



Health Reform Monitor

Mental health system reform in Moldova: Description of the program and reflections on its implementation between 2014 and 2019



Ionela Petrea^{a,*}, Laura Shields-Zeeman^a, Rene Keet^b, Raluca Nica^c, Karel Kraan^d, Jana Chihai^e, Victoria Condrat^e, Ghenadie Curocichin^e, MENSANA Consortium

^a Trimbos Institute, Da Costakade 45, 3521 VS Utrecht, the Netherlands

^b GGZ Noord Holland Noord, Alkmaar, the Netherlands

^c Romanian League for Mental Health, Bucharest, Romania

^d Luzerne Psychiatrie, Luzern, Switzerland

^e Trimbos Moldova, Chisinau, Moldova

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ABSTRACT

In 2014, the Republic of Moldova started a systematic process of reforming its mental health system, implementing priority actions set out in the National Mental Health Programme. The reform entailed a service delivery re-design, instituting mechanisms for collaboration across health and social sectors, and revision of the policy framework. Outcomes of the first 4 years of the reform included: 1) the establishment of a network of mental health services in 4 pilot districts embedding mental health diagnosis, treatment and referral in primary and specialized mental healthcare; 2) creation of an enabling policy environment at the national and district level; and 3) strengthened community support and acceptance of mental health issues. Objectives of the first Phase were achieved and the reform is now in its second Phase (2018–2022). The implementation strategy in Phase 1 focused efforts on 4 pilot districts, whereas Phase 2 harnesses lessons learned from Phase 1 and facilitates local leaders and actors to scale-up the model to all 32 districts and municipalities in Moldova. Ownership over the reform process shifted from project-led in Phase 1 to national and local government-led in Phase 2. We reflect on the process and contents of the mental health reform, discuss lessons learned and implementation challenges encountered. We conclude with learning points for policymakers and researchers considering mental health reform in other countries.

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1. Purpose or idea of the policy

In 2014, the Moldovan government started to reform its mental health services, which entailed a major service delivery re-design, instituting mechanisms for collaboration across sectors (e.g. social welfare, health, education), and revision of the policy framework. The reform is implemented with technical assistance from the Swiss Agency for Development and Cooperation (SDC) funded project “Support to the reform of mental health services in Moldova” (hereafter “Moldova reform project”), led by the MENSANA Consortium.¹ The goal of the reform is to enable people with mental health issues to achieve their recovery goals and be able

to lead meaningful lives in their communities. The first 4 years of the reform have recently passed, reached their objectives, and the reform is now in its second Phase (2018–2022). The plan for the first Phase of the reform built upon the Ministry of Health’s priority actions in the National Mental Health Programme [1,2] and the Strategy on Development of Community-Based Mental Health Services 2012–2016 [3]. Three outcomes were set for the first 4 years of the reform (Table 1). First, the reform aimed to improve access to appropriate mental health by establishing a network of community-based mental health centres. The sustainability of this network of services hinged on creating an enabling policy environment. The second outcome aimed to introduce changes in the legal and organisational framework, led by decision-makers from health and social sectors at the national and district level. The third

* Corresponding author. Present address: INSIGHT International Institute for Mental Health and Integrated Health Systems, the Netherlands.

E-mail address: ionela.petrea@insightinstitute.nl (I. Petrea).

¹ MENSANA Consortium is led by the Trimbos Institute, together with its partners the Romanian League for Mental Health and Luzerner Psychiatrie. Project Steering

also includes GGZ Noord-Holland-Noord. NIVEL Institute was a partner in the first 2 years of the project.

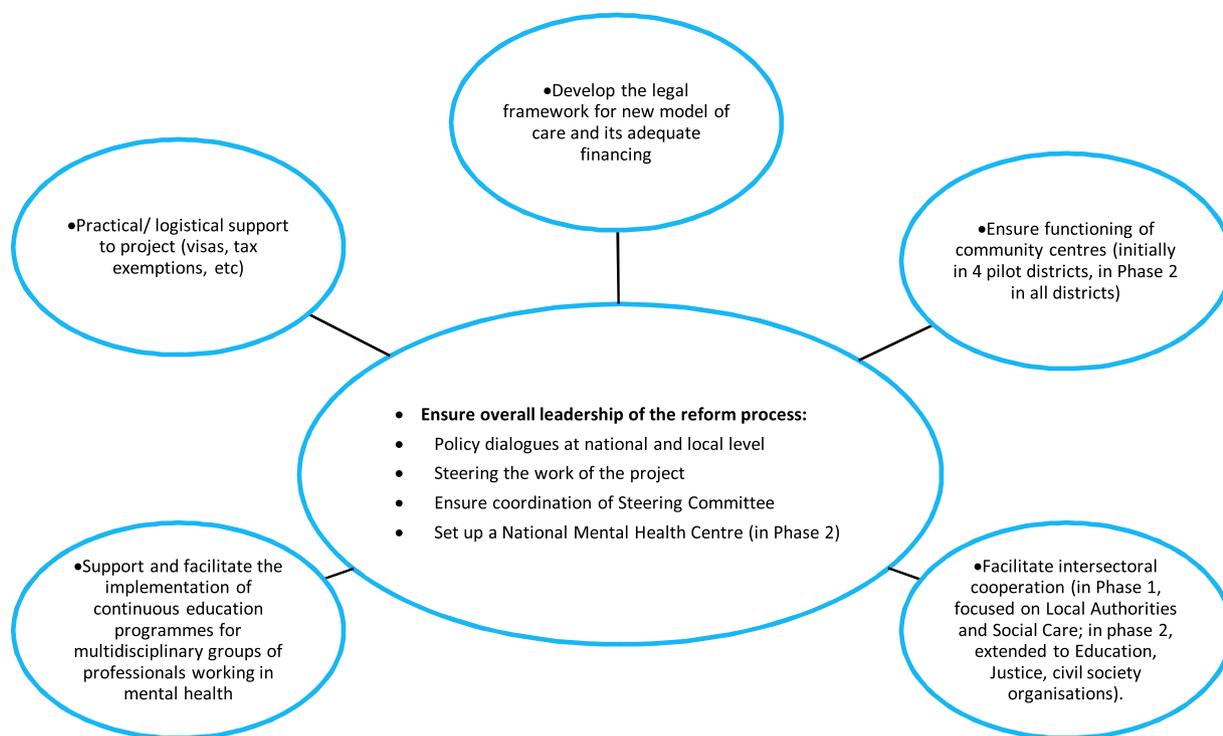


Fig. 1. Contribution of the Government of the Republic of Moldova.

Table 1
Outcomes of Phase 1 and 2 of the reform.

	Phase 1 (2014–2018)	Phase 2 (2018–2022)
Outcome 1:	People with mental health issues have access to a comprehensive network of good quality mental health and social community-based services in 4 pilot raions	A country-wide network of integrated community-based services for mental health that ensures equitable access to quality and affordable care, responsive to user needs.
Outcome 2:	Decision-makers at the national and local level create an enabling policy environment for the model of care to be implemented	People across Moldova are more aware of the importance of their own and others' mental health, improve their mental healthcare-seeking behavior, and support the social inclusion/recovery of people with mental health problems.
Outcome 3:	Community members in 4 pilot raions are supportive of the re-integration of people with mental health issues back into the community.	

outcome focused on strengthening community support and acceptance of mental health issues. These outcomes were revised and refined during the second Phase (Table 1). As a precursor to starting up the SDC funded implementation project, the Government of the Republic of Moldova, through its Ministry of Health, has committed itself to leading and providing resources for the implementation of the reform, by undertaking an agreed set of actions (see Fig. 1). This is a formal as well as active commitment; delays in delivery can lead to suspension or even termination of the agreement with the donor.

2. Political and economic background

During the 1990's, Moldova was substantially affected by the collapse of the Soviet Union, which led to 68 % of the country's 3.5 million people falling under the poverty line [4]. Since inde-

pendence in 1991, Moldova has made political, economic and social progress; however, Moldova remains one of the poorest countries in Europe and its economy relies heavily on external funding [5]. Minority populations in Gagauzia, Transnistria, the Roma and female-headed households are particularly socially and economically disadvantaged [6]. Difficult living conditions, limited employment opportunities and poor access to low-quality public services have contributed to a third of the working-age population migrating abroad [5]. While migration generates remittances equivalent to 20,16 % of Moldova's Gross Domestic Product [7,8] it has also created social fractures, particularly in rural areas. Moldova's governance structure is volatile with a high turnover of politicians. Financial investment in infrastructure from foreign donors is an important component of Moldova's economy and thus securing external opportunities attracts political support from officials, health professionals and the broader public [9].

3. Health policy processes

Though progress has been made in policy and legislation reform in healthcare, implementation has been uneven and slow. After independence in 1991, Moldova was left with a Semashko system of health care [10], a centrally organized system dominated by the biomedical model focused on quantity rather than quality of care. At present, the health system include both public and private medical facilities, and public authorities are involved in providing, financing, regulating and administering health care services [10]. In primary and secondary care, public medical facilities offer services to communities and are governed by local public authorities. Emergency care (i.e. ambulance services) are available in every district, under the Ministry of Health, Labour and Social Protection's (MoHLSP) jurisdiction. Tertiary level services offer specialized medical care for the entire population of the country and are governed by MoHLSP. All public medical facilities are independent, non-profit making organizations which are contracted by the National Health Insurance Company.

Table 2
Health system and mental health system indicators for Moldova.

Indicator	N or %
% of the Moldovan population reported to have health insurance coverage	75 %
% of out of pocket payments for health care (2012)	3.3 %
% Disability adjusted life years accounted for by mental disorders	8.03 %
% Prevalence of mental disorders	17.34 %
Suicide (age-standardized rate per 100,000)	13.8
Existence of mental health policy	Yes, partial implementation
Total health expenditure as a % of the GDP	10.3 %
Mental health spending per capita (US\$)	4.77
Total no of mental health workers per 100,000	65.2
No of psychiatrists per 100,000	5.92
Total no. of mental hospitals in 2014 (per 100,000)	3 (0.08)
Total no. of beds in mental hospitals in 2014 (per 100,000)	2070 (59.8)
Average No. of beds per mental hospital in 2014	690

Notes: Sources of data for this table adapted from Hone et al. (2016), IHME Global Health Data Exchange, WHO Europe European Health Information Gateway, WHO 2014 Mental Health Atlas, and WHO Mortality Database [36–41].

4. Mental health system in Moldova

Historically, mental healthcare was largely institution-based provided within 3 psychiatric hospitals (Table 2), and residential institutions, referred to as *internats* in many Central and Eastern European countries, function as a long-term care facility for people with mental illness [11,12]. Specialised outpatient services within small psychiatric units based in general hospitals largely renewed medication prescriptions and staffed by small teams (psychiatrists and nurses).

National activities aiming to transform the mental health system started in 2005, leading to initiation of a national mental health reform. Between 2005 and 2014 when the reform started, the government adopted several legal and policy documents (Fig. 2) which set the strategic direction and priorities of the reform. In addition, Moldova had several externally-funded pilot mental health projects implemented by local non-governmental organizations (Fig. 2), including participation in the Mental Health Project in South-Eastern Europe [13]. Though pilot project results were promising and contributed to building a case for a reform of mental health services, most services initialised through these projects were implemented outside the mental health system, and failed to induce systemic changes [10,14–19]. This conclusion contributed to the decision to launch an implementation strategy for the reform of mental health services led and championed by national and regional authorities, with involvement of all relevant stakeholders in health and other sectors.

5. Content of reform and preliminary implementation results

During its first Phase (2014–2018), the scope of implementation for the reform was at both national and regional level, excluding Transnistria. At the national level, the policy framework was amended to support the transformation of services, and academic and continuous education curricula was updated and implemented to sustainably strengthen capacity of professionals in mental health and connected sectors. At the regional level, four pilot districts (*raions*) were selected for implementation of a new model of mental health care. Districts were selected by the Ministry of Health based on a set of criteria related to local capacity, demonstrated



Fig. 2. Timeline.

commitment of local authorities to support implementation of the new model of care, and geographic distribution of new model of care across the country.

In the second Phase (2018–2022), the reform harnessed lessons learned in Phase 1 and facilitates local leaders and actors to scale-up the model from 4 to all 32 districts (excluding Transnistria) and municipalities in Moldova. The second Phase takes a different

approach in terms of the technical assistance provided to national authorities and key stakeholders by shifting ownership over the results and the direction of the mental health reform from project-led implementation in Phase 1 to a national authorities led-process in Phase 2.

The intervention strategy for Phase 1 employed a multi-pronged intervention strategy consisting of service delivery, policy and communication and advocacy components. Major tools to progress the intervention strategy were: 1) policy influencing and policy changes; 2) capacity building with training, supervision and coaching of all specialized mental health professionals in the country and a selection of primary care professionals providing mental health care; and 3) peer-to-peer mentorship and networking. This was the first time such a comprehensive approach had been implemented in Moldova.

To achieve the first outcome, service delivery re-design was initiated to facilitate better access to mental health services and supports in the community, closer to where people live, work and study. A care pathway was developed with new roles and responsibilities defined for family doctors and nurses, specialized multidisciplinary community mental health teams, and specialists working in psychiatric hospitals. The premise of the model was to provide care for mild and mild to moderate mental health problems in primary care settings, care for moderate and severe problems (including crises) in community mental health centres (CMHCs). Acute cases which could not be solved through crisis intervention at home and in community, and complex cases which for clear reasons could not be solved by the CMHC teams would be referred to acute units in general hospitals or to psychiatric hospitals. The Flexible Assertive Community Treatment (F-ACT) model [20–24] developed in the Netherlands, served as an inspiration for a locally adapted service delivery model in Moldova for severe mental illness. To implement this new model of care, family doctors and nurses were trained in taking on responsibilities for identification and treatment of mild and mild to moderate mental health problems, who not only work in primary and specialized community settings but psychiatric hospital staff as well. Multidisciplinary community mental health teams (consisting of psychiatrists, psychologists, social workers and nurses) were set-up and trained in providing specialised outpatient mental health care (including home visits) for moderate and severe mental illness at CMHCs. Ongoing coaching, refresher training and mentoring sessions were put into place for primary care professionals and CMHC staff to tackle issues such as managing shared caseloads and referral and discharge procedures. The initial legal framework also stipulated establishment of five geographically distributed acute inpatient units in general hospitals which are not yet in operation and thus inpatient functions remain in psychiatric hospitals. The process of introducing psychiatric beds in general hospitals has been slow, for reasons that go beyond the mental health reform. The Ministry of Health has been working extensively on reforming hospital-based care throughout the country, resulting in dynamic discussions between key stakeholders involved in the reform. After two years of negotiations on how to organize general hospitals and if and how psychiatry fits into this, it appears that psychiatric units will open up in regional general hospitals by the end of Phase 2 of the reform (2022) in planned locations. These units are planned not in every district in Moldova, but in larger districts; their catchment area will cover several neighbouring districts. It is likely (but not certain) that psychiatrists working in the CMHC's in districts will be required to share their time between their work in the CMHCs and the work in the psychiatric ward, as there are not presently enough psychiatrists in the country that can cover all these duties. Existing psychiatric hospitals are unlikely to lose staff in this process of initializing psychiatric wards in general hospitals. Instead, the National Association of Psychiatrists, Psychologists and Nar-

cologists as well as universities in Chisinau have been devising a strategy for attracting new staff and plans for attracting junior staff and residents to do rotations or take up positions in more rural districts of the country.

Psychiatric hospitals continue to play an important but new role in service delivery. It is expected that once the psychiatric units will start operating in general hospitals, the psychiatric hospitals will continue to provide acute inpatient care for districts in their respective catchment area. In addition, they are expected to focus on super specialized care, and also provide long-term care for complex cases. Psychiatric hospital staff started to take on different roles and/or to be re-allocated to different settings. Changes in staff roles have been achieved through a concerted set of actions, as follows. First, managers and leading professionals were provided with peer-to-peer capacity building and culturally sensitive mentorship. Bringing them on board with the envisaged changes has been critical in the tripling down and acceptance of new roles by the other professionals. Many of these managers and leading professionals have later on championed the changes. Second, hospitals' staff have been provided with an extensive program of capacity building, which sought to genuinely engage with these professionals to discuss the new model of care and the value each of them would bring in their new roles to its successful implementation. Third, the decision makers from MoHLSP have taken a strong stand on the need to change. They have directly and actively engaged with managers and lead professionals both in meetings organised at MoHLSP as well as in repeated field visits to these services. In parallel with these actions, national policy changes were made detailing the new mental health services structures and workforce specifications; and workflows and referral pathways were created that changed the flow of patients throughout the mental health system.

It should be noted that financial mechanisms to fund psychiatric hospitals did not change in connection to the reform of the mental health system. There were, however, several internal organizational changes in some of the psychiatric hospitals, particularly the two largest in the cities of Chisinau and Balti, which resulted in changes in how funds were used and allocated by the hospital. As an example, Balti Psychiatric Hospital has closed down some of its departments and re-allocated funding for those departments to other sections/ of the hospital and used some of the re-allocated resources towards diversification of services they offered to patients. In other words, the budget remains the same for the hospitals but is utilized and allocated differently in order to improve the type and breadth of services that they provide. Psychiatric hospital budgets have not been reduced as a result of the reform, as The National Health Insurance Company uses separate budget lines for psychiatric hospitals and for community mental health centres. As a result of the service delivery changes, there were 14–30 % fewer referrals for psychiatric inpatient admissions across the 4 pilot districts, a core outcome of the first Phase of the reform.

For the second outcome, Moldovan policymakers developed with the support of MENSANA technical expertise, a more conducive policy and legislative framework that lends itself to a more progressive, responsive, easier to access and rights-based mental health system. To engage policymakers and have buy-in for the reform, mechanisms to facilitate intersectoral cooperation (between health and social care sectors, and between local public authorities and health services) were set up in the 4 pilot districts. Additionally, a nationally focused policy influencing strategy endorsed by the funder of the project was developed with strategies for distilling key reform results to policymakers, through regional and national policy dialogues. Another strategy for buy-in was involving decision-makers from the very beginning of the reform and creating opportunities to see examples of progressive mental health systems where they could, as a country, grow into. Through

study visits to The Netherlands and Romania, decision-makers had the opportunity to understand first-hand how the mental health system was governed and financed and interacted with both health professionals and persons with lived experience of mental illness.

Institutional policy changes were also needed to consolidate results from capacity building efforts. Curricula were modified or developed and implemented for academic and continuous education programs to reflect the changing profile of health professionals. Evidence-based practices were also defined and detailed in clinical guidelines (both for specialised and primary care practitioners) for key priority mental health conditions identified by the MoH. Guidelines were developed using existing evidence syntheses from international guidelines and through a consultative multi-stakeholder working group employed an adaptation strategy to tailor recommendations to the Moldovan health system [25,26].

The third outcome of Phase 1 of the reform was grounded in recognition of the implications that transitioning care and supports from hospital to community-based settings has for community members. This outcome was set halfway through the first Phase, after considering that greater community engagement efforts would be necessary to sustain any results obtained in service delivery or policy level transformations. Several strategies were employed to engage community members, local (village-level) opinion makers, and regional and national decision-makers to be more aware of the goals and plan for the reform and of the need for stronger and continued cooperation between the health and social sector. First, small-scale awareness campaigns were held, leveraging opportunities to have local celebrities share their experience with mental health issues, holding public events such as mental health information brunches, and actively publishing stories, facts and media that captured the progress of the reform, particularly from the service user's perspective. Mentorship and coaching for service users was provided by the Consortium team to empower sharing of lived-experience, culminating with two service users chairing and speaking at a national UNHCR conference held in Chisinau, Moldova in 2018. Second, media professionals from both district and national media outlets were trained in responsible media reporting of mental health issues. Third, effective strategies for increasing social contact with people with mental health problems were explained through community stakeholder meetings in villages. Collaborative mechanisms were fostered between medical and social care stakeholders in the 4 pilot raions for the first time. CMHC social workers started to meet regularly with social workers from the Social Welfare Department to discuss management of complex cases. Local public authorities and MoHLSP representatives led 13 workshops in 37 villages involving about 400 opinion leaders that subsequently requested follow-up roundtable discussions to understand more about mental health.

6. Lessons learned

Several lessons from implementation of Phase 1 have been garnered and are applied throughout Phase 2 of the reform. First, national promoters of the reform were essential, who not only understand the need and utility of the reform of the mental health system in Moldova, but believe in it as well. Building a cadre of reform promoters was done through initiation of a number of platforms facilitating communication and dialogue about the reform, such as national and regional policy dialogues. Networking with other projects in education, health or development was also an essential mechanism to share progress of the mental health reform.

A key implementation challenge was initial limited capacity of the mental health workforce to work within new roles and with new responsibilities. To address this, a core component of the reform and technical expertise provided by the Moldova

reform project consortium was a comprehensive capacity building programme delivered by international and local health care professionals (training, supervision and coaching), upgrading knowledge and skills of newly developed community mental health teams, primary care doctors and nurses, staff working in the 3 psychiatric hospitals in the country, and social workers at the local district level. Multidisciplinary community mental health teams had to be created and receive training in team-based care, joint case management, home visits, and collaborating with other levels of care (primary and tertiary care). Another implementation challenge was the ability to see changes in quality of life and functioning in the population when there are substantial unmet basic resource needs (e.g. food security, income and housing stability) at the population level. The mental health system reform had a mandate to transform legislation and care within the medical sector and not within the social care sector. Without efforts devoted to advance community re-integration and engage communities to be engaged in the reform, mental health system reform efforts (particularly deinstitutionalisation processes) cannot be fully realized.

7. Conclusion

Substantial strides have been made in countries around the world in reforming mental health systems, particularly emphasising policy and services development that moves away from institutional care towards community-based services [27–29]. A number of countries have embarked on a process of reforming their mental health system where the focus has been on reforming the regulatory and policy framework as well as development of services, particularly primary care and community mental health centres/teams. The latter has been accompanied by capacity building programs, typically involving training, supervision, and auditing as implementation strategies [27,29–33]. There is comparatively limited examples of large-scale national reforms of mental health services in Central and Eastern Europe, particularly where plans to sustain and scale-up results is a priority for all stakeholders involved [34].

Reforms of complex dynamic systems take time – sustainable results take years to occur [35]. Key drivers for the results achieved in Moldova so far have been the legislation and policy changes, as well as continued support and motivation for the reform among policymakers and decision-makers. Ongoing challenges include mitigating the impact of migration among the mental health workforce, limited investments in the social care sector which compromise basic resource needs from being met and impact mental health and service utilisation outcomes, and creating a system more inclusive of service users voices and opinions in the ongoing design and delivery of mental health care in the country.

Declaration of Competing Interest

All authors declare that they have no competing interests.

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