Development of PHC in Albania and Mental Health

Mission report

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Disclaimer

- The views and ideas expressed herein are those of the author(s) and do not necessarily imply or reflect the opinion of the Swiss Agency for Development and Cooperation, Swiss Tropical and Public Health Institute or Health for All Project (HAP).
- The term Mental Health and Psychosocial Support (MHPSS) will be used in the report since the term englobes psychosocial stressors and its management, beside medical psychiatric conditions, which makes in more inclusive, less medical and less stigmatizing.

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Abbreviations

CMD	Common Mental Disorder
CMHC	Community Mental Healthcare Center
FD	Family Doctor
FHN	Family Health Nursing
FN	Family Nurse
FTMS	Faculty of Technical Medical Science of the University of Tirana
HC	Health Center
HIF	Health Insurance Fund
LGU	Local Government Unit
MHPSS	Mental Health and Psychosocial Support
MoHSP	Ministry of Health and Social Protection
NCD	Non-Communicable Disease
NCCE	National Center for Continuous Medical Education
NHG	Dutch FD Society
PH	Public Health
PHC	Primary Health Care
PRG	Peer Review Groups
SDC	Swiss Agency for Development and Cooperation
STPHI	Swiss Tropical and Public Health Institute
ToR	Terms of Reference
WHO AIMS	World Health Organization Assessment Instrument for Mental Health Systems

Summary

The main objective of the consultancy was to support the local HAP team and identify possible directions on how **to improve quality of Mental Health care in the Primary Health Care setting.**

Preparation of the site visits in October 2021 were online and relevant literature was reviewed. Different settings and professionals were consulted and then findings were discussed during an on-site visit to Albania. The used approach and literature was sufficient to reach the ToR objectives. Local practice at PHC level relating to handling mental health conditions was identified and compared with international guidelines and experiences in other countries.

The findings indicated that **main light to moderate Mental Health complaints to focus on in the Albanian PHC setting are depression, anxiety, somatoform disorders, substance use, sleeping problems and chronic but stable cases.** Other conditions can be identified at PHC level and then be referred to specialists. The check-up program in place in Albania and the related yearly screening of adults between **35 and 70 years** at PHC level was discussed with different health experts. Mental Health Recommendations were identified related to the **improvement of feedback on population level and simple e-health or group interventions that can be offered at PHC level when tobacco/alcohol use or depression are present and detected within the yearly screening but not too severe**.

In terms of better handling mental health conditions with PHC services, **the development of the guide of management of the mental health disorders in primary health care can support treatment and conduct at PHC level and serve as reference point for capacity building**. For service integration, 2 strategies were identified 1) MH specialist consultation on a regular basis in the PHC setting and 2) developing a regional GP specialist with mental expertise. This is further elaborated on in the report annexe 4 of this report. Further, different easily applicable group and e-intervention entry points were identified, of which the iFight depression online toolkit will need further investigation on its validity and applicability in the Albania setting.

Introduction

As described in the ToR the HAP project contributes for a better health of the Albanian population thanks to improved primary health services. Phase 2 of the project supports the MoHSP redefining PHC service models, strengthening the role and functions of family medicine teams with special focus on nurse -based services. **In Phase 2 there's a focus on improving the essential service package at PHC level, including Mental Health and Psychosocial Support (MPPSS). In view of further strengthening capacities of PHC professional for better quality of services in accordance with Basic Package of Services in PHC, HAP initiated in 2021 the development of a specific local "guide of management of the mental health disorders in primary health care" in PHC**. A local consultant was contracted to develop it together with HAP and a group of Family Doctors (FDs) and Family Nurses (FDs). An international consultant has been recruited as well so to feed in international experiences of embedding mental health services in PHC. The present report reflects on this.

In the frame of implementation of the Strategy on Development of PHC Services in Albania 2020-2025 and the Basic Package of Services in PHC the objectives of the consultancy were:

- Analyze the role of mental health services within Primary Health care in Albania, and recommend what services to offer and what conditions to focus on.
- Review professional competencies of health workers in place (family doctors and nurses) so to handle key mental health conditions and identify possible capacity strengthening measures;
- Analyze available tools and processes (e.g clinical guidelines, communication process with social services) at PHC level relating to mental health and identify possible practical and educational tools for improving the handling of mental conditions through PHC services;
- Recommend possible next steps in terms of better handling of mental health conditions within the Albanian PHC setting with focus on satisfaction of the identified need for practical and educational tools and for more competent PHC professionals in provision of integrated mental health services.

Approach

Pre-mission online preparation meetings were held July 9th, July 15th and September 15th 2021with the Swiss TPH project manager, HAP project coordinator and the quality of care officer. Relevant documents, as well as additional scientific literature were read and analyzed. They can be found in the literature chapter. Full text version is available on request.

In the period, September 27th – 30rd 2021 different on-site visits were done and different stakeholders were spoken in Albania as summarized including names in Annex 1. There was a focus group discussion with a group of FNs and FDs from the HAP supported regions and

the local consultant. There were interviews with professionals with a variety of professional backgrounds: FD, FN, HC director, social worker, MoHSP technical staff, psychiatrist, HAP staff, CMHC director, Head of Public Health Department, Faculty of Medicine, Medical University. Unfortunately, it was not possible to talk to service users or families of service users. There were site visits to: 2 CMHCs, 2 HCs, MoH, University. HAP project staff supported the mission with transport, connecting to people and institutions, communication, language interpreting and bridging cultural barriers.

Preliminary findings and recommendations were discussed at the end of the mission. The report was finalized after additional input and feedback from HAP management. The realized approach is in line with the approach as described in the ToR. The recommendations are given in line with the project expected outcomes:

1) Improve stewardship, management and effectiveness of PHC services
2) Accessible and effective use of better quality PHC services

Findings:

Literature

About 20% of the burden of disease is made up by neuropsychiatric disorders, with depression (4.8%) and anxiety (3.8%) one year prevalence rates contributing most in Albania. The age standardized suicide rate is 3.72 in Albania, placing it in the lowest WHO category (<5).

Standardized suicide rates (2019, both sexes):

Albania	Netherlands	Bosnia and Herzegovina
3.72	9.27	8.25

The WHO mental health atlas Albania refers to an existing National Plan for Development of Mental Health 2013-2022 that ambitions to shift resources from mental hospitals to the community and integrate mental health in primary care. **Official policy does not expect any concrete interventions, measures and tools to help primary health care doctors and nurses to independently diagnose and treat mental disorders within the primary care system as Basic Package of Services in PHC foresees.**

No specific post-graduate MHPSS training is available for PHC doctors. Referral systems are in place to refer to secondary/tertiary care but not the other way around. In patients in mental health hospitals only 18% are discharged within 1 year and 64% stay more than 5 years, stressing the importance to prevent hospitalization and to continue to work with families, communities in order to refer back to PHC (1).

WHO Assesment Instrument for Mental Health Systems (AIMS) results show that the amount of psychiatrists in Albania 1.83 per 100.000 population is about average for a upper middle

income country. The amount of nurses working in mental health, however, is with 6.18 much lower than is to be expected (10 nurses). Actually there is a neither a family of patients with mental health disorders Association or users of mental health sevices organisation in Albania. The family organization is not routinely involved in policy/guideline design and implementation (1). A summary of Specialized Mental Health services in Albania was analyzed, it can be found in Annex 2. During the consultancy there was identified only one Family Organization of children with intellectual disability. **An example of the WHO AIMS method in Albania** was published in 2011 (2). This report was found to be in line with the articles findings.

A recent overview on Mental Health in Albania, written by Durmishi et al. was found online but there was no access to the full text so the content has not been taken into account. The table on content can be found via:
https://www.worldscientific.com/doi/abs/10.1142/9789811205644_0002
One of the authors (Ariel Como) was in the program to meet and discuss topics but this meeting was cancelled last minute due to COVID-19 related issues.

Challenges in decentralizing MH services in Albania were discussed by Frashëri et al and can be summarized as follows: lack of financing, management, citizen's participation, lack of reaction to demographic changes and the increase NCD prevalence, limited access in rural areas and limited quality of care, brain drain to urban areas and abroad. Transformation from the tradition residential psychiatric services to more community based multi-disciplinary services evolves implementing a fundamental new care model requiring new skills and competencies (3).

For the PHC setting MH services **should focus on light to moderate CMDs like depression, anxiety, somatoform disorders and light or moderate substance use including alcohol and tobacco as well as other drugs.** Other diagnoses should be identified at PHC level and referred to specialized services. In case of chronic stable cases after a treatment in CMHS monitoring cases is feasible at PHC level.

Concerning finance: public healthcare is financed by compulsory health insurance contributions by employers and employees and additional state budget. Use of services, including MH care services, and prescriptions are therefore reimbursed. Several groups, like unemployed and children are automatically included in the HIF, facilitating equal access to care. Around the country there are 9 community mental health centers with multi-disciplinary treatments. They often appear to be full (4) and are described by the MoH summary in Annex 2.

In the HAP project phase 2 (2019-2023) the question was raised on how to integrate Mental Health and Psychosocial Issues in the project (5).

1) Enhanced capacities of Healthcare providers
2) Models of home based care
3) Inclusive policy and strategy implementation.

Concerning the development of the CGPs for MH in PHC that will be developed in Albania; there's 9 CGPs specifically developed for the use within PHC in the Netherlands 1) ADHD in children 2) anxiety 3) delirium 4) dementia 5) depression 6) enuresis nocturna 7) work related burn out 8) problematic alcohol use and 9) sleeping problems (6). A summary of disorders included in the mhGAP intervention guide, mhGAP HIG and in the Dutch CGPs are summarized in Annex 3. **Albania is not considered a humanitarian setting by the author and the recommended areas to focus on are depression, anxiety, alcohol and drug related disorders, psychosis, somatoform symptoms, self-harm/suicide and delirium. It is important that dementia is covered either by the MH GCP or the geriatric one**. Epilepsy is considered part of MH CGPs in many countries but for the Albanian setting I consider it the area of expertise of neurologists.

The Netherlands has a model in which FDs, beside their regular work, specialize in a specific area of health. After 2 years of part-time education they are entitled **"Regional GP specialist in mental health profile"**. This title was translated in English in cooperation with a Dutch FD and University professor (7). Several examples exist like palliative care, asthma/COPD, cardiovascular disease, geriatrics and mental health. Specific tasks, as well as a specific profile of the Regional GP specialist in mental health, can be found in Annex 4. There was no Scientific literature found on this subject. **For the Albanian context, this concept can prove interesting because it can empower FDs with specific interest/motivation in the field of MH, it can improve quality of care or referral by supporting inter collegial consultation within PHC, making the HCs less dependent on nearby psychiatrists for consultation.**

Saraceno at al. (2007) describe barriers in improving mental health services including: prevailing public-health priority agenda and its effect on funding; the complexity of and resistance to decentralization of mental health services; challenges to implementation of mental health care in primary-care settings; the low numbers and few types of workers who are trained and supervised in mental health care; and the frequent scarcity of public-health perspectives in mental health leadership (8). Many of the mentioned challenges are recognized for the Albanian context. Recommendations in this paper are in line with the recommendations in this report and HAP project objectives in general.

Site visits

- At the community, mental health center no.2 the following topics were discussed: referral system in place via FD, directly, family, police. Referral back to FD only in curative cases. Low suicide rate. No specific work with users of families in policy making/implementation. Outreaching services existing. Number of places in residential living (15) much too low. No practice of handing out medical statements. 2900 actively well-known patients in 2020, as well as 10.600 other consultation. Multi-disciplinary approach with occupational therapist, psychologist, social work and 3 psychiatrists. Surprisingly no waiting list was reported. Only adult MH. Identified

challenges: referrals don't distinguish neurological vs mental problems, HIF issues with the fact that prescriptions from psychiatrist are not reimbursed, so they give "treatment recommendations", FDs that repeat prescriptions don't do counseling, there's database of the patients, but it cannot be shared with the CMHC. Other expressed challenges were: lack of number of community mental health centers, electronic medical file, HIF stress, the catchment area is too big.

- The visit to the Health Center no. 1, Tirane, resulted in the following findings. There's 25 FDs, of which 10 are officially specialized as FD's. FDs work together in the consultation room with FNs in "family doctor teams". As of 35 years of age all citizens are invited for a yearly checkup which includes among others: ECG, LAB, nutrition and screening on MH issues like alcohol use, tobacco use and screening for depression using the PHQ-9 locally translated (9). There's separate referral systems for service users with mental disorders and addiction. The service expressed the need for FDs to implement an agenda system to better manage time and can spend more time with mental health related issues. There's no specific attention for health care worker's self-care and psychosocial or mental stress. The suggestions of specialist consultation in PHC and framework FDs was well received in terms of support.

- The visit to another Health Center (no. 2), in Tirane, can be summarized as follows. There's an information system on paper concerning diagnosis but it remains unclear whether this aggregated information is used to improve services. Description of tasks by the FD as follow up, handling of less severe cases and prevention. People get medication from pharmacy without prescription. There used to be 1-2x/year a nurse visiting from a CMHC to follow up cases (no supervision/peer support). Catchment area 2700 patients. 25 years of experience. 15 knows MH cases to be followed up + few in private clinic. Specialist consultation onsite from surgeon, cardiologist and pediatrician. Guided tour and talk with nurses on yearly checkup and what to do with results on PHQ (main task is to gather info to give to FD, average score 3-4, if needed advice). Clean facility with different health promotion material present. FDs knowledge on MH issues is limited, in line with found literature describing that only 1.4% of the overall training hours in the university is dedicated to MH (10).

- Meeting with, Head of the Sector for the Development of Public Health and Primary Health Care, MoHSP. Current MH reforms: closing of 2 main psychiatry clinics in Elbasan (310 beds) and Vlora (160 beds), increasing number of CMHCs, increasing number of protected living services (N=14 with 10 patients each). Tasks for FDs: early detection, follow up also for chronic cases after CMHC involvement, treatment of light CMDs. Some HCs have child & adolescent MH service from child/vaccination follow up. CMHC is considered 2nd line treatment, and the clinical psychiatric facilities are considered 3rd line. Future directions: implementing social assistance (social work background) in the HCs to give a more psychosocial approach possibility. No user's organization known. Family of children with mental retardation (intellectual disability) organization existing, they even provide services to users (not

families) under the national committee of protection of people with disabilities. Making MH more appealing for FDs by awareness raising and capacity building. No attention to self-care, beside regional NGO project till 2019, can be of added value to prevent dysfunction of workforce and to involve on a more personal level to MH issues.

- A meeting was held with the local consultant in charge of the development of the Guide, about integration of MH in primary care, historical context of MH reforms in Albania (MoH, WHO, NGO), which disorders to focus on in the Guide/CGPs. Different examples of MH integration in primary care were discussed.

- A focus group discussion like meeting was held with FD's, FNs and the local consultant. There were 5 topics discussed:

1. Introduction of professionals, type and purpose of the meeting

2. Sharing of success stories of dealing with mental health problems in PHC. Some of the cases were reflected upon by the local consultant. The exercise was set up in a way that the effect was empowering for the participants. The following successful ingredients were mentioned as best practice: a transfer of the patient from clinic to FD/FN with a real-time meeting with the MH clinic of CMHC staff, collaboration with social services, provide low threshold MHPSS support in case of severe somatic illness, presence and persistence in dealing with a case, actively weight and make the decision to speak the patient with and/or without family member, pro-active approach. Some of the mentioned ingredients seem feasible and realistic innovations and are therefore included in the recommendations.

3. A discussion was held about MH related stigma and health professional's motivation and compassion to work with MH related pathology. Possible strategies to enhance this motivation were identified like: share successes, raise capacity of nurses, encourage colleagues to take longer for a consultation and do a complete MH history, be a role model on how to deal with MH problems, stimulate colleagues to fight internalized stigma, use the appointment system, encourage colleagues to treat MH patients like they were a direct family member with a MH condition, use the "head to toe" nursing evaluation form, stimulate colleagues to do active follow up and home visits.

4. The importance of self-care and mental health and psychosocial well-being of the health professional was briefly touched in relation to the already existing peer groups.

5. There were 3 possible strategies discussed on how to integrate MH in PHC (see table below). All practices are present in the Netherlands. The use of MH CGPs for PHCs are also part of this approach but were not discussed in this meeting. This was already done September 8th. The 3 discussed strategies were:

Psychology MH nurse counseling in PHC	Consultations of a psychiatrist in PHC	Framework FD/FN with a specific expertise in MH
Referrals can be prevented or prepared using a maximum number of counseling consultations within PHC (f.e.10)	The FD/FN collect cases/questions and meet with the psychiatrist. The consultation is aimed to empower the FD/FN team and to prevent referrals	After a followed curriculum, this professional will be able: • function as a consultation source • be a contact person for MH services in the area • develop policy or CGPs at local level • teach in CMHE • participate in research aimed at MH in PHC

In an exercise, it was made clear that the participants understood the essentials of the 3 strategies. They had to express a preference for one of the strategies and motivate why. Both **the consultation and the framework strategy got equal support.** Nobody was supportive of the counseling strategy so that a MH specialist (e.g. doctor or nurse) consultation on a regular basis in PHC settings as well as a regional GP specialists with MH competencies appear to be tailored to the Albanian PHC setting.

- In a meeting with the University of Tirana PH Department progress and challenges in MH decentralization and de-institutionalization were discussed. The department of PH is a strong advocate for MH integration in PHC, supported by literature (11). Through a EU project the iFight depression online MH platform was launched in Albania. The platform also uses the PHQ-9 and is implemented with 12 partners. Access to the platform was initially through a MH professional, but in the last part of the project also a small number of FDs were authorized. It was reported that the iFight depression platform is suitable for online follow up as well as blended care. Without authorization, the MH professional cannot enter the platform. One consortium publication was found (12) describing the platform in which iFight depression is assumed to be part. The publication describes the study protocol so no results are yet available. During the visit the number of Albanian users of this platform remained unclear. Basic Package of PHC services were discussed. Concerning self-care for professionals the PH collaborated in a program called MentUP, it is used in 3 professional settings 1) ICT 2) construction work and 3) health. During the meeting, no further details were discussed and no reliable English language internet source was identified.

- The visit at CMHC nr 1. 8000 patients of which 1000 children (child and adolescent service available). Only communication with FDs is via official paper referral letters. The catchment area was 300.000 inhabitants. 3 psychiatrists, of which one Child & Adolescent. Role of social work in multi-disciplinary approach was difficult in the beginning. In recent years, the multi-disciplinary approach is appreciated. Social worker writes down the whole history in the file, including MH history, financial-, household and living conditions. Collaboration with the local government unit and a protected living home for children.

The iFight depression website in Albanian includes the possibility of an internet based self-test (comparable to the PHQ-9 used in the yearly screening) and has an easy to understand overview of self-help recommendations concerning eating, exercise, sleep, social contacts and daily organization of your day. This internet based self-help programs are efficient in the PHC level treatment of light to moderate depression in many parts of the world. On the Albanian part of the website it's not clear if the iFight depression online toolkit is available. I hope the local HAP team can find that out. I can conclude that the iFight depression platform is a feasible, accessible tool to treat mild/moderate depression in PHC. It's translated in Albanian, known in Albania, in some of the CMHCs as well as internationally. The Mentup program for self-care is still too vague to recommend looker further into.

A family of user's association was identified during one of the visits. Website visit and phone consultation revealed that the service was set up by and for parents of children with intellectual disability. This organization proves of no additional user for HAP on this dossier. No current users of family of users organization was identified what makes the possibility of user and family feedback in the guideline development process difficult. To recommend the founding of such organization will go beyond the scope of this consultancy.

Other

During several visits the concept of Mental and Psychosocial Health of the health workforce was mentioned as being important. This is supported by found literature which states " psychological needs of workforce working with Mental Health proofs relevant" (13). The consultant has good experiences with "visual management", a concept derived from LEAN management principles (14). There's 2 approaches discussed during the consultancy. One is sharing successes, in which a peer group or team takes a short moment to share (professional) successes with each other in a regular schedule. The second example can be found in Annex 5, a description of a LEAN way to start a professional day or meeting using the "traffic light" methodology.

One of the mhGAP authors could be interesting to contact concerning Mental Health in PHC: Ivbijaro Gabriel, Portugal: HIC Medical director and chair of the World Organization of

Family Doctors working party on mental health. https://www.linkedin.com/in/gabriel-ivbijaro-mbe-aa2a0bb5/

During and in between the visits topics like the Professional Master program in Family Nursing and home based nursing were discussed, given the possibilities that are present in this part of the HAP project. The indications for home based nursing in the HAP program were described as elderly persons and chronically ill patients bed-bound incapable to attend HC due to their health conditions

A home office document mentioned Home office document refers to ARCT (Albanian Rehabilitation Centre for Trauma and Torture). We did not get any further into this organization because the meeting with Dr. Como was cancelled and we didn't have time with the local consultant.

Recommendations:

There's been different possibilities identified during the consultancy visits. Some of them are small, very practical and easy to implement. Some are more abstract and will need further institutional effort. The recommendations relate to expected outcome 1 and 2.

In term of which MH problems to focus on the recommendation is the following:

Identify and treat	**Light to moderate depression/anxiety/somatoform disorder/substance use disorder. Chronically stable patients after CMHC involvement. Delirium if the case is not to severe meaning requiring hospitalization. Sleeping problems**
Identify and refer	Psychosis, suicide and self-harm, childhood development disorders, trauma related disorders, disorders described above but severe.
Include in other CGPs	Epilepsy, dementia.

Related to expected outcome 1 of HAP

- **Include Mental Health issues in NCD agenda and CGPs development**.
- Refer to MH as part of the NCD program. So "NCDs like for example mental health" instead of "NCDs and mental health"
- **Include Mental Health aspects in redesigning professional profiles and job descriptions of FN personal, specifically the nurses**.
- Locally validate the Albanian translation of the PHQ-9 (or PHQ-2) with the golden standard CIDI or psychiatric assessment, as part of the research agenda, after MoH approval.
- Monitor psychosocial and mental wellbeing of the PHC workforce, specifically in rural areas, as part of the policy and/or research agenda.
- Support research operational capacities of teachers and students of the Masters' program(s).
- **Include the redesigned professional profiles for FDs and FNs in the MH capacity building program.**

Related to expected outcome 2 of HAP

- **Include MHPSS in the newly developed service models for home based visits** like for example: **evaluate the possibility of existing domestic violence, signs at home for extreme alcohol use, helping in medication compliance, giving depot medication at home for patient that avoid care.**

- **Integrate mental health by facilitating MH specialist consultation on a regular basis in the PHC setting** (same person, same day, fixed frequency approach).
- Integrate mental health by selecting and training of number (1 per 15 FD/FN) professionals to perform tasks that must be described in a job profile (see findings and Annex 4) and facility them for a fixed amount of hours/week (for example 8).
- Given the fact that the respective (yearly) screening tool on tobacco use is in place and works: develop a simple group interactive activity for services users and their families for those who score positive on tobacco use on the yearly checkup. Check with peer groups and local MH consultant if the intervention is culturally appropriate.
- Develop a simple digital or SMS activity for services users and their families for those who score positive on tobacco use on the yearly checkup.
- Given the fact that the respective (yearly) screening tool on alcohol use is in place and works: develop a simple group interactive activity for services users and their families for those who score positive on alcohol use on the yearly checkup. Check with peer groups and local MH consultant if the intervention is culturally appropriate.
- **Given the fact that the respective (yearly) screening tool on depression is in place** and works: **develop a simple preventive and interactive group activity for services users and their families for those who score 4-9 on the PHQ-9 in the yearly checkup.**
- Develop a simple digital or SMS activity for services users for those who score 4-9 in the yearly check up on the PHQ-9 or link them to the "Ifightdepression platform" (see literature)
- Linkage to the Ifight depression platform for patients includes self-help recommendations on the items as mentioned in the finding and available in Albanian online (social contacts, exercise, daily routines, diet).
- Local HAP team checks if the iFight depression online toolkit is available in Albania because beside the self-help recommendations it includes simple homework tasks to monitor complaints, structure your day and other relevant topics.
- Offer the above-mentioned interventions by 2-person multi-disciplinary team in which one is a nurse and the other one is a service user, family member of nurse in training.
- **Make sure the CGP's on MH in PHC are in line with the MoH basic package of services and the HIF**
- Feedback at HC level about the outcome of the yearly checkup concerning MH, alcohol and tobacco.
- **Use the existing peer group structure to implement self-care through visual management strategy using the "traffic light" method.** See Annex 5.
- **Use the existing peer groups or teams that work together daily to structurally "share successes" in terms of patient care, research or policy**.
- Maybe in the future there could be a peer supporter role in delivering services as part of a multi-disciplinary package provided by people with lived experience
- If a patient is referred to PHC as a chronic stable case, realize a "real-time handover" between the CMHC, the FD/FN team and the patient/relatives. If travel constrictions apply this can be done by telephone or video call.

- **Include 2 working days for the international consultant to support the local consultant in developing the local CGP on MH in PHC.**
- **Make sure that delirium (diagnosis and conduct if somatic cause is not to severe) and dementia (monitoring, psycho-social support, not diagnosis) have a place in the CGPs that HAP supports**. Either in the MH version or in the geriatric or somatic version.
- **Give sleeping problems a position in the CGPs for MH in PHC** since it's a common problem and it does not always reflect psychiatric disorder and can be dealt with in PHC.
- **Give psychosocial support in case of severe somatic condition a position in the CGPs for MH in PHC since it's a common problem and it was mentioned as being important in the focus group discussion.**

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Annexes

1) MoH and Social Protection: summary on mental health services in Albania

- Community-based mental health services, such as:

  - Community Mental Health Centers (CMHC) are specialized outpatient mental health services that provide multidisciplinary and/or multidimensional community services. The CMHC carries out identification, diagnostic, treatment and rehabilitation activities for any person suffering from mental disorders, as well as plays an important role on prevention of disorders and promotions of positive mental health, in a certain coverage area. This service coordinates its activity with primary and secondary health care services, but also with regional social services.

    Since 2000, when the first pilot CMHC Tirana was introduced to the mental health system, at the national level are established10 (ten) CMHC, respectively 3 (three) centers in Tirana, 1 (one) in Elbasan, 1 (one) in Vlora, 1 (one) in Korca, 1 (one) in Shkodra, 1 (one) in Berat, 1 (one) in Kavaja and 1 (one)in Gramsh.

    4 (four) of these CMHCs have a dedicated team for children and adolescents (2 of CMHC of Tirana, CMHC of Elbasan and CMHC CCMs in Shkodra).

    The service in CMHC is provided by a multidisciplinary team, consisting of a psychiatrist (and a psychiatrist for children and adolescents in the CMHC where there are teams dedicated to this age group), psychologist, social worker, nurse, occupational therapist, etc.

    In districts where these services have not yet been established, their role is played by neuro-psychiatric cabinets at the district's hospital services, consisting of a neuro-psychiatrist specialist and a nurse, who are considered the nucleus for the establishment of future CMHC in these areas

  - Supported Homes are functional units of community mental health services, which aim to provide residential services to individuals in an environment as similar as possible to the family one, where the main goal is to care and rehabilitate individuals with mental disorders.

    The rehabilitation process is carried out through an individual plan, based on therapeutic-rehabilitation continuity, as well as through residential care, supported by multidisciplinary staff, composed by psychologist, social worker, nurse and occupational therapist.

Supported homes are part of the community mental health services network, in close relation to other health and social services, in the respective area. These structures cooperate with the community to which they belong and aim to provide residential, care and rehabilitation services to:

a) chronic patients who no longer need inpatient treatment, but have lost or been impaired in the ability to live in the community due to institutionalization; and
b) patients with a sever mental health disorder who lack family care or social support and have a sever disability that does not enable them to live independently.

Based on the above, referrals for admission to supported homes are made by both Inpatient Mental Health, as well as by Community Mental Health Centers, based on the specific problems of the individual, his family and social network.

This service typology was first introduced in 2007 in Elbasan, with the opening of the first supported home. Over the years this number has gone to 14 (fourteen). The category of patients accommodated in these typology of services are mainly former chronic patients from the psychiatric hospitals, who were hospitalized in these hospitals for more than 10 years without the need for hospital treatments but due to the luck of community services and have lost or been impaired in their ability to live in the community due to institutionalization.

14 (fourteen) Supported Homes accommodate around 140 people with chronic mental health disorders, mainly in areas where there are other specialized mental health services are located, respectively;

- ✓ 2 (two) supported homes in Elbasan, with 14 sites the first one (9 men and 5 women) and the other with 10 sites (all women), former resident of Psychiatric Hospital of Elbasan;

- ✓ 4 (four) supported homes in Shkodra, two of them accommodate only women, with 10 sites and 14 sites respectively, and two others accommodate only men, with 14 sites and 13 sites respectively. There are transferred most of the chronic residents of the former Psychiatric Hospital of Shkodra, turning this hospital into a service that provides acute and subacute care;

- ✓ 3 (three) supported homes in Vlora, with a capacity of 10 people each, respectively 10 sites for men the first home, 7 men and 3 women the second and 10 women the third one.

- ✓ 2 (two) supported homes in Tirana, with a capacity of 8 people (men) each (12 in total), where have been transferred most of the chronic residents of Psychiatric Service of Tirana, near Mother Tereza University Hospital Center;

- ✓ 2 (two) supported homes in Korca, with a capacity of 6 beds each (6 men and 6 women) also former resident of Psychiatric Hospital of Elbasan;

- ✓ 1 (one) supported homes in Kavaja, with a capacity of 8 persons (women), also former resident of Psychiatric Hospital of Elbasan

- Inpatient Mental Health Services are represented at the national level by 2 (two) psychiatric hospitals (in Elbasan and Vlora) and two psychiatric services (in Tirana and Shkodra).

  - ✓ Psychiatric Hospital of Elbasan, is the biggest psychiatric hospital of the country, with a capacity of 310 beds, where most of the capacity (more than 1/3 of it) is occupied by chronic residents (patients who have been hospitalized in this service for many years and suffer from chronic mental health disorders or mental retardation);

  - ✓ Psychiatric Hospital of Vlora has a capacity of 160 beds, and most of this services capacity (more than 1/3 of it) as well is occupied by chronic residents.

  - ✓ Psychiatry Service at the University Hospital Center "Mother Teresa", Tirana, has a capacity of 90 beds for adults and 8 beds for children and adolescents. This capacity is mainly occupied by acute and sub acute patients, as the largest number of chronic residents has been transferred to the two supported homes of this region;

  - ✓ Inpatient Specialized Mental Health Service in Shkodra, with a capacity of 35 beds, functions entirely as an acute and sub acute service. All chronic residents of this service have been transferred to the four supported homes of this region or have returned to the community.

3) Overview of MH CGPs in PHC

mhGAP intervention guide:

1) ECP Essential Care & Practice
2) MC Master Chart
3) DEP Depression
4) PSY Psychoses
5) EPI Epilepsy
6) CMH Child & Adolescent Mental & Behavioral Disorders
7) DEM Dementia
8) SUB Disorders due to Substance Use
9) SUI Self-harm / Suicide
10) OTH Other Significant Mental Health Complaints

mhGAP Humanitarian Intervention Guide (HIG)

1) Acute Stress (ACU)
2) Grief (GRI)
3) Moderate-severe Depressive Disorder (DEP)
4) Post-traumatic Stress Disorder (PTSD)
5) Psychosis (PSY)
6) Epilepsy/Seizures (EPI)
7) Intellectual Disability (ID)
8) Harmful Use of Alcohol and Drugs (SUB)
9) Suicide (SUI)
10) Other Significant Mental Health Complaints (OTH)

Dutch Family Doctor Association

1) ADHD in children (included in child/adolescent mhGAP
2) anxiety
3) delirium
4) dementia
5) depression
6) enuresis nocturna
7) work related burn out
8) problematic alcohol use and
9) sleeping problems

4) Regional GP specialist in mental health profile

Disclaimer: Information distracted and translated from the website of de Dutch FD association as well as from the University of Groningen website that offers this specialization. There was no information or publications in English found.

The specialization in GP Specialist in Mental Health in the Netherlands is offered by the the University of Groningen. It focusses on enrichment of knowledge about diagnosis and treatment of MH problems in PHC and takes 2 years (16hrs/week). https://huisartsgeneeskunde-umcg.nl/nhg-kaderopleiding-geestelijke-gezondheidszorg-ggz)

The specialization consists of a theoretical part, practical part, self-study and a peer to peer coaching. There is full accreditation available, like the NCCE accreditation.

The theoretical part includes: knowledge, theoretical models and tools, skill training in motivational interviewing, cognitive therapy, solution focused conversation, consultation, supervision, literature search and interpretation.

The practical part can consist of internships in specialized MH services or small MH related projects.

- Continues education of colleagues
- Consultation
- Being a contact person for MH services in the catchment area
- Guideline and policy development
- Participation in research
- Above average competence in dealing with MH problems in daily practice
- Keeping up to date with literature

5) Using visual management in self care

The method is used by a group of peers of colleagues that work together on a regular or daily basis, it is used at the beginning of a day or a meeting. The moderator or chair of the meeting takes the initiative to start the traffic light method and makes sure that everybody speaks and that it does not take too long. As an introduction is said:

- What the different colors mean
- The problems bothering can be professional or personal
- The colleague is NOT obliged to go into details about the problem
- That the exercise will not take more than 5 minutes

The introduction will be known by colleagues when the method is used in daily practice, but still it's recommended to mention it. If colleagues start asking questions about the mentioned problems bothering: that's OK but make sure the colleague is at ease to answer and manage time. The idea is that teams the apply this method learn that: it's OK to have problems and still come to work, it's OK to share your problems. The peer group of colleagues will often start to help the "red" colleague by, for example, supporting the colleague with a specific task that day or asking again how somebody is doing later that afternoon. That is a good result.

The meaning of the colors.

Red: I am not OK. There's a professional or personal problem bothering me severely. I am here but I don't really feel like working, I would like the working day to be finished as soon as possible.

Orange: I am reasonably well. There's a professional or personal problem bothering me. I feel like working but I will not be able to function as I would normally do.

Green: I am fine. I feel energetic and relaxed at the same time. I am looking forward to my day and confident that we will be able to confront the challenges that come up.

The start of the meeting or day with the traffic light method can be finalized with the invitation of a colleague to share a “success”. Something that went very well and can make the colleague and the team feel proud. The method can result in cultural change concerning empowerment and self-care if applied as a routine and short activity in which team leaders/directors give an example.