External review of the SDC funded project

Development of the Community Mental Health Services System in Moldova

Planned duration: March 2009 - August 2011

Evaluation period: March 2009 – May 2011

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Executive Summary

The project team has managed to further develop the field of community mental health in Moldova, though in some respects better, in others not so well. Concerning the human resources (Output 4), which is an especially important topic for all types of psychiatric services, the project team has been rather successful in creating a community mental health curriculum for medical students and psychiatric residents and carrying out trainings for staff of community mental health centres. Also, with respect to raising awareness (Output 5), the activities of the project can be generally evaluated positively. In contrast, the objectives of developing a "National Mental Health Strategy 2011-2015" (Output 1) and a "Model of organizing, functioning and financing medico-social services" (Output 2) have been not so well achieved, although much effort has been put into them. Many questions remain open for these two outputs. Finally, the objective of creating a "community" mental health centre in Chisinau (Output 3) has been changed completely into its reverse by setting this centre up in the large mental hospital ten kilometres outside the city centre (Costiujeni), a place which is not only difficult to reach geographically, but also psychologically, since such large mental hospitals are related to stigma everywhere in the world. Annexes 6a and 6b include a problem and solution tree, which show the main problems in a nutshell.

On a six point scale (0 = nothing achieved .... 5 = maximum achieved) we rank the overall project output as 3 with the following individual scores for the main outputs (CMH = Community Mental Health):

Output 1: Mental health strategy 3
Output 2: Organizational issues of CMH services 3
Output 3: New CMH Centre in Chisinau 1
Output 4. CMH Curriculum 4
Output 5: Awareness campaign 4

We interpret the shortcomings in the project outcomes not so much as a consequence of organizational weaknesses, but rather as related to the discontinuity caused by frequent changes of relevant partners on the political and administrative level and the related changes in power constellation, which prevented the project from working smoothly and consistently. Also, from our point of view, the project plan intended to accomplish too many different tasks in a relatively short time period. The documents received and consulted (including the original project plan) are characterized in some instances by a certain degree of unevenness and inconsistency, which sometimes made a proper evaluation of the project difficult.

Since the project team has some additional time to finalize its outputs, we suggest how some outputs might be improved (e.g. amend Output 1 "Mental health strategy" and related topics in Output 2: elaborate clear definition of the CMH Centre; Output 3: prepare the transfer of the misplaced CMH Centre from Costiujeni to the city centre of Chisinau). Such recommendations are also contained in Annexe 3 (concerning the detailed description and analysis of the de facto health and mental health care system in Moldova).

Finally, we suggest several topics for potential funding in a possible next funding period, which might contribute to the sustainability of the progress achieved and carry forward the reform of the Moldovan mental health care system in the direction of placing the emphasis on community mental health services. The potential new project(s) should be built around already existing resources (e.g. on the experiences of the existing community mental health centres), which is most important for achieving sustainability.

Preface

This review of the SDC project "Development of Community Mental Health Services System in Moldova" (2009-2011) is based on the study of documents and on a nine-day visit to Moldova in May 2011.

Documents were received before the visit, during and after the visit. Unfortunately not all information could be obtained before finishing the report).

The visits were made to psychiatric hospitals, to general hospitals, to primary care centres and to community mental health centres, where the facilities were inspected and interviews were carried out with directors and staff members.

In addition, talks took place with representatives of the SDC, the Ministry of Health, the National Health Insurance Company (CNAM), the National Health Management Centre (CNMS) and the University of Chisinau. Whenever possible we also accessed information on the internet. Dr. Jana Chihai, the project leader, helped with the organization of the visits of services and representatives of the above mentioned organizations, and provided helpful advice for obtaining information and documents we asked for. The list of persons contacted is contained in Annexe 1, and the list of documents consulted in Annexe 2.

The structure of the review includes a Section A, relating to general aspects, and a Section B following the structure of questions set out in the "Terms of Reference". First the general questions are discussed, then the specific questions related to the five intended project outputs. Whenever in Section B (and in the annexes relating to it) deficits or problems were encountered, we made recommendations directly in the text, but have included in a separate Section C a summary of all recommendations made earlier. They include recommendations which could be picked up by the project team during the remaining project time, as well as options of what the potential next stages of the project could be. Annexes are provided as separate documents.

We thank the many persons who were willing to meet with us, provide detailed information and share their experiences with us. We also thank SDC for the comments on the first draft of this document (30 June 2011). By answering these comments we have prepared this revised and final version of the report.

Heinz Katschnig Raluca Sfetcu

Vienna and Bucharest, 15 October 2011

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A. General remarks

The project to be reviewed started in March 2009 and has a planned duration of 30 months, i.e. until August 2011 (with a potential extension period). Until May 2011, when the review of the project took place, many tasks had been fulfilled, however some had not been fulfilled yet. Also, some of the intended outputs had not been achieved in an adequate way, as will be detailed below (e.g. setting up a community mental health centre in Chisinau, Output 3).

That some tasks have not been fulfilled must be seen in relation to two facts: First, in the eyes of the reviewers, the project had too many objectives from the beginning which also in other countries would have been difficult to fulfil in such a short time period. Second, several adverse external circumstances existed and still exist, which could not be foreseen when the project was planned. These adverse circumstances are briefly discussed below. We have also identified some weaknesses in the project management (see B.2.6), some of which can be regarded as being related to the adverse external circumstances.

Some tasks can be judged also from an international perspective as difficult to perform, e.g. increasing the knowledge of mental health issues in the general population and among other health professionals; or establishing combined financing mechanisms between the health care and the social care system. These are difficult tasks in most countries of the world and they have not been well achieved in many countries.

In addition, during the project time there was a change of the main contact persons in the Ministry of Health and in the National Health Insurance Company, partly because of the general elections in 2009 which led to a change of government and responsible politicians, which has created difficulties for maintaining continuity in the project activities.

Another difficulty is that the actual psychiatric workforce in Moldova is rather aged and that relatively little interest exists among medical students to choose psychiatry as a specialty. In addition, because of a lack of perspectives and very low salaries there is a substantial brain drain of young doctors to other countries.

Finally, in Moldova unfavourable conditions exist for the introduction of a bio-psycho-social model, mainly because of the dominance of a biological model of mental disorders within the psychiatric profession, correlating with a strong reliance on psychotropic medication, probably also based on the fact that psychiatrists are mainly confronted with severe mental disorders in the hospitals (less than 10% of patients there suffer from affective or anxiety disorders, but more than 90% from organic disorders, schizophrenia and mental retardation). In the psychiatric hospital, where psychiatrists are trained most of their training time, nearly no psycho-social interventions and appropriate day structure are offered, and virtually no occupational therapy is available. Psychiatrists in training, while working for some time in outpatient departments, seem to receive no systematic experience in community mental health care.

B. Answers to the questions of the Terms of References

B. 1 General issues

B. 1.1 Is it possible to assess whether the project did contribute to a change of mentality within the medical world and within the population? If yes, what can be observed in terms of changes?

The project has had some effect concerning the visibility of the concept of community mental health care and has raised awareness to this issue in several fields:

- At the administrative and political level, in the Ministry of Health, at the National Health Insurance Company, where we have met quite a few people who favour the concept of community mental health and some of whom were involved in some stages in the project.
- At the level of the general health care system (primary health care centres, general hospitals, specialized outpatient treatment in the ambulatory sections of general hospitals) in geographical areas where community mental health centres existed before the onset of the project (Balti, Ungheni).
- At the level of the psychiatric profession the impact is ambiguous, with the majority of psychiatrists working in the three psychiatric hospitals and in the consultative sections of general hospitals (with a large proportion reportedly reaching retirement age soon), and a handful of younger psychiatrists working in community mental health centres and obviously open to a new approach (see also the comment above in A. on the prevailing biological model of mental disorders). Concerning the training of psychiatrists a specific community mental health curriculum will reportedly be officially included in their training.
- The information campaign is still ongoing, brochures and other PR materials have been produced and media involved (however, the impact of such time limited campaigns at the population level cannot be expected to be very big though)

B. 1.2. What are the effects of the project with regard to the situation of mental health patients in Moldova (at outcome/impact level)?

Very little impact on the overall situation of patients in treatment can be observed, mainly because the duration of the project was too short to expect such an impact to happen.

- The project had focused on creating only one specific so-called community mental health centre which was opened in March 2011 and at a location (the very large psychiatric hospital Costiujeni 10 km outside the city centre of Chisinau) where it will not be functional.
- The project objective of establishing a combined “medico-social” financing mechanism has not been achieved. Such a combined financing mechanism would be the backbone of establishing community mental health services in a systematic way across the country, which would then help to change the situation of mental health patients in Moldova (for details see Annexe 8).
- The total de facto system of mental health care in Moldova is not sufficiently visible in the project outputs. According to the statistics provided for 2010 more than 20.000 episodes of in-patient care were registered in the three mental hospitals, and nearly 100.000 patients were in specialized psychiatric outpatient treatment at the consultative section of general hospitals. In contrast, the patients in care in the existing community mental health centres constitute only a very tiny fraction of these numbers and no concepts about referral of patients and cooperation with the other sectors of the mental health care system are provided.

- The same applies to the general health care system: It is scientifically well documented that persons with mental disorders show up quite often in general hospitals, non-psychiatric specialized outpatient care and at the level of general practitioners/family doctor (the reasons are manifold: physical and psychiatric co-morbidity, misinterpretation of symptoms, easier geographical accessibility, avoiding stigma and discrimination). While the family doctor's importance is stressed in the "Mental health strategy 2011-2015" and while 20 family doctors have been trained, the relationship and potential referral system between the mental health care system, especially the so-called CMHC, and the family doctor sector is not discussed in any systematic nor practical way.

B. 2 Expected outputs

B. 2.1 Output 1
National Mental Health Strategy

TOR Questions: What is the quality and development stage of the current draft of the National Strategy on Mental Health? How much work still needs to be done on it? What are the main challenges the system still faces, that the project should address?

I. Main observations

The borderline between the concepts of "strategy", "plan" and "program" are not very clear, also on an international level. In general a strategy is more abstract, and plans and programs are more concrete. However, also a "strategy" nevertheless must start from the concrete de facto situation.

(1) *Modern principles, but lack of concrete suggestions how to realize them*
The current version of the National Strategy on Mental Health is too general and too "visionary". It adopts internationally acknowledged principles for user friendly community oriented mental health services, including prevention and establishing links with the primary care sector, and many others to which everyone can agree, however they rarely go beyond theoretical texts or even headings (see the section on indicators, pp.31 ff). The current draft of the strategy does not sufficiently address the starting point, i.e. the de facto situation of the Moldovan health and mental health care system, from which every reform of mental health services has to start out and has to proceed strategically. As it is now, the document rather defines idealized endpoints than a strategy.
> ..... Include the actual situation of the structure and the functioning of the mental health care system and contrast it in a concrete way with the objectives to be achieved and define concrete measures to be taken in order to proceed from the actual to the desired structure.

(2) *The existing de facto health and mental health care system is not adequately analysed*
In relation to (1) above: The problems of the specialized psychiatric care system, i.e., (a) the existing psychiatric hospital system (more than 22.000 admissions in 2010, extremely high re-admission rate in three oversized psychiatric hospitals – "revolving door psychiatry", with many aspects needing clarification, e.g. large admission numbers for disability pensions, very low compulsory admission rates, questionable financing mechanisms, no day structure, etc., see Annexe 3) and of (b) the existing psychiatric ambulatory system of the consultative section of the raion hospitals (about 100.000 patients in 2010; shortage of psychiatrists, age structure rather old) are neither described nor discussed but only referred to in a very general way and not analysed in any detail. The same applies to (c) the existing non-psychiatric health and social care system, in which a large proportion of persons with mental disorders show up – especially

in the primary health care sector, the general non-psychiatric hospital and ambulatory care system (physical and mental co-morbidity > need of C/L services!) and (d) the social care institutions for persons with disabilities. The ideas exist (see progress indicators 5.3: Existence of the strategy for integration of mental health services in primary care; Number of psychiatric departments in general hospitals), but no concrete way of how to arrive there is discussed.
> ..... Carry out an analysis of the functionalities and dysfunctionalities of the total existing system of care for persons with mental disorders (e.g. describe the profile of existing types of services, patient flows between them), define the place of CMHCs in the total mental health care system and also potential pathways of patients as well as criteria for choosing these pathways (see (3) and (4) below and Annexe 3, which contains detailed suggestions on which aspects of the de facto mental health care system should be analysed in depth). Established international service mapping tools might be used for this purpose (e.g. the European Service Mapping Schedule – ESMS-2).

(3) *The concept of the Community Mental Health Centre is not clearly and realistically defined*
The existing so-called CMHCs are all differently organized and financed and are just carrying the same label "CMHC". It seems that different key actors have different visions and concepts of what a CMHC should be.
> ..... Find a clear common definition of the concept of the CMHC (see also (4) below) which is realistic in the sense that not only a vision is provided but also a stepwise implementation plan of such centres across the country, with – depending on the availability of staff and other resources - some components being implemented sooner, others later.

(4) *Isolated Community Mental Health Centres*
The impression one gets from the current version of the strategy is that of an isolated life of CMHCs which care for a small number of patients, while the majority of patients with mental disorders continue to be processed in the traditional mental hospital centred system together with the outpatient sections in general hospitals (strangely enough the strategy talks about patients being "rotated" between outpatient and inpatient care, p.8, last paragraph). One could get the impression that a parallel ideal world of community mental health services is to be built up, while the old system continues to exist. However, CMHCs should not be seen as isolated components, as a kind of "counter world" to the traditional psychiatric care system, but only in relation to the other types of services which exist, and which will continue to exist, although they should do so in a different way.
> ..... A clear definition of the role and place of the CMHC in the total system of a balanced care model between community and hospital care should be provided. A differentiation of the patients/clients according to diagnosis, severity, stage of illness and in relation to need of services would be appropriate. A stepped care model should be considered to describe the patient flows and referral systems between the service components (see also (1) above and reviews of Outputs 2 and 3 below).

(5) *Integration of mental health care into the general health and social care system remains unclear*
Concerning connections with the general medical system, the ideas are there (e.g. Specific Objective 5.3. of the strategy says: Connections with general medical system: Development of liaison psychiatry, Psychiatric departments in general hospitals, Elaboration of strategic directions for integration of mental health services in primary care, Application of measures to reduce tendencies to reject mentally ill patients manifested in somatic medicine community), but no systematic cooperation relationships and referral systems are described between psychiatric services and general and non-psychiatric services (especially the primary care sector) in order to show how such integration and connections can practically happen.

> ..... Potential referral pathways and alternative models of "cooperative care" should be established concerning primary care, and also non-psychiatric departments in general hospitals and social care homes, especially for patients suffering from both a mental and a physical disorder (e.g. psychiatric consultation/liaison C/L services: psychiatrists and other staff visiting general hospitals and social care homes to deal with such co-morbid patients). The existing consultative services in the raion hospitals could serve as a starting point for such services.

(6) *The establishment a mental health information system is not discussed systematically*
A large number of progress indicators are mentioned, but it is not clear how they should be measured
> ..... Include a chapter on establishing an integrated and meaningful health and mental health service utilization information system (chances are not too bad for this in Moldova, since it is a tradition since Soviet times to report such service use, though in a fragmented way) and stay realistic in terms of which indicators can be measured

(7) *Work force issues are not discussed systematically*
While workforce issues are mentioned, no systematic approach is employed for this topic.
> ..... A chapter should be included on work force development (especially in view of the aging workforce of psychiatrists) which may include an evaluation of the impact of workforce prognoses on the implementation of the strategy.

(8) *Financing mechanisms need to be discussed in detail*
A lengthy part of the document deals with financing mechanisms, but without a careful analysis of the de facto and desired total mental health care system such financial analyses make no sense (see (2) above)
> ..... Develop a chapter on financing mechanisms on the basis of describing and analysing the total de facto mental health care system, compare the present and the desired financing mechanisms and the built in incentives and disincentives for community mental health care.

(9) *Pre-existing planning and legal documents are not - or not adequately - taken into consideration*
The actual draft of the mental health strategy 2011 to 2015 does not make reference to many existing previous documents and ongoing developments in the health care planning sector. We would like to especially mention in this respect a sensible reform document elaborated a few years ago by Professor Nacu (see Annexe 7), where a decentralization of the mental health care system (including in-patient care) is suggested with concrete proposals on how mental health services should be distributed across the country. While the strategy briefly says on p.43 in the section "progress indicators 5.3.1": "Development of liaison psychiatry: psychiatric departments in general hospitals", nowhere else in the text mention is made of decentralizing psychiatric hospital care from the large psychiatric hospitals to such departments in general hospitals). Also, on the home page of the Centrul Naţional de Management în Sănătate (http://www.cnms.md/areas/ int/SanatateMintala) a number of useful documents on mental health services are provided (resulting seemingly from previous projects) which have not been taken into consideration or commented on. In addition, the governmental Hotarire for hospitals 2010-2012, as well as the ongoing development of reorganizing general hospital care ("master plan") have not been taken into consideration. Furthermore, no mention is made of a recently published article, in which the Moldovan psychiatric hospital sector is profoundly and critically assessed (Moldovan et al. International Journal of Mental Health, 36, 2007-2008, pp.46-56).
>..... Analyse existing documents about mental health care reform, quote them and argue why some concepts and ideas were picked up in the strategy and others not – always in relation to

international standards which are clearly defined nowadays.

(10) *The relationship between the "National Strategy for Mental Health" of the project and the "National Mental Health Plan 2012-2016" (in development at the Ministry of Health) is unclear*
It became known to the review team during the visit to Moldova that the Ministry of Health is already developing a "National Mental Health Plan 2012 to 2016", which we could see in its present version. Is largely based on the draft National Mental Health Strategy 2011-2015, without making reference to it and having obviously been developed in parallel and reportedly without informing the project leader of the SDC project. It seems though that several persons were both members of the National Mental Health Strategy team of the project and the team for the National Mental Health Plan of the Ministry of Health. It has the same deficiencies as criticized above for the National Mental Health Strategy.
> ..... It would be very unfortunate for the Moldovan mental health care system if such a rudimentary plan would be legalized – it would paralyze developments towards a mental health care system following modern standards. Such a Mental Health Plan should only be developed once a consistent National Mental Health Strategy is available (which, in turn, should take the suggestions made above into consideration).

II. Additional observations

(11) *Incorrect numbers*
Many numbers provided in the strategy (especially on pages 5-15) are either not correct or not correctly explained
> ..... Correct and explain numbers quoted in the strategy (see Annexe 3 for examples)

(12) *Involvement of primary care stakeholder representatives*
Although the strategy puts so much emphasis on integrating mental health care and primary care, reportedly in no single working group session a representative of primary care was present (only once written comments were received) and no concept is provided for how such an integration can practically happen
> ..... Make sure that knowledgeable primary care representatives are included in the preparation of the final version of the strategy

(13) *Terminology and text in this lengthy document are not always coherent*
The latter part of the document (p 35ff) deals with progress indicators, for which in the preceding text often no terminological equivalent can be found
> ..... Develop a glossary of terms used > .....align text and progress indicators

(14) *Timelines*
Timelines are not realistic anymore (Period I: 2010-2013)
> ..... Based on an analysis of the de facto mental health care system the objectives of the strategy should be realistically divided into short term (immediate), medium term (a few years) and long-term objectives.

III. Conclusion

Given that the project is very likely to be extended by several months we recommend ..... that the issues mentioned above are taken care of when finalizing the strategy, with special emphasis on a thorough analysis of the functionality/dysfunctionality of the present de facto mental health care system as a starting point for further steps. It is also recommended to carefully check the numbers provided in the present draft of the strategy (see also Annexe 3)

B. 2.2 Output2
Model of organizing, functioning and financing medico-social services

TOR questions: Where does the project stand with the development of a working model of organizing, functioning and financing medico-social services? What are the main opportunities and threats on it?

A lot of work has been invested into this output by the project team and several documents have been produced. The project leader has evaluated this output as "partly realized", pointing at the intention to complete the outstanding tasks during the remaining project time. However, for an external reviewer the situation of this output is somewhat confusing, as will be discussed below. The main expected result was the development of a clear organizational framework for the establishment and functioning of Community Mental Health Centres (CMHC, CCSM), including accreditation criteria, quality standards and financing mechanisms. At the time of the external review, several outputs were presented by the project team:

a. A feasibility study on the development of community mental health services
b. A volume comprising all laws and orders relating to mental health care up to 2010
c. A draft legal proposal for the establishment and functioning of the CMHC as well as draft versions of the accreditation norms and quality standards.
d. Printed materials concerning the organization and functioning of the mental health services (which we assume corresponds to project achievement 13 of Output: Elaboration and printing of the guidelines "*Recommendations for organizing of the CMHS in Moldova"*).

The expected results dealing with defining financial mechanisms for the payment of CCSMs were not yet available at the time of the review.

(1) *Terminology*
A problem encountered is that the terminology used changes within one and the same document and across different documents, e.g. for CMHCs different terms are used: medico-social institution, socio-medical institution, community mental health centre, community mental health services.
> ..... Use a consistent terminology and also a glossary of terms

(2) *The existing legal situation*
The existing legal arrangements are documented in the volume (produced by the project) "Indrumar legislativ si normativ in acordarea servicilor de sanatae mintale, Chisnau 2011". Many included documents contradict each other, or are even contradictory in themselves (see examples in Annexe 4). This is probably not the fault of the project team, since it just compiled the existing legal regulations. It is, however, unclear how much the project team was involved in producing some of the regulations, since some of them came into force during the project time. In any case, legal documents would have needed a careful analysis, showing strengths and weaknesses of this legislation, since the legal documents to be developed by the project have to be related to the existing legislation.
> ..... Carry out a thorough analysis of the legal situation before suggesting new laws and governmental and ministerial orders

(3) *Community mental health centre (CMHC) – see also comments to(3) and (4) to Output 1 above*
In the available documents it does not become clear what, in view of the project team, the definite concept of a CMHC is. A brief content analysis of the documents available at the moment of the visit in Moldova, indicates that, the project team proposes that the organization of future CMHCs in Moldova should take as a model the existing CMHC SOMATO in Balti. While the services offered by SOMATO are of appropriate quality and adequate for the present

beneficiaries of the centre, the CMHC in Balti rather represents a socio-medical structure, which because of its location, categories of users, financing mechanism (funded by the local authority only for persons with a disability certificate), is not suited as CMHC model at the national level.
> ..... Clarify the issues above

(4) *Integration of the CMHC into the whole system – see also (4) in Output 1*
While on the one hand some of the documents already developed do make sense in themselves (e.g. suggestion for a "Regulamentul-cadru al centrului comunitar de sanatate mintala"; Serviciile Comunitare de Sanatate mintala, Ghid Practic, and others; see also caveats above), the project team does not sufficiently consider the perspective of how to integrate the CMHC into the whole system. This problem is related to that already raised for Output 1: While the formulation in Output 2 (that the model of medico-social services is developed "within the health care system") stresses the integration of these "medico-social" services into the existing general health care system, no systematic approach is used, how this integration should happen.
> ..... Base the documents on an analysis of the total de facto mental health care system and integrate all service components on the basis of a clear concept.

(5) *Role of the hospital in relation to the CMHC – see also (1) in Output 1 and Annexe 3*
The hospital sector is not discussed in any detail and the few included statements are ambiguous. For instance, in the "Feasibility Study" (Output 2, achievement 5) it is stated on p 27: "Setting up community mental health centres should not however determine closing up hospitals", while it is stressed in several documents (e.g. Nota informativa to Suggestion for a "Regulamentul-cadru al centrului comunitar de sanatate mintala") that already Chapter XII of the Polititica Nationala de Sanatate 2007 said that "mental health departments in general hospitals should be established". It should be made clear what the function of such mental health departments in general hospitals should be and if and to what extent they could replace the existing large mental hospitals (e.g. keeping the function of treating mentally ill offenders, what aout social cases, etc.;see Annexe 3).
> .... Clarify discrepancies

(6) *Feasibility study*
The feasibility study contains quite a few wrong or not understandable figures
> ….. Clarify figures and eliminate discrepancies in the feasibility study (see also Annexe 3)

(7) *Financing mechanism of the socio-medical service*
No financing mechanism was established
> ….. Outline at least the problems which have to be considered relating to a common mechanism of financing by the National Health Insurance Company and the social systeme (municipalities, Ministry of Labour)

(8) *Accreditation and quality standards for CMHC*
It has not become clear to us whether these tasks where realized or not (project achievements 8 and 9 of Output 1), whether they have been tested (project achievements 7 and 8 of Output 2), or even whether they existed already as a legal proposal from 2010 ("Regulamentul-cadru al centrului comunitar de sanatate mintala", with respective annexes)
> ..... This needs clarification

B.2.3 Output 3

Community Mental Health Centre in Chisinau

TOR questions: What is so far the result achieved with the establishment of the Community Mental Health care in Chisinau with regards to the three elements emphasized in the project document namely: a) as a nationwide model for 'urban' community mental health centres, b) as a centre to provide information and training to professionals , and c) as a centre which contributes to improving the management of people with mental health problems according to international standards

(1) *New community mental health centre in Chisinau*

A new community mental health centre has in fact been established, staff was selected and it was opened on 30 March 2011 (as a part of the National Centre for Mental Health, see (2) below). Therefore, this part of Output 3 has been fulfilled, at least formally (expected activity: "A multifunctional Community Mental Health Centre in Chisinau is created"). However, the so called multifunctional Community Mental Health Centre (which according to the project plan should include: a day care centre, a temporary placement unit, an ergo-therapeutic workroom, a crisis centre, a day in-patient department, a mobile team ,etc.) has been established in the grounds of the large mental health hospital in Costiujeni, outside the municipality of Chisinau. This does not make sense by any international standards as a "Community" Mental Health Centre providing services to patients "in the community", because:

a. it is 10 km away from the city centre,
b. it is located in the grounds of a large mental hospital which, all over the world, is a stigmatized and stigmatizing place, and
c. it may also turn out to be problematic that it is administered as a section of the hospital

In relation to these issues, we heard from a high level expert in the field of family medicine that "no family doctor will send a patient to such a centre". This statement is especially alarming and disturbing, since one of the main issues in the mental health strategy is that of integrating mental health care into primary health care. This centre cannot be taken as nationwide model.
> ……..A new community mental health centre should be established in the city centre, the actual adapted place in the psychiatric hospital Costiujeni could be used for occupational therapy for hospitalized patients.

(2) *National Centre for Mental health*

Apart from the discussed clinical component of the newly founded National Mental Health Centre the functions of this centre, relating to providing information and training to professionals as well as to contributing to the improvement of the treatment of people with mental health problems in the community according to international standards, cannot yet be evaluated because the review visit only took place six weeks after its opening. The location of these components in the psychiatric hospital of Costiujeni can be principally accepted. However, we regard it as problematic that these components are not administratively separated from the hospital but are (as a part of the NMHC) a section of the hospital.
> …… It is regarded as necessary that these components of the NCMH are administratively independent from the management of the hospital Costiujeni in order to assure that: a) there is a clear separation between the funding of the hospital and that of the NCMH, and b) interests of the hospital are not mixed up with the planning of the reform of mental health services in Moldova, which should move in the direction of shifting the focus toward community care.

(3) *Training of staff*

Concerning the training of staff working in existing CMHCs (relating to the expected result "training of 60% of professionals of 3 CMHC from Moldova by using a new curriculum in modern

mental health problems"), this was implemented according to the plan between 1 December 2010 - 18 February 2011 (30 training sessions), and for a larger group than foreseen (5 CMHCs instead of 3). It is not clear, though, whether the curriculum used is entirely new or is mainly based on previously produced materials.
> …… Before using the training materials for further trainings we recommend that they should be reviewed by external experts.

B.2.4. Output 4
Training of professionals

TOR questions: What are the results achieved so far in the field of education (acceptance and use of curricula by the Medical University, number of physician having access to this knowledge, acceptance of this knowledge among professionals).

(1) *Community mental health curriculum for university students and psychiatric residents*
We have received a document about the community mental health curriculum with six groups of topics with altogether 30 teaching hours (14 for theory and 16 for practice). The majority of these topics are meant to be taught to psychiatric residents and only a selection to medical students. This curriculum is offered on an optional basis for medical students since the academic year 2010/2011. For psychiatric residents the curriculum has been optional until now and will be integrated into the psychiatric curriculum for the academic year 2011/2012. Also, it will be offered for continuous medical education for psychiatrists (see Annexe 5).
>…….. it should be evaluated whether the content of the curriculum is too theoretical and not sufficiently adjusted to the practical needs of doctors working in the future CMHC.

(2) *Continuing medical education on community mental health topics for general practitioners*
No offer of continuing medical education for general practitioners exists.
>……. It would be desirable to also offer this (or a similar) curriculum in continuing medical education activities for general practitioners.

(3) *Handbooks and guides*
Eight handbooks and guides providing assistance in handling issues related to mental health and psychiatric disorders have been published
>…….Since the evaluation of the content was not the task of the review, we recommend that materials produced should be checked for proper quality by external experts. (We recommend Dr. Dan Ghenea, a psychiatrist in Bucharest, who has developed training materials for the Romanian European Commission Twinning project on de-institutionalization. His email address is: danghenea@yahoo.com).

(4) *Trainings and seminars for family doctors, nurses and professionals*
In the project document it says "two workshops per month on community psychiatry (principles, goals and objectives) will be conducted in Chisinau during the 11^{th} – 18^{th} months of the project implementation. The trainees will include family doctors, psychiatric nurses, and NGO representatives": only 6 such workshops have been carried out instead of the approximately 16 planned.
>…….We recommend that the remaining seminars should be carried out in the remaining project time

B 2.5 Output 5

Raising awareness among the population

TOR questions: Are there examples of quick KAP study tools from other countries that the project could use to assess the results of their campaign?

The activities planned under Output 5 dealt mainly with the preparation (concept, motto, etc.) and organization of an information campaign aimed at informing citizens and communities about mental health care problems and initiatives. A wide range of activities had been already implemented at the time of the review visit in Moldova, when the information campaign was still running, targeting both the general public and the local communities in Balti, Rezina, Chisinau and Ungheni, where four round tables were organized. Most of the planned activities have been implemented and have reached their goal. A media spot[1], brochures and other PR materials have been produced (including a guide on how to run anti-stigma campaigns[2]), and media has been largely involved (e.g. interviews and banner of the campaign on hotnews.md).The round tables have created a good opportunity for interaction among participants, at two of the four round tables (where the review team was present) a constructive dialogue on the topic of community mental health in Moldova took place. In Chisinau relevant stakeholders were present (e.g. WHO officer, primary care specialist of the Ministry of Health, etc.) and new connections have been established.
> ..... One of the foreseen activities was not implemented at the moment of the review: the evaluation of the impact of the information campaign. Since there was no baseline research planned or implemented, it is our view that such an activity is not relevant anymore at this stage of the project. So we cannot suggest a "quick KAP study tool". Anyhow, similar international experiences have also proven that the impact of such time limited campaigns at the population level cannot be expected to be very large. Changes in attitudes cannot be achieved in the short term. It is a long term process which needs many actions and stakeholders (e.g. also family and patient associations, which, as it seems to us, are completely absent in Moldova). The best way is a) to abolish large mental hospitals (they are the main source of stigma) and set up psychiatric departments in general hospitals, as well as CMHC, b) to eliminate legal discrimination, c) to carry out anti-stigma actions in schools, e.g. for pupils 15 years and older, involving both users and carers (we can offer a model for this developed in Romania).

B.2.6 Transversal themes

TOR question: How is the project taking into account gender and governance issues?

A. Gender equality

More than 50% of the members of the project team (including the project leader) were female. This project intended to pay much attention to the equal access of women with mental health problems to the CMHC. The staff of the CMHC intends to provide equal chances for every client and CMHS activities are intended to be based on non-discriminative and non-stigmatization principles. Special services like a day center for small children, where they can stay under qualified attendance and occupational therapy assistance, were to be offered for young mothers to increase their access to CMH services. To identify the gender specific problems in people with mental health disorders, the project foresaw a gender disaggregated data collection during the feasibility study and a situation analysis at the beginning of the project. While testing the newly elaborated minimum quality standards the addressability of women for and their satisfaction rate with the offered services were intended to be monitored and evaluated.

[1] http://www.youtube.com/watch?v=5bOrcknjnDU&feature=player_embedded

[2] http://www.somato.md/index.php?option=com_docman&task=cat_view&gid=19&Itemid=52

> ..... It was difficult for us to verify which of these activities were in fact accomplished. We recommend that when carrying out the thorough analysis of the de facto mental health and mental health care system (which we have suggested in the comments to Output 1 and in Annexe 3) gender aspects should be carefully considered, also in terms of the different diagnostic groups of mental disorders and the age structure of the patient population to be cared for.

B. Governance issues

On the conceptual and terminological level, the project plan was not clear in some instances - which might have been a disturbing factor for the actual project work. For instance, it says on p. 2 in the project plan that community mental health centres should be *fully* (our italics) funded by the National Health Insurance Company, whereas, as it says later on in the project plan, *joint* (our italics) financing mechanisms between social and medical sources should be elaborated as outputs. Another example is that the concept of a community mental health centre, which is central to the project, was not clearly defined and also different names were used for it in different parts of the documents ("Centru Comunitar de Sanatate Mintala", "Centru medico-social de sanatate mintala", "Centru socio-medical de sanatate mintala").

In addition, previous activities of mental health care reform in Moldova and the experience of existing CMHCs (e.g. that of CMHC Ungheni), were not fully integrated into the project, and previous documents on mental health care reform were not adequately considered (see, for instance, the documents on the website of the "Centrul Naţional de Management în Sănătate; www.cnms.md" and, as discussed under (9) in Output 1, previous publications and plans on decentralizing mental health care), thereby missing the opportunity of building up a cumulative practical and relevant local knowledge base.

We cannot make a definite judgement on the management structure of the project. However, it looks as if there might have been too many working groups with a) the same participants taking part in many different working groups, b) unclear roles of participants, c) conflicting interests of participants. It seems that no minutes of working group sessions exist pointing out agreement and disagreement between participants and how discrepancies were finally solved (or not).

It is not clear to us, to which extent the SDC could influence the ongoing project. There is at least one instance where the Output was codetermined by the SDC – the establishment of the CMHC in the hospital grounds of Costiujeni, which, as we have discussed extensively above (Output 3), is a wrong location for a "community" mental health centre.

Finally, some significant stakeholders were de facto not or not adequately included systematically (medici de familie, other professional organizations, human rights groups).

C. Recommendations

Recommendations are divided here into those which follow directly from the output assessment and might be partly implemented during the remaining project time until the end of 2011 (C.1), and those concerning potential newly funded projects (C.2). Some C1 suggestions might also go into C.2

C.1 Recommendations related to the outputs of the current project

These recommendations are summarized here from those provided in the respective chapters above of this assessment report. More detailed explanation of the rationale of these recommendations can be found in the respective sections above.

Output 1: National Mental Health Strategy, and
Output 2: Model of organizing, functioning and financing medico-social services

(1) For a Mental Health Strategy to be realistic, it is essential, not just to state the principles and visions, but to start from the actual de facto mental health care system. Therefore it is recommended to carry out an analysis of the functional and dysfunctional aspects of the total existing system of care for persons with mental disorders, including all service components and their interfaces, especially also the hospital sector. The profile of existing types of services, the actual patient flows between different service types and factors determining these pathways should be analyzed. The place of CMHCs in the total system should be clearly described, taking also into consideration pre-existing planning and legal documents. In Annexe 3 suggestions how to proceed in such an analysis are provided. An international tool (ESMS-2) could be used.
(2) The strategy lacks a set of concrete suggestions for implementation. It is important to include the actual situation of the structure and the functioning of the mental health care system as a starting point, contrast it in a concrete way with the objectives to be achieved and define concrete measures to be taken in order to change from the present to the desired structure.
(3) The strategy does not seem to be based on a clear and uniform concept of what a CMHC should be (the existing ones are very different in many respects). It is necessary to agree on a clear definition of the concept of the CMHC and to design a functional referral system between the other components of the psychiatric care system and the CMHC. A differentiated description of patients' profiles to be served by CMHCs in terms of diagnosis, severity, stage of illness and complexity of need should be provided.
(4) The integration of mental health care into the general health and social care system remains unclear. Therefore, potential referral pathways and alternative models of "cooperative care" should be described, relating to primary care, non-psychiatric departments in general hospitals and social services (especially social care homes), as well as how these models could be implemented when starting from the de facto situation. Make sure that informed stakeholders of the non-psychiatric sector (especially primary care representatives) get a say in the preparation of the final version of the strategy.
(5) Use a "stepped care model" in order to describe the pathways of access to care and to arrive at an adequate balance between hospital and community care, general health and psychiatric care and clearly define the place of the CMHC in the total system.
(6) An integrated mental health information system will be needed if community mental health services develop, hence a chapter on establishing an integrated and meaningful mental and general health service use information system should be included in the strategy.
(7) The work force in the health care sector, and especially in the mental health care sector, represents a burning issue nowadays. In the strategy, a chapter should be developed on work force development (especially in view of the aging workforce of psychiatrists) together with an evaluation of the impact of workforce prognoses on the implementation of the strategy.
(8) Clear financing mechanisms are essential for regulating the development of the community mental health sector. A chapter should be included in the strategy which describes the actual financing mechanisms for the different components of the mental health care system as well as how these mechanism could be changed in order to support the development of community mental health services.
(9) The timelines of the implementation of the strategy are not realistic anymore. The objectives of the strategy should be divided into short term (immediate), medium term (a few years) and long-term objectives (longer than a few years).
(10) The actual text of the strategy should be cleared from inconsistent formulations, and incorrect figures should be amended.
(11) Carry out a thorough analysis of the legal situation before suggesting new laws and governmental and ministerial orders and harmonize the legislation in the field of mental health care. Review all drafts for normative acts so that they are in accordance with the final version of the strategy and base these documents on an analysis of the total de facto mental health care system (see Annexe 4).

(12) Define and include clear financial mechanisms, with a particular focus on the intended common financing by the health and the social systems.

Output 3: The Community Mental Health Centre in Chisinau

(1) Since the newly founded community mental health centre of Chisinau was established in a most inappropriate location (in a stigmatizing large hospital outside the municipality of Chisinau) we recommend that a new community mental health centre should be established in the city centre, where it can in fact fulfil its function to serve people with mental health problems as close as possible to their homes and their place of work.
(2) The management and research departments of the National Centre for Mental Health (training, accreditation of services, etc.) could stay where they are, but it is extremely desirable that these components are administratively independent from the management of the hospital Costiujeni in order to assure that: a) there is a clear separation of funding from the hospital and b) interests of the hospital are not mixed up with the planning of the reform of mental health services in Moldova, which should move in the direction of shifting the focus toward community care.
(3) Concerning the training materials developed under this output, it might be useful to have them reviewed by external experts.

Output 4: Training of professionals

(1) The content of the curriculum may be too theoretical and not adjusted to the practical needs of doctors working in the future CMHC. Since the evaluation of the content was not the task of the review, we recommend that the curriculum, as well as other materials produced, should be checked for proper quality by external experts, and possibly adapted in a second edition.
(2) Although it was not the specific task of the project, in view of the strategic direction of integrating the mental health care in primary care, we recommend to introduce the community mental health care curriculum also in continuing medical educational activities for general practitioners.
(3) Some of the seminars for family doctors, psychiatric nurses, and NGO representatives have not yet been implemented. We recommend that further seminars should be carried out in the remaining time of the project.

Output 5: Awareness raising among the population

(1) One of the planned activities was not implemented at the time of the review: the evaluation of the impact of the information campaign. Since no baseline research was planned nor implemented, such an activity is not relevant anymore at this stage of the project. Similar international experiences have also proven that the impact of such time limited campaigns at the population level cannot be expected to be very large. We therefore recommend not to ask for an evaluation of the awareness raising activities.

C.2 Recommendations concerning potential new projects

Progress has been made and useful resources have been developed as a direct result of SDC involvement in the mental health care field in Moldova. In order to make the best use of all these resources and to strengthen the capacity of mental health care organizations in Moldova, further action is required. We have identified several areas where action could be useful in order to secure sustainability of the progress made. It is clear that choices have to be made and the pros and cons should be discussed with all stakeholders. Since most of the suggestions mentioned below require cooperation from the political and the national and local authority side and from other stakeholders, success cannot be guaranteed even if the most sophisticated management strategies are used (we have included a preliminary stakeholder analysis in Annexe 9). The potential new projects should relate to the objectives set in (the amended) Mental Health Strategy and should carefully consider

what could and should be achieved in the short term, medium term, and long term. If SDC is considering a long term funding strategy this type of time scaling would be extremely important, and a respective Gantt chart should be developed showing the potential time sequence of projects. Also, SDC might wish to consider seeking cooperation with other international projects (we have mentioned some possibilities below and could provide more information on these). Also, possible new projects should be built around already existing resources (e.g. on the experiences of the existing community mental health centres), which is most important for achieving sustainability.

The suggestions below are made without knowing what the financial commitment of SDC and what the time perspective of such a new project could be, and how the political situation and relevant persons would influence the feasibility of projects, i.e., what the risk would be that projects might not achieve their objectives out of external reasons and the investment is lost. In order to provide as many ideas as possible also for the more distant future we have developed a lengthy list of potential projects (see Annexe 9, where all projects have numbers which are used below for easy reference), but have selected below a limited number of these potential projects which we would give a high priority. The rationale for this setting of priorities is based on three considerations.

a. We have derived the proposals from our analysis of the de facto situation of mental health care in Moldova care (e.g.C.1 and C.2).
b. We have considered the achievements obtained over the last decade (especially also with the help of SDC) and have based some suggestions on the resources which had been built. The intention was to foster continuity and sustainability of what had been achieved already (e.g. the CMHC in Ungheni is very promising > C.3; basic training structures for staff and GPs have been developed > B.1, B.4, B.7)
c. We have followed internationally agreed guidelines for how mental health care should be organized. From cooperation with WHO these should be rather clear, but we elaborate on them here. Today, the internationally acknowledged and advocated approach to mental health care reform is to abandon large mental hospitals and to establish mental health services in the community, thereby observing a balanced care approach between different components of the services system, such as psychiatric beds in departments in general hospitals, day care facilities, ambulatory and mobile services, as well complementary services in the non health sector (such as residential facilities, work facilities, patient clubs, etc.). Also, the integration of mental health care with the general health care sector, especially with primary care, and the social care sector, is regarded as essential, as well as establishing links with the educational, labour, legal and other societal sectors. The principles behind these psychiatric reform approaches are: human rights, rights of disabled people, social inclusion, participation, empowerment, responsiveness of services, accessibility and universality. When trying to implement this community mental health care approach in a given country, the local characteristics of the existing health and social care system need to be taken into consideration in addition to international experiences, in order to aim for and establishing effective, efficient, equitable, accessible and high quality care for persons suffering from mental disorders. In several industrialized countries such approaches exist and have been at least partly implemented, whereas in many low and middle income countries mental health care still relies on large mental hospitals, with community mental health care only punctually implemented on the basis of local initiatives and NGO support. Few steps toward a mental health care envisaging the health and social care system as such have been taken so far in these countries.

The concrete proposals are presented here in order of our choice of priority (see also Annexe 6b).

Priority 1: Further develop mental health services in the community: C.1, C.2, C.3

C.1.Develop a new urban community mental health center in Chisinau, following on the decentralization initiated when the Buiucani CSM was founded in the SEE stability pact project,

assuming that the new centre should be fully equipped with staff and resources, in order to be able to offer a broad spectrum of recovery oriented services.
C.2.The establishment one or two psychiatric departments in general hospitals can be an important step towards a balanced mental health care system (we wish to reiterate here that in many European countries hospital care is taking place almost exclusively in psychiatric departments located in general hospitals instead of psychiatric hospitals, which are highly stigmatizing).
C.3 Develop day care, mobile care, vocational rehabilitation, residential facilities and other community mental health services, including setting up local user and carer groups or associations in one or two locations

While, if considering the whole country, these actions are only a first step, they are most important first steps towards improving mental health care in Moldova, when following the internationally acknowledged principles discussed above. Apart from the improvement of quality of life of persons with mental disorders, the proposals have in common that they are per se also anti-stigma and antidiscrimination activities (this relates to your previous answers to question 4). Large mental hospitals are not only detrimental to patients' quality of life but are a main source of wrong ideas on mental illness in the population and consequently of stigma and discrimination. The best way of changing negative believes in the general population ("mental disorders cannot be treated", "mental disorders are chronic", "patients suffering from mental disorders are dangerous") is to confront people with persons suffering from mental disorders (by the way it has been shown that the risk for a person with mental disorders becoming dangerous is not higher than this risk in the general population - latest research shows that the risk is higher in one group of patients only, those with a so called "double diagnosis", i.e. schizophrenia plus substance abuse). Entering a psychiatric ward through the door of a general hospital is per se acting against stigma and discrimination.

While for C.1 the location is clear (Chisinau), we suggest explore whether Ungheni might be suited for C.2. and/for C.3. We have visited this centre and found a very motivated multi-professional team and rather pleasant premises (established with the help of SDC – so this would also be a contribution to sustainability). The idea would be to set up a complete model there of coordinated inpatient, day patient outpatient and mobile care and of establishing complementary social services (living arrangements, vocational services etc). C.2 and C.3 might also be considered for Chisinau (i.e. for the Community Mental Health Centre in C.1). Concerning a psychiatric department in the general hospital in Ungheni, several issues have to be considered: the minimum number of beds necessary for running such a psychiatric hospital ward, travel time for reaching the hospital from the catchmenta ares, how would this be in accordance with the new hospital master plan in development for the whole country (Nota bene: in the plan by Professor Nacu included as attachment 7 in our review report, Ungheni is one of the 8 mental health districts forseen for Moldova).

Priority 2: Human resources development, B.1, B.3 and B.7.

B.1. Establish a sustainable training strategy for staff in the mental health and related care system by using the "train the trainers" concept. Structured resources are already available in Romanian (e.g. http://lubis.lbg.ac.at/de/publikationen/manuale). Options, among others are: (a) intensify training of general practitioners in recognition and management of frequent mental health problems by training "trainer general practitioners", (b) making better use of occupational therapy rooms created in hospitals; these spaces are not used since staff has limited knowledge of occupational therapy, and there is lack of occupational therapy materials. We recommend an in depth training of staff (3 to 6 months) with supervising and monitoring on how to do occupational therapy (OT) by using cheap or no cost recycled materials (see website above).
B.3. Develop and use for training user friendly mental health care tools and technologies
B.7. Empower staff and support the development of intervision and supervision mechanisms

These activities could be built on activities of the previous project, which we had judged as having been running rather successfully. Until now basic training of selected staff was conducted. We believe that in the next phase it is necessary to continue to build specific competencies and training capacity (very few people have specific knowledge in the field). Also, where trainings have failed to yield the expected results (e.g. introduction of occupational therapy in hospitals) a new approach must be used in order to make maximum use of the infrastructure already in place (occupational therapy rooms and equipment). User friendly mental health care tools and technologies are important in order to attract staff and keep them in the services. “Intervision” (feedback from other staff members) and supervision are extremely important for the difficult job of working in mental health services. These activities could be carried out in the new CMHC in Chisinau for an urban environment, and in Ungheni for a rural environment (see priority 1)

Priority 3: Mental health care system activities A.2, A.3, A.4

A.2. On the basis of a thorough analysis of the health and mental health care system (see C.1 (1) of the review report): Study the financing mechanisms including an incentive analysis and necessary changes in the financing mechanisms to arrive at a community centred mental health care system (connections would be possible with a currently ongoing EU project in this area, REFINEMENT)
A.3. Human rights assessment of the three mental hospitals: Use of a structured tool recently developed by 15 European countries - the ITHACA toolkit, which is available in Romanian (www.ithacastudy.eu).
A.4. Align the existing pieces of legislation and initiate new normative acts which clarify the role of the CMHC and creates a mainstream mechanism for supporting their activity

It is more and more recognized that system aspects of the total health and social care system are relevant for providing optimal health and mental health care. If political context is favorable and time and financial resources are available, system level actions can be initiated, preferably on financing issues (A.2), human rights in institutions (A.3), legislation (A.4). These activities could be performed in conunction with the NCMH, but it should be made clear that it is not dependent in terms of organization and its funding on the psychiatric hospital in Costiujeni (where it is located right now).