატორული დაწესებულებები/ ამბულატორიები: დაწესებულება, რომელიცორიენტირებულია ამბულატორულ პირობებში ფსიქიკური აშლილობებისა და მასთან დაკავშირებული კლინიკური და სოციალური პრობლემების მართვაზე.

მოიცავს:ამბულატორულ სამსახურებს კონკრეტული ფსიქიკური აშლილობებისათვის ან სპეციალიზირებული მკურნალობისათვის; ფსიქიკური ჯანმრთელობის ამბულატორულ განყოფილებებს ზოგადი პროფილის საავადმყოფოებში; ფსიქიკური ჯანმრთელობის პოლიკლინიკებს; სპეციალიზირებული არასამთავრობო ორგანიზაციების კლინიკებს, რომელთაც ჰყავთ ფსიქიკური ჯანმრთელობის პერსონალი და უზრუნველყოფენ ფსიქიკური ჯანმრთელობის ამბულატორულ დახმარებას (მაგ. გაუპატიურების მსხვერპლთათვის ან უსახლკაროდ დარჩენილთათვის).

მობილური ჯგუფები/ადგილზე გამსვლელი გუნდები / შინზრუნვა და სახლის პირობებში მკურნალობა: მკურნალობა (ფსიქოლოგიური, ფარმაკოლოგიური და სოციალური), რომელიც უზრუნველყოფილია პაციენტისათვის სახლში ან მის სამეზობლოში, როდესაც ეს უსაფრთხოა. ხშირად ის გულისხმობს მულტიდისციპლინარული გუნდის (MDT) მიდგომის პრინციპს და შესაძლოა მოიცავდეს ხშირ კონტაქტს (როგორც წესი, ის მერყეობსყოველდღიურსა და ყოველკვირეულ კონტაქტებს შორის).

ფსიქოსოციალური ინტერვენცია: ინტერვენცია, რომელიც გამოიყენებს პირველ რიგში, ფსუქოლოგიურ ან სოციალურ მეთოდებს ფსიქიკური აშლილობის მკურნალობისა და / ან რეაბილიტაციის, ან ფსიქოსოციალური დისტრესის არსებითი შემცირება-შერბილების მიზნით.
მოიცავს: ფსიქოთერაპიას; კონსულტირებას; ოჯახთან დაკავშირებულ აქტივობებს; ფსიქო-საგანმანათლებლო პროცედურებს; სოციალური მხარდაჭერის უზრუნველყოფას; სარეაბილიტაციო ზომებს (მაგ. დასვენებასა და საზოგადოებრივ და საკომუნიკაციო აქტივობებს, ინტერპერსონალური და სოციალური უნარების დასწავლის ტრეინინგებს, შრომითი თერაპიის ღონისძიებებს, პროფესიულ მომზადებას, დაცულ დასაქმებას, ანუ დასაქმების შერბილებულ პირობებს სპეციალური საჭიროებების მქონე პირთათვის); ასევე მოიცავს უფრო ფართო ფსიქოსოციალურ მხარდამჭერ ღონისძიებებსა და ზომებს, ისეთს, როგორიცაა გადაუდებელი ფსიქოლოგიური დახმარება, თემის მობილიზაცია და სხვა.

სარეაბილიტაციო სამსახურები: უზრუნველყოფენ ფსიქიკური ჯანმრთელობის მძიმე, დადგენილი პრობლემების მქონე პაციენტების მკურნალობასა და მხარდაჭერას. ისინი, ძირითადად, ფოკუსირებულნი არიან ქმედითუუნაროობის შეზღუდვისა და შემცირებისაკენ. უფრო ხშირად ისინი ემსახურებიან კომპლექსური დაავადებების მქონე პაციენტებს, რომლებსაც, მიუხედავად საუკეთესო მკურნალობის უზრუნველყოფისა, ვერ შესწევთ დამოუკიდებლად არსებობის უნარი სპეციალიზირებული დაწესებულებების გარეთ მათთვის გაწეული ინტენსიური მხარდაჭერის გარეშე.

ფსიქიკური ჯანმრთელობის დღის ცენტრი: დაწესებულება, რომელიც, ჩვეულებრივ, უზრუნველყოფს დახმარებას იუზერებისათვის დღის განმავლობაში. დაწესებულებები, ზოგადად: (1) ერთდროულად ხელმისაწვდომია იუზერთა რამდენიმე ჯგუფისათვის (მომსახურების მიწოდება არ ხდება მხოლოდ ცალკეულ პირთათვის ერთჯერადად, დროის გარკვეულ პერიოდში - თითოეულისათვის), (2) უზრუნველყოფს იუზერთა დარჩენას დაწესებულებში იმ პერიოდების გარდა, რომლის დროსაც მათ უშუალო, პირისპირ კონტაქტი აქვთ პერსონალთან (ანუ სამსახური უბრალოდ არ ეფუძნება იუზერების მიერ პერსონალთან შეხვედრისათვის დანიშნულ დროს მოსვლისა და შეხვედრის შემდეგ დაწესებულების მაშინვე დატოვების პრინციპს); და (3) მოიცავს დაწესებულებაში იუზერთა ყოფნას, რაც შესაძლებელია გაგრძელდეს ნახევარ ან თუნდაც მთელ დღეს.

მოიცავს: დღის ცენტრებს; დაცულ პრაქტიკულ მეცადინეობებს იუზერებთან; კლუბის ტიპის სახლებს; დასაქმების/ სარეაბილიტაციო ღონისძიებებსა და პრაქტიკულ მეცადინეობებს; სოციალურ საწარმოებს.

ფსიქიატრიული საავადმყოფო: სპეციალიზირებული საავადმყოფოს ტიპის დაწესებულება, რომელიც უზრუნველყოფს სტაციონარულ მოვლასა და დახმარებას, დაგრძელვადიან საყოფაცხოვრებო-საცხოვრებელ მომსახურებას ფსიქიკური აშლილობის მქონე ადამიანთათვის.

პირველადი ჯანდაცვის დაწესებულებები/ პოლიკლინიკები - ზოგადი პირველადი დახმარების სამსახურების ფარგლებში უზრუნველყოფილი ფსიქიკური დახმარება

სხვა სპეციალისტები -სხვა სპეციალისტების მიერ გაწეული ფსიქიკური დახმარებაზოგადი პროფილის საავადმყოფოების ამბულატორულ ან სტაციონარულ განყოფილებებში;მაგ. ნევროლოგები არიან ზოგადი პროფილის საავადმყოფოში

არაფორმალური მოვლა-დახმარება : როგორც ოჯახებისა და საზოგადოებრივი ქსელების მიერ მიწოდებული დახმარება, ასევე თვით-დახმარებისა და იუზერთა მხარდაჭერის გზით უზრუნველყოფილი დახმარება, ანონიმური ალკოჰოლიკების ჯგუფების ჩათვლით.

“ტრავმით ინფორმირებული დახმარების“ სამსახურები (trauma-informed services) და “ტრავმაზე ორიენტირებული სპეციფიკური” სამსახურები (trauma-specific services)არ წარმოადგენს ერთსა და იგივეს. ტრავმით ინფორმირებული სამსახურები სენსიტიურნი დაინფორმირებულნი არიან ტრავმასთან დაკავშირებული საკითხების შესახებ; ტრავმით გამოწვეული პრობლემების პაციენტებში/კლიენტებში არსებობის შესაძლებლობის შესახებ და, ამ პრობლემების არსებობის პოტენციალის მიმართ, მიუხედავად იმისა, მოცემული საკითხები ან პრობლემები უშუალოდ ან აშკარად არის თუ არა დაკავშირებული კლიენტების/პაციენტების მიერ წარმოდგენილ საჩივრებთან ან მდგომარეობასთან. ტრავმით ინფორმირებული სამსახურები არარის გათვლილი ფიზიკური და სექსუალური ძალადობის ან სხვა ტრავმული გამოცდილების შედეგების მკურნალობაზე. მათგან განსხვავებით, უშუალოდ ტრავმაზე ორიენტირებული სპეციფიკური სამსახურები ექსპლიციტურად მიმართულია მიმდინარე ან წარსულ ტრავმასთან დაკავშირებული სიმპტომებისა და სინდრომების მკურნალობა-რეაბილიტაციაზე (ბათლერი და სხვები. 2011, 197-210).