Proposal for Mental Health Policy Framework in Libya

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The proposal for Mental Health Policy Framework in Libya 2012 – 2025

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**Abbreviations**

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<tbody>
<tr>
<td>CDC</td>
<td>Centre for Disease Control</td>
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<tr>
<td>CMHC</td>
<td>Community Mental Health Centres</td>
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<td>CBR</td>
<td>community based rehabilitation</td>
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<td>EU</td>
<td>European Union</td>
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<tr>
<td>GP</td>
<td>general practitioner</td>
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<td>ILO</td>
<td>International Labour Organization</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>NCDC</td>
<td>National Centre for Diasese Control</td>
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<tr>
<td>NGO</td>
<td>non-governmental organization</td>
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<td>OPD</td>
<td>oputpatient department</td>
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<td>PFA</td>
<td>psychological first aid</td>
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<td>PHC</td>
<td>primary health care</td>
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<td>THL</td>
<td>National Institute for Health and Welfare, Finland</td>
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<tr>
<td>UNESCO</td>
<td>United Nations Science and Culture Organization</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Foreword

The past history of Libya has had an impact on the mental health of Libyan citizens. Mental health care services, among other health services, have been underdeveloped and hospital based. In addition, the armed conflict during 2011 has caused significant psychological and social consequences to many people in several locations of Libya. Although the impact of the stress factors is acute in short term, they can also affect the long term mental health and psychosocial well being of the population, especially in areas directly and indirectly affected by the war. This is at the same time challenging and giving positive view for the future. Mental health has been chosen as a priority in Health Policy, indicating that there is a clear momentum for building up needs-based mental health services. Still, it's unclear how long the momentum will last.

The international direction for developing mental health services is clear and strong: the new configuration of services will be based on combining community-based services and hospital care. In this combination the community-based services will take the leading role. The community-based services will operate in close networks and partnerships with primary health care, social services, employment authorities, education and similar.

In order to develop the country's mental health services accordingly, Libya has been engaged in development projects with international partners especially from the year 2011 onwards. A special project is the MOH/WHO project "Coping with emerging mental health and psychosocial needs in Misurata". In addition to modernizing the structures and functions of mental health services, the projects have aimed at making them compatible with WHO standards, and also at tackling deficits in the services calling for urgent action.

To achieve a central role for the Community Mental Health Centres (CMHCs), changes and/or revisions may be required in their funding, legislation, inter-institutional collaboration, and managerial capacity. Their funding should have a solid and sustainable basis. Whenever new service structures are introduced, there will be competition between recipients of funding, and this may lead to unwanted rivalry between those that should – in fact – engage close co-operation. Therefore, the coordination of allocation of funding is of great significance for future development.

Mental health should be taken into serious consideration in all levels of the future legislation. The legal provisions and the norms of application of the future mental health law need to be fully implemented and collaboration between the relevant Ministries enhanced. Managers of the institutions should receive further training and continuity of care aspect needs to be fully supported.

At the same time, special attention ought to be paid to human rights and to further diminishing the stigma attached to mental health issues. It has also become increasingly evident that structures and measures that support promotion of mental health and prevention of mental disorders represent sustainable development for both the population's health and health services. Advocacy and participation of both service users and their family members is a valuable asset in achieving the optimal mix of services, and an indispensable part in the path to recovery.

This course of development would lead towards a modern constellation of mental health services through a gradual transition from mental hospitals toward community-based mental health services covering the whole country and subsequent broader networking of community-based services. This will be a long process, which requires for long-term commitment and continuous effort. A realistic timeframe would be more than 10 years, targeting to year 2025. That's why the timeframe for this policy document is from year 2012 to year 2025.
Background for preparation of this document

The World Health Organization (WHO) has been involved in health sector development in Libya before the conflict and continues to support the current Libyan Government in restructuring and strengthening health services in the country. One of the strategic priorities in the country cooperation strategy between WHO and Libya for the period of 2010-2015 is developing a long-term national vision for health development and reforming and upgrading the health system. After the conflict period the WHO Regional Office for Eastern Mediterranean has produced a document “A Concept Paper Note; Post Conflict Health Systems Assessment, Restoration & Development in Libya”. The document notes that after initial assessment and immediate interventions there is a need to develop an intermediate national health plan, reorganize the health system and governance, as well as set priorities and policy directions in health sector. After that a comprehensive national strategic health sector development plan can be made through national policy dialogue, which defines national priorities for different components/building blocks of the health system (governance, financing, technology, human resources, information, and service delivery). For these tasks the transitional Libyan government has requested also foreign support.

In January 2012 the delegations from the Ministry of Health of Libya and Ministry of Social Affairs and Health of Finland had initial discussions on the support to the planning and development of health system in Libya. The prioritised areas during these discussions were primary health care (PHC) and mental health. The Ministry for Foreign Affairs of Finland decided to fund an assignment on this matter and provide Finnish expertise for the use of the Libyan Ministry of Health, in close cooperation with ongoing support and coordinated by WHO.

The objective of the assignment was to support the reform and development of the Libyan health system by providing short term technical assistance. The Finnish experts, working closely with national and WHO experts, were tasked to prepare a concept paper on the core definition and ingredients of PHC and and recommendations on how to proceed in developing PHC system in Libya. The experts were also tasked to prepare a draft policy framework document for mental health system and delivery of services. Both of these papers can serve as background papers in the discussions during the planned national consultations for health system strengthening.

This proposal for Mental Health Policy Framework has been produced through collaboration of Libyan and Finnish mental health experts, coordinated by WHO. The experts who actively participated in preparing this policy document are, from Libyan side Dr Ahmed Sewehli (Ministry of Health), Dr Amjad Shagrouni (Mental Health Department in National Center for Disease Control), Dr Adel Abu Azza (Director of Tripoli Mental Hospital), Dr Ahmed Kara (Medical Director of Tripoli Mental Hospital), Dr Mohammed Elkwafi (Medical Director Benghazi Mental Hospital), Dr Tarek Alareby (Acting Director Benghazi Mental Hospital); Dr. Fahmy Bahgat from WHO; and Dr Timo Tuori from the Finnish team of experts. Dr Tuori is the main author of this document.

During this assignment the Finnish team has relied on the assistance from the WHO Office and the Libyan authorities, including the Ministry of Health. The Finnish Expert Team bears the sole responsibility of the interpretation of the information, recommendations and other contents of this paper. The paper does not necessarily reflect the views of the Ministry for Foreign Affairs of Finland.
1. Policy priorities

The imperative for a reform is based on the high occurrence of mental health problems and to their impact on health and on quality of life.

Two sets of recommendations are presented: The first set describes the envisaged general principles of mental health services which are in line with what has previously been envisaged by both Libyan present policy planning and in international projects. The second set of recommendations outlines how community-based services should be networked and integrated with other relevant services in the community and thus contributes to promotion of mental health and well-being.

1.1. General principles of mental health services

(1) Respect human rights and dignity

Respect of human rights and dignity need to be the guiding principle at all levels of mental health services. This principle should be applied in all the phases of a treatment chain and it is especially crucial to apply it in the admission phase (both voluntary and involuntary) and during hospital care.

It is important to include these topics in the training of professionals at all sectors (e.g. police, the social sector), which provide services to people with mental health problems. The general public would benefit from accepting such an attitude change through public campaigns (human rights, combating stigma).

In the long run, this approach will also help to alleviate the negative attitudes and stigma attached to patients with mental health problems. It will also increase the empowerment of service users and their families.

(2) Make the Community Mental Health Centres (CMHCs) central actors of the integrated mental health service system

To pursue this goal, development in issues such as legislation, financing, intersectoral collaboration – especially at regional and local communities’ levels –, territorial considerations, and managerial reflections need to be initiated and appropriate measures implemented.

Furthermore, it is crucial that the CMHC has at its disposal all the required support services and treatment options, as well as the human resources needed. Besides utilising their own comprehensive services they should be able to rely on the support of psychiatric hospital care, care in the psychiatric departments of general hospitals, day hospitals/day care centres or with the primary health care (PHC). In addition, the CMHCs should be able to coordinate the collaboration with other community level stakeholders and the organizations of service users and caregivers of mentally ill persons.

The status and regulatory position of CMHCs in Libya should be defined in the upcoming health and mental health legislation and ministerial orders. More design of the normative and funding status of these centres is needed and large numbers of staff would need to be transferred or recruited.
(3) Improve psychiatric inpatient care

During the reform process, the necessary inpatient care in psychiatric hospitals and the psychiatric departments of general hospitals will remain an integral part of service provision. The network of community-based services will only be functional when it includes hospital beds, usually for emergency situations.

Rapid and effective treatment will be the objective in these institutions and respect for human rights and dignity are core values visible in the everyday work. Modernisation and renovation of the facilities of the psychiatric hospital wards must be continued.

(4) Give primary health care an appropriate role in mental health

Primary health care should cater for all human health problems and needs. In many countries where primary care has only recently introduced general practice/family practice as the cornerstone of PHC, mental health has remained too much in the margin of the tasks. This is true also for Libya.

The major challenge for PHC resides in detection, intervention and care of common mental health problems such as depression, anxiety, substance abuse and in Libya especially posttraumatic stress disorders. PHC professionals encounter persons with these problems, often in hidden expressions behind somatic complaints. All health systems are currently actively seeking to respond to such unmet needs by building the capacity of PHC professionals and providing them support.

The role and potential of general practitioners (GPs) or family doctors needs to be recognized in the patterns and practices of care. Currently the family doctors are not allowed to initiate psychopharmacological treatment. Those who have completed specific training (a curriculum designed for GPs/family doctors) should be given rights to prescribe antidepressive and other first line medication according to commonly accepted guidelines (e.g. WHO essential drug list).

One important task for the GPs/family doctors is to follow the physical health of the outpatients suffering from mental health problems.

1.2. Expansion of mental health policy beyond psychiatric services

(1) Strengthen intersectoral collaboration at all levels of administration

Internationally shared view, for example the principle of "Health in all Policies" of the EU, sees mental well-being and health as being determined by a broad range of factors, many of which lie outside the realm of the health sector. This should be recognised also in Libyan policy-making, where intersectoral collaboration could be based, for example, on a ministerial order between different ministries such as the Ministry of Health, Ministry of Social Affairs, Ministry of Justice, Ministry of Interior, Ministry of Labour, Ministry of Higher Education and Ministry of Education. Practical modes of intersectoral collaboration need developing and strengthening.

In addition to engaging the neighbouring fields in the public sector, international experience shows that it is vital to build partnerships between services and to include relevant non-governmental mental health organisations, other stakeholders, service users and their families to this collaboration.
(2) Build multisectoral rehabilitation

Modern rehabilitation in mental health encompasses actions by social services (for example assistance in housing, subsidy support and help with management of everyday life's demands), education, employment and voluntary organizations that can have a irreplaceably important role in the process. Actions between different actors should be coordinated. This is best achieved by tailored case management for those with multiple needs.

THE VISION

By the year 2025, Libyan mental health services have been raised to the level recommended by WHO and in other international standards.

The cornerstones of the mental health service system are the Community Mental Health Centres, which have the needed flexibility to provide and advocate the informal and formal services in the local communities. These services also contribute to supporting people's functioning in everyday life.

The high-quality, flexible, well-functioning and easily accessible inpatient care mostly in general hospitals will remain an integral part of the service provision. Rapid and effective treatment and psychosocial rehabilitation are key activities of the system.

Primary health care, social services, education and employment authorities and voluntary organisations are joined to work towards the common goals. Through this network, the mental health service system becomes truly integrated.
2. Introduction

2.1. The burden of mental illnesses

There are no epidemiological surveys on mental health situation in Libya. It is, however, possible to use global epidemiological studies also in Libya, while keeping in mind that the decades of the former regime and the conflict during the last year has increased the number of people suffering especially from psychological distress reactions, depression and anxiety disorders. The children are one of the risk groups after the conflict.

Mental ill health is a major contributor to disability across the world. Five of the ten leading causes of disability worldwide are psychiatric disorders. Poor mental health contributes to physical diseases and to poor compliance with prevention and treatment programmes. Parental illness causes intellectual and emotional consequences to the next generation. Mental disorders are also a major contributor to premature mortality and suicide alone is the tenth leading cause of death in the world.

The cost of not tackling mental disorder efficiently and effectively arises from:

- Lost production from people with mental illness being unable to work in short, medium or long term.
- Reduced productivity from people being ill while at work.
- Cost of accidents by people who are psychologically disturbed (especially people responsible for the safety of others like bus drivers, factory workers).
- Supporting dependants of the mentally ill person.
- Unemployment, alienation, and crime in young people whose childhood problems (e.g. depression, conduct disorder) were not sufficiently well addressed for them to benefit fully from the education available.
- Cost of not properly addressing the consequences of dyslexia, mild mental retardation and other special educational needs in childhood.
- Poor cognitive development in children of mentally ill parents.
- Higher costs incurred when disorders are not tackled early or when they remain untreated.
- Lost production from premature mortality from suicide and other causes of death.

2.2. Positive mental health as a resource

Mental health is an essential component of general health. World Health Organization (WHO) defines health as a state of complete physical, mental and social wellbeing. Mental health is a result of various predisposing factors (e.g. early childhood experiences), precipitating factors (e.g. stressful life events), social support, and individual resources (e.g. self-esteem) and experiences. Socio-economic factors, notably education, employment, income distribution and housing play also an important role. Mental health is more than an absence of symptoms of mental illness or distress. Mental health refers to a positive sense of well being and a belief in our own worth and the dignity and worth of others.

Positive mental health includes the capacity to perceive, comprehend and interpret our surroundings, to adapt to them and to change them if necessary, and to communicate with each other. Mental health also contributes to our ability to cope with and manage changes, transitions and life events: the birth of a child, unemployment, bereavement, or physical ill health. Mental health is mediated by the quality of interaction with others, societal structures and resources, and cultural values.

Mental ill-health is a broad term used to describe the range of mental health problems, from those with mild symptoms to the most severe mental disorders.
Mental health and well-being are issues of everyday life and should be of interest to every citizen and every employer, and to all care, education, and administration sectors. Mental health is influenced, enhanced, and jeopardized in families and schools, on the streets and in workplaces – where people can feel safe, respected, included, and able to participate or may be in fear, marginalized, and excluded. It is the result of, among other things, the way we are treated by others, and the way we treat other people and ourselves. Everyone has mental health needs, whether or not they have a diagnosis of mental illness. Mental health promotion is therefore relevant to everyone.

2.3. The global situation

2.3.1. Mental Health as a priority of WHO

WHO has had a strong focus on mental health for several decades, and has conducted a number of key studies and programs on mental health. There is a mental health division at WHO Headquarters in Geneva and there is also a mental health advisor in each of the WHO Regions supporting country development and organizing inter-country meetings and workshops.

In the late 1990s, WHO's Nations for Mental Health Campaign included an emphasis on mental health policy.

In 2001, WHO devoted both its annual health day and its annual health report to mental health, and called for countries to adopt clear mental health policies. This emphasis has subsequently been further developed into a major WHO project on mental health policy and legislation. As a result of the activities, in 2001 the Mental Health Global Action Programme (mhGAP) was created. The programme was based on four strategies that should help enhance the mental health of populations. The strategies were:

1. Increasing and improving information for decision-making and technology transfer to increase country capacity.
2. Raising awareness about mental disorders through education and advocacy for more respect of human rights and less stigma.
3. Assisting countries in designing policies and developing comprehensive and effective mental health services. The scarcity of resource forces their rational use.
4. Building local capacity for public mental health research in poor countries.

Mental Health Global Action Programme (mhGAP) was launched from 2008. The goal of this programme was to close the gap between what is urgently needed and what is available to reduce the burden of mental, neurological and substance use disorders worldwide.

Guideline Packages

During 2000s WHO published a mental health policy and service guidance package consisting of:

- The WHO mental health policy and plan checklists, and
- 14 interrelated modules, which are user-friendly modules to support policy development and service planning

Mental Health within the WHO/Eastern Mediterranean Region

WHO Regional Office for Eastern Mediterranean Region published in 2012 "Regional strategy on mental health and substance abuse" (http://www.emro.who.int/mental-health/publications/regional-office-publications.html). The aims of this strategy are to strengthen the integrated response of the health sector and other related sectors through the implementation of evidence-based and achievable plans for the promotion of mental health and the prevention, treatment and rehabilitation of mental, neurological and substance use disorders, with respect for human rights and social protection.
WHO Regional Office for Eastern Mediterranean Region published, in addition to the strategy, in 2010 "Maternal, child and adolescent mental health. Challenges and strategic directions for the Eastern Mediterranean Region". The starting point for this publication was that among the priority conditions identified for action in the MhGAP are child and adolescent mental disorders.


2.4. Projects by WHO in Libya

The first mental health project by WHO in Libya was a joint project by Ministry of Health and WHO called “Coping with the Emerging Mental Health and Psychosocial Support Needs in Misurata”. The objectives of the project were:

- Enhancing the access of population from Misurata to quality mental health and psychosocial services.
- Raising awareness of the public on mental health and psychosocial care.
- Having team of multidisciplinary professionals equipped with skills and knowledge for mental health and psychosocial interventions based on the international standard guidelines in the field.

WHO has recently produced a document, called “A Concept Note: Post Conflict Health Systems Assessment, Restoration & Development in Libya”. This document concentrates on looking at the health system’s situation in relation to the recent conflict. In effect, the paper is not only about fixing the damage of the conflict, but also of how the health system should be reorganized and how the Ministry of Health could find its right role in governance. The paper envisages three phases in the time sequence:

- **Phase I** (the most severe shortcomings would be dealt with) - the essential services would be put back to operation by solving problems with staff, premises and logistics.
- **Phase II** (in 1-3 years) - an interim general plan would be developed and health care delivery would be optimized.
- **Phase III** (3-5 years) - a comprehensive national strategic health sector development plan would be produced.

Belonging to this plan there is a Project Proposal in mental health for the next 12 to 18 months, which is piloted in south and west of Libya. The key objectives in this project are:

1. To develop an effective management system for mental health services,
2. To ensure the mental health and psychosocial service providers are equipped with the skills and knowledge needed to carry out their roles and applying evidence-based practices and a community based approach,
3. To increase availability of and accessibility to quality mental health and psychosocial services through community based approach,
4. Raising the awareness of the public towards mental health issues and empowerment of service users and care givers.

2.5. National Mental Health Policy in Libya
During the former regime there was no official mental health policy in Libya. The present government has prioritized mental health in health policy and as a first step an Interministerial Meeting was organized on 28th to 29th of April 2012 by Centre for Disease Control and WHO for setting the key strategic directions of mental health in Libya. Representatives from different ministries and governmental agencies participated the meeting and signed the document “National Consensus statement: Call for action for a multisectoral approach for mental health and psychosocial support in Libya”.

2.6. Objectives of this document

This document is meant to support forthcoming decisions of the Ministry of Health and can be used as a framework for the mental health policy and strategy in the future.

The Government of Libya, through supporting the implementation of this policy framework, aims to ensure prevention of mental ill health and disorders, promotion of mental wellbeing among population and provision of mental health services by:

- Delivering appropriate services for care, treatment, and rehabilitation, especially for patients with severe mental disorders and patients of all age groups suffering of psychological distress reactions after the conflict,
- Improving the health and social functioning of people with mental illness,
- Reducing the overall mortality of people with mental disorders,
- Reducing stigma,
- Protecting the human rights and dignity of people with mental illness,
- Preventing mental disorders,
- Developing the human resources for the above tasks.

2.7. The process of preparing the document

This document is the final product of the collaboration between Libyan, WHO and Finnish experts. The collaboration was implemented from Libyan side by the Ministry of Health (MOH) and the National Centre of Disease Control (NCDC) and from Finnish side by the National Institute of Welfare and Health (THL), and financed by the Ministry for Foreign Affairs of Finland. In addition to these authorities, WHO participated in and coordinated the process. The process had following steps:

1. Three visits by the Finnish experts in Libya: 9.4-18.4.2012 in Tripoli (expert team), 8.7-13.7.2012 in Tripoli (Dr Timo Tuori) and 11.8-16.8.2012 in Tripoli and Benghazi (Dr Timo Tuori).

2. The objectives of the missions were:
   - To collect relevant information and get as reliable understanding as possible concerning mental health in Libya,
   - Networking with the key experts and decision makers concerning mental health in Libya, other sectors like education, higher education and social affairs and local and international NGO’s. The list of the institutions and met are in Annex 1.

3. The proposal was finalized during Dr Timo Tuori’s third visit in August 2012. The proposal for the document was presented in the National Health Systems Conference in Tripoli on 27 of August 2012.

One of the main strategic approaches in this process has been the participatory approach, which means that both the Libyan and WHO experts were invited to give their recommendations for the document from the early beginning of the process.
3. Situation analysis of present mental health care

3.1. Governance and legislation

At the moment all the legislation in Libya is in a transitional phase. The legislation of the former regime is no longer valid and new legislation is not yet available.

Governance is centralized to the Ministry of Health. The regional and local governance is almost missing. On the national level there are mental health units/focal points both in MOH and in NCDC. The Ministry has a Mental Health Coordinator and NCDC has a Mental Health Department consisting of a multi-disciplinary team. The MOH has prioritized mental health as one of the key priorities at present and for the future.

3.2. Financing of Mental Health Services

Public mental health services are financed by the same way than all public health services: government budget of Libya. All public health services are free of charge for all citizens. The citizens are paying only in private services. There is no health insurance system in Libya.

3.3. Primary Health Care

The situation of primary health care in Libya is a problematic one. The facilities are existing, but the citizens don’t trust the PHC services and usually don’t use them, although access is free to all services. This means that patients usually select the specialised polyclinics of hospitals, not PHC centres or PHC polyclinics. In addition, the GPs have a minimal training in psychiatry and most of them are not interested in seeing psychiatric patients. This means that – at the moment – the role of the PHC is marginal in mental health care. The secondary care (hospital level) is more involved in mental health care than the primary care level.

3.4. Psychiatric specialist care

3.4.1. General

The volume of psychiatric services in Libya is minimal and the services are institutional based. The main facilities are two psychiatric hospitals, one in Tripoli and one in Benghazi. The number of psychiatric beds is in Tripoli 220 and in Benghazi 400, all together 620 psychiatric beds. This means about 0.01 psychiatric beds per 1,000 people. There are no psychiatric wards in general hospitals.

Tripoli Mental Hospital has 60 beds for acute patients, 120 for chronic patients and 40 beds for forensic psychiatric patients. The only beds for patients with addiction problems are in Benghazi. The number of long-stay patients in Benghazi Mental Hospital is about 80 - 90. Libya has no psychiatric beds for children or adolescents. Adolescents are treated, when needed, in the wards for adults. The physical conditions in the inpatient wards of mental hospitals may vary but they are, nevertheless, unsatisfactory. Usually too many patients share the same room without any privacy and the patients have hardly any personal space. The hygienic standard of the wards is often not satisfactory. The wards are under-staffed.

Both hospitals have their own outpatient clinics (OPD) in close vicinity with the wards. In addition to these OPDs, there is one outpatient clinic at Tripoli Central Hospital, which is mainly targeted for people with "minor" psychiatric disorders like depression, anxiety disorder and psychological distress after the conflict, and follow-up of chronic cases and cases discharged from hospitals.
Misurata has a Mental Health Centre, which is located in a previous primary care centre, which was taken over to be a Mental Health Centre. In Sabha there is an outpatient clinic run by a general practitioner and a multidisciplinary team. Benghazi also had an outpatient department in the General Hospital, but it has been closed. So all together, the number of outpatient clinics for adults in Libya is five, located in four cities.

Libya has neither day hospitals or day care centres or social clubs for people with mental health problems. Neither there are any supported housing or employment services for them. There are no rehabilitation services either.

Benghazi has one addiction unit as a separate department within the hospital premises.

The private sector is thin. In practice private sector means that some of the few psychiatrists have their private clinics, in addition to their public work.

3.4.2. Distribution of services and referral procedures

The psychiatric services in Libya are very unevenly distributed. This is true regarding both inpatient and outpatient psychiatric services. There are many, especially urban regions which don’t have any mental health services neither provided by specialized or PHC services. Most of the psychiatrists are working in bigger cities, Tripoli or Benghazi. This uneven distribution leads to existence of large hospitals in two areas, while in other parts of the country the provision of both inpatient and outpatient services is almost non-existing. There are no defined catchment areas for services, which means that patients can use any hospital or outpatient clinic they want across the country.

The Libyan mental health care system gives – in principle – the clients a freedom of choice. This means that the citizen may choose any service provider. Such a system could be adequate in terms of common mental disorders where people usually are in a position to actively seek help when needed. This, however, is not the case when considering severe mental illnesses when a proper referral system is usually needed, starting from primary level assessment and referral to and treatment in specialized care services. Establishing catchment areas for psychiatric care could help in ensuring the regional equality and the continuity of the care. The referral procedures are currently totally missing.

3.4.3. Mental health services for children and adolescents

Mental health services for children and adolescents are also almost missing. In Benghazi there is a child psychiatric outpatient clinic linked to paediatric unit in the General Hospital lead by the only child psychiatrist in Libya. In Tripoli there is an OPD for psychosocial support for children in a General Hospital established by a pediatrician. The OPD in Tripoli is however under a threat of closing. The adolescents are usually treated in the adult psychiatric services.

3.4.4. Mental health services for elderly people

There are no special services for elderly people and it seems that there is neither any awareness programmes that focus on the special mental health needs of the elderly people.
3.5. Treatment practices

At present, the quality of treatment practices is on high level regarding biological treatment methods, mainly drug treatment. Unfortunately the drugs are not always available and a major problem is that the GPs are not allowed to prescribe psychotropic medicines. The so-called comprehensive need-adapted and integrated treatment is not developed, and not used in everyday clinical work.

The lack of continuity of care seems to be a major problem in the Libyan mental health care. One of the main reasons for this is certainly the existing administrative discontinuity. Another reason is the scarcity of resources and the lack of proper after-care system after hospital discharge. Also the missing referral procedures are a big problem.

Team work approach is clearly an area where there is need for development in the Libyan mental health service system. A mental health team should usually consist at least of the following professionals: psychiatrist, psychiatric nurses, psychologists and social workers. For working effectively and successfully continuous collaboration and support to each other is needed from all team members.

3.6. Psychosocial rehabilitation

There is a lack of psychosocial rehabilitation activities and models in the Libyan institutional care. A system to outreach people with severe mental illness living at home and for home-based rehabilitation is also lacking.

3.7. Inter-sectoral liaison

There is usually no systematic inter-sectoral liaison either on horizontal or vertical level. The liaison is missing or not regular with social affairs, police, prisons, schools, higher education etc. usually at every level: national, regional, and local. There are no joint work programmes, joint agreements or trainings for key partners from other sectors, although in few regions there are informal joint agreements on local level between the mental health services, police departments, and the court, regarding implementation of the emergency and obligatory treatment procedures. Specifically, there is a lack of mental health training for police, prison staff and teachers.

3.8. Human resources

The very small number of mental health professionals is one of the major problems in mental health care. Second problem is that the training for them in mental health is inadequate. Third problem is that almost all of them are working in two mental hospitals and very few are working in outpatient clinics. Fourth problem is the very uneven distribution of mental health professionals. Almost all of them are working in Tripoli and Benghazi and some in Misurata.

In general, it is difficult to give exact information about human resources for several reasons. There are no national statistics on human resources. The human resources situation is different in Tripoli and in Benghazi and especially in other regions of Libya. Also the undergraduate curricula for mental health professionals in mental health vary in different universities.

Psychiatrists

The number of senior psychiatrists in 2012 was 12 and the number of junior psychiatrists, who are specializing in psychiatry, is about 20. This figure is very low. The distribution of psychiatrists is
mostly on inpatient sector. Some of the psychiatrists working in inpatient facilities have also private practices.

The curriculum for doctors specializing in psychiatry is actually non-existing. The clinical experiences during the specialization period seems to be insufficient, because the specialization is taking place only in institutional treatment level and not at all in community based treatment level.

The number of medical students to be graduated quite soon is high, which means that in the future there might be overproduction of medical doctors in Libya. This might probably help to solve the huge shortage of psychiatrists.

Nurses

The exact number of nurses working in mental health care is unknown, but it's clear that it is low and there are no nurses specialized in psychiatry.

Nurses presently working in psychiatric settings have low status and often lack generic skills to empower them to function in a multidisciplinary team.

Psychologists

The number of psychologists working in the mental health sector is unclear, but it is estimated to be about 50. Also, their roles within the mental health care are varying. Some of them are doing psychological test and practicing also psychotherapy. Many of them have recently got training in psychological first aid (PFA). The theory and skills in clinical psychology are not included in the undergraduate curriculum in all universities.

Social workers

The number of social workers working in mental health care is unknown, but it is estimated to be about 35-40. They usually do not have special training in mental health except training in PFA, which many of them have got recently. Social workers are working mostly in psychiatric institutions. Their job description is mostly connected on taking the family history when patient is coming to the hospital and organizing the transfer home, usually with collaboration with the family when the patient is discharged from hospital. The undergraduate curriculum does not usually include mental health.

Occupational therapists

There are no occupational therapists in Libya.

3.9. Mental Health Promotion and Prevention of Mental Disorders

There are many special training activities implemented by international organizations during the transition phase focused on helping people with psychological distress syndromes caused by the policy of the former regime and the armed conflict. Currently, these consist the major prevention activities for mental health disorders. During May 2012 WHO has implemented training for programme managers on Inter Agency Standing Committee guidelines for mental health and psychosocial support in emergencies, in addition to training of trainers on mhGAP guide for mental health in non-specialized settings.

In addition to this, there are some mental health promotion and prevention activities in Libya implemented especially by the international non-governmental organizations (NGOs), but a systematic and planned approach is missing.
3.10. Mental Health NGOs

There are many international NGOs working in Libya, but there are also local NGOs, especially in east Libya. For example, international NGOs such as International Medical Corps are giving professional training for social workers so that they can be more skillful in helping people in this transitional phase.

3.11. Future challenges and priorities in Libyan mental health care

From the point of view of the public health, the common mental health disorders – depression, anxiety disorders, drug addiction problems etc. – are of tremendous importance. There is evidence from research that the prevalence of all these disorders will increase after armed conflict. That is why there is an urgent need to rapidly develop Libyan mental health care services.

The Government of Libya (Ministry of Health) should, as the next step, prioritize the treatment and prevention of severe mental health disorders as well as disorders followed by the armed conflict. Special focus should be given to the risk groups.

Planning of activities for improving the treatment and prevention of these disorders should start immediately and the activities should start as soon as possible. In the treatment of these mental disorders psychiatric and the primary and secondary care and the liaison between these are very important. This means improved training in undergraduate education for physicians and nurses, in specialization to psychiatry and general medicine, and postgraduate courses for professionals working in primary and secondary care.

4. Conclusions and main recommendations

4.1. Legislation, funding and governance

In general, legislation, funding and governance should follow the decisions to be made in coming years regarding the whole health care system.

Regarding legislation mental health issues should be recognised in every level of coming legislation in Libya. International experiences are indicating that that a separate Mental Health Act often serves better the development of mental health care in the country than a chapter in general health law.

Funding of mental health services should follow the funding of all health services. However, because of the huge shortage of human resources, it would be wise to consider some economical incentives for recruiting mental health professionals. The next Parliaments and Governments must decide, what will be roles of state budget funds, insurance and out-of-pocket payments in the funding of health services, including the mental health services.

The governance of the mental health services should follow the governance of all services. When mental health is prioritized it should have its own department/unit with a multidisciplinary team at the Ministry of Health, taking a real leadership and considering the interests of the whole country when improving the services. The Mental Health Department at the NCDC should continue and its role in the national development of mental health care and services should be defined clearly. The
MOH, NCDC and all the regions should form a joint mental health committee with a clear terms of reference and responsibilities.

The crucial questions are: what will be the level of decentralisation of health services in Libya? How many regions are needed and what will be the minimum size of the region? How independent the regions will be concerning the funding and decision making? What will be the role of municipalities?

Without basic research of mental health care and services, including epidemiological research, good governance is difficult. That is why it is crucial to build up adequate research capacity also in mental health and psychiatry.

4.2. Developing a model for optimal organization of integrated mental health services

The objective is to develop a model for optimal organisation of the Libyan mental health services on the basis of the present situation analysis and international experiences and guidelines, especially in WHO Eastern Mediterranean Region.

Special attention will be paid to:
1. Client pathways in the system,
2. Inter-institutional collaboration in order to integrate mental health services,
3. System management and administrative framework of the mental health services system,
4. Regulations relevant to the capacity building of the management of mental health services system.

The topics to be included in the model for organising Libyan mental health care, in addition to institutional, intermediate and outpatient mental health services, will be:
- The role of government and the municipalities in providing community based services,
- The decentralisation issues in general,
- The specifics in catchment areas,
- The role of the primary health care in mental health care,
- The child and adolescent mental health services,
- The role of the NGOs in integrated mental health services,
- The voice of the patients and relatives.

The international frameworks for integrated mental health services are in Annex 2

4.3. Optimal mental health services pyramid

Based on the revised version (WHO 2007) the optimal mix of the mental health services pyramid will be realised when the mental health services are integrated with the general health care system and coordinated with other sectors' community services. Another main feature is that the community level mental health services are organised in accordance with the multi-sectorial collaboration with formal and informal stakeholders and by involving service-users and their families.

The following figure describes schematically the expected future structure for the service system based on the concept of the optimal mix of services as defined by WHO experts:
The key messages of the above pyramid model are (from bottom up):

- The informal care and support in the community, advocacy and self-care have high frequency of need and can be provided at relatively low costs. The idea is based on all available resources in local communities. People with mental illness need support to create friendships, social networks and to participate in different meaningful activities in the community. The fact is that family members, friends and relatives are taking care of major part of the daily care and support for psychiatric patients.

- Primary health care should be seen as major setting for the medical care of the most common mental disorders, like depression, anxiety and substance abuse problems. In Libya the primary health care is based today mainly on the work and services of the family doctors.

- In the integrated structure of the mental health services a special set of supporting activities for persons with mental illness are needed, e.g. day hospital services, day care centres and clubhouse type of services. Supporting housing, sheltered work and supported employment and transitional work in the open labour market are important.
Proposal for Mental Health Policy Framework in Libya

August 2012

- According to the pyramid framework, the specialized psychiatric outpatient care should be concentrated either in the Community Mental Health Centres (CMHCs) or in the psychiatric units of the General Hospitals. These units and CMHCs should work in close collaboration with other mental health professionals at different levels, as well as to organise collaboration with other sectors and informal groups and voluntary organisations.

- Psychiatric inpatient care should be organised in psychiatric and general hospitals. Both hospitals should offer consultation and advisory services for other medical specialities and for family doctors.

- According to the WHO pyramid framework, it should be kept in mind that psychiatric hospitals present the highest costs in the mental health field, but they are least frequently needed as compared to the whole panorama of mental health service system.

- Finally, the close collaboration and consultation relationships should be created across the different “floors” of the pyramid, as well as across organisational boundaries between different service fields at local community and regional county levels.

The key message of the WHO optimal Pyramid model is that psychiatric hospitals and specialist services present the highest cost, and yet they are least frequently needed services of the mental health pyramid. The informal community services, advocacy and self-care, on the contrary, have high frequency of need and can be provided at a relatively low cost.

As the Pyramid model illustrates the majority of mental health care can be self managed or managed by informal community mental health services, e.g. by community groups, peer support, voluntary associations and NGOs of people with mental illness and their families. When additional expertise and support is needed a more formalised network of services is required. In ascending order these include primary services like family doctors and school nurses and psychologists, followed by specialist community mental health centres (CMHCs) and psychiatric services in general hospitals, and lastly by specialist and long stay mental hospital services.

The WHO recommends that countries:

- Promote and organise self care;
- Build informal community mental health services;
- Integrate mental health services into primary health services (e.g. family doctors’ services in Libya);
- Build community mental health centres and other community services;
- Develop mental health services in general hospitals; and
- Limit the use of traditional mental hospitals.

**Self Care Management**

As far as possible persons with mental disorder should limit contacts with situations likely to negatively affect their mental health, develop skills to manage stress, ability to discuss and manage emotional problems as they arise, knowing when to seek help and who to seek help from. One field of good practice in many countries is the psycho-education to teach persons how to manage hearing voices and other symptoms, how to manage medication, how to participate in local activities, when to ask help or support from family members and/or friends etc. In addition, service users should be activated to join self-help groups and peer support teams to strengthen their self-respect and self-determination.
In Libya attention is needed to:

- Organise peer support groups and psycho-education activities;
- Empower family members with skills to support the service user;
- Allocate government’s economic support for creating self-help groups and the voluntary associations of and for people with mental health problems.

**Timetable:** These activities should be started immediately; the main timeframe for developing these could be the years 2015-2020.

The main authorities responsible are the Ministry of Health, National Center for Disease Control, regional and especially local authorities and both local and international NGOs.

**Informal Community Services**

Informal community mental health and other services are services provided in the community but that are not part of the formal health system. The idea is based on using all available resources in local community. People with mental illness need activation to create circles of friends and to participate in activities of the NGOs and using other possibilities for local daily activities.

In the informal communities the formal mental health resources can be complemented by cooperating with local teachers, police, employment officers, employers, social workers, health workers, education and training experts, cultural centres, NGOs, user and family associations, lay persons etc. Informal activities are usually accessible and acceptable to the community as they are an integral part of the community.

Advocacy is considered to be one of the key areas for action in any successful mental health policy because of the benefits that it produces for people with mental disorders and their families. The intensive mental health advocacy helps to promote the human rights of persons with mental disorders and to reduce stigma and discrimination in local communities and in the society in general.

The advocacy actions to promote the development of mental health services contain, among other things, e.g. awareness-raising and information about mental illnesses, education and training activities on understanding the nature of being mentally ill and real possibilities for recovery, mutual help between service users, counselling and mediating help, and defending human rights of persons with mental disorder, as well as denouncing defects and bad practices of the prevailing services.

The emergence of mental health advocacy movements in several countries has helped to change society's perceptions of persons with mental disorders. Service users have begun to articulate their own visions of the services they need. They are increasingly able to make informed decisions about treatment and other matters in their daily lives.

Voluntary and non-governmental associations are able to fulfil many of the advocacy activities described above. That is why the Libyan community level mental health service system should include the advocacy promotion activity as integral part of the Community Mental Health Centres.

Attention is needed to:

- Strengthen the cross-sectorial collaboration at national, regional, community and local levels between mental health professionals and other service agencies (e.g. employment, social welfare, adult education, police and courts, vocational training);
Use the local community housing services, recreational, cultural and other activities to support the individual recovery and empowerment; and

In all CMHCs employ either a community nurse or social worker for organising the advocacy work at the sub-regional and local levels.

**Timetable:** These activities should be started immediately; the main timeframe for developing these could be the years 2015-2025.

The main authorities responsible are the Ministry of Health, Ministry of Social Affairs, Ministry of Employment, Ministry of Higher Education, Ministry of Interior, the same authorities both in regional and local level, the CMHCs and both local and international NGOs.

### Mental Health Services through Primary Care GPs/Family Doctors

This is the primary level of mental health services and includes early identification of mental disorders, management of stable psychiatric patients, referral to other levels when required, as well as promotional and prevention activities. Services are carried out by general practitioners, nurses or other staff depending on who the first level staffs are.

Seeking and receiving treatment as part of a general health services is less stigmatizing for an individual with mental disorder. International experience has shown that most of the common mental disorders can be treated with success at primary care level.

**Attention is needed to:**

- Start training programme of GPs/family doctors (by using the training material produced in other Northern African countries and possibly adapting or translating internationally standardized training toolkits);
- The community mental health centres should have the responsibility in their catchment areas for supporting GPs/family doctors' learning to treat most frequent mental disorders;
- Define the division of responsibilities between CMHCs, GPs/family doctors, secondary care and the private offices of psychiatrists to avoid overlapping use of resources.

**Timetable:** These activities should be started immediately; the main timeframe for developing these could be the years 2013-2020.

The main authorities responsible are the Ministry of Health, National Center for Disease Control, regional and local authorities

### Formal Community Mental Health Services

The formal community mental health services are consisting of the network of Community Mental Health Centres. The Centres are responsible for e.g. psychiatric ambulatory services, mobile assistance services, day psychiatric services, individual and group therapy and special rehabilitation, crisis intervention and home care services.

Other formal community services can include mental health day centres, community based rehabilitation and development, case management, residential services and working possibilities either in the sheltered work centres or transitional employment in enterprises or supported employment in normal workplaces. Part of these can be organised as part of informal or formal community services under some other sectorial agencies. For example, some special courses for service users to strengthen their self-management symptoms, to develop their computer skills and other working abilities can be organised in cooperation with local adult education institutes as has been done in many other countries.
Many service users need empowering training in skills for independent living in community. They also need to take part in different kinds of occupational, vocational training, sheltered work and employment initiatives. Supported employment, social cooperatives and clubhouses (look e.g. www.fountainhouse.org) are examples of the evidence-based formal re-integration activities. In many European countries these units are established in inter-organisational collaboration.

In countries where mental health services are shifted from psychiatric hospitals to community level organisations, mental health professionals have taken a more active role in protecting service users' rights and raising awareness for improving services. The similar advocacy tasks should be part of the clinical work, as well as support to users' participation in the voluntary associations, or in case these are not available, to encourage users and families to create new NGOs of and for people with mental disorders.

Attention is needed to:

- Ensure gradually the increasing amount of resources for the estimated about 50 CMHCs in 2025 in the whole country for about 50 catchment areas with a population of about 100,000 citizens for each catchment area;
- Promote advocacy activities in the catchment areas of all CMHCs and hire the needed human resources for this work;
- Develop psychosocial and vocational rehabilitation and social re-integration services including sheltered housing services, as well as the (part-time) employment opportunities;
- Study the opportunities to open social cooperatives and clubhouses which can support the development of integrated pathways to a more independent living and social inclusion in local communities.

Timetable for establishing the CMHCs: five at the end of year 2013, ten at the end of 2015, twenty at 2020 and fifty at 2025. The psychosocial rehabilitation services should be started in small volume year 2013 in the psychiatric hospitals and during the years 2015-2020 in CMHCs. The day care activities should be started in some region in 2013, but the main timeframe for establishing these services should be the years 2015-2025. The model for developing the rehabilitation and day care services could be piloting these services in some regions.

The main authorities responsible are Ministry of Health, Ministry of Social Affairs, Ministry of Employment, and especially the same authorities both in regional and local level and the National Center for Disease Control.

Psychiatric Services Integrated in the General Hospitals

Mental health services at general hospitals are consisting of acute inpatient care, crisis stabilisation, consultation liaison services etc. The development of mental health services in general hospital settings is a critical element of any optimal organisation of mental health services. New psychiatric wards should be established in general hospitals, not in separate psychiatric hospitals.

Integration of mental health services in the general hospitals has many positive impacts, e.g. the stigma experienced by users decreases, patients get better somatic services and psychiatry becomes equal with other specialties and consultations are easy to organise in the same hospital with colleagues.

Attention is needed to:

- Start the investment programme for renovating and modernising the facilities for psychiatric units and departments in general hospitals;
- Ensure the qualified staff and other resources for these units and departments;
Collect comparative follow-up information and statistics region-by-region to build up knowledge based administration and steering system.

**Timetable** for establishing psychiatric wards in general hospitals: during the years 2013-2015 there should be three psychiatric wards in general hospitals, during the years 2015-2025 all the big general hospitals in Libya should have at least one psychiatric ward.

The main authorities responsible are the Ministry of Health, the National Center for Disease Control and especially the regional and local health authorities.

**Psychiatric Hospitals and Specialist Services**

Based on WHO’s recommendations the volume of asylum care in mental hospitals should be minimised. Specialist services should be available in the CMHCs. The major part of all psychiatric resources should be available at the community level mental health services and in general hospitals.

For the future the two specialised psychiatric units; the Tripoli and Benghazi psychiatric hospitals can be seen as resource centres for supporting the development of community based CMHCs and mental health wards and outpatient departments in general hospitals.

However, modernisation and renovation of the facilities of the psychiatric hospitals should be continued to guarantee the enforcement of international standards and acceptable conditions in the hospital wards.

The special wards: the ward for forensic psychiatric patients in Tripoli Mental Hospital and the unit for patients with drug addiction problems should be preserved and developed.

**Psychiatric Services for Children and Adolescents**

The psychiatric care and psychosocial support for children should be one of the priorities for many reasons:

1. The high prevalence of disturbances in general and especially after the conflict, where the children are one of the biggest risk groups;
2. The suffering of the children and their families;
3. Availability of good best practices;

The services for children should be community and outpatient based. The whole country should have two to four community based child psychiatric centers located in big cities. When inpatient treatment is needed it should be separate from adult inpatient treatment in child psychiatric wards in general hospitals, not in mental hospitals. The number of child psychiatric wards could be two to three in year 2025. Intersectoral collaboration is extremely important in child psychiatric services.

When developing the adolescent psychiatric services the special needs of the adolescents should be taken into the consideration. It needs to be decided if adolescent services will be part of the adult or child psychiatric services or should the adolescent psychiatry be an independent subspecialty.

**Timetable** for developing child psychiatric services: the next outpatient based child psychiatric center should be established before year 2015 and after that the next before year 2020. The first child psychiatric ward in general hospital should be established before year 2015.
The main authorities responsible are the Ministry of Health, the National Center for Disease Control and especially the regional and local health authorities.

**Psychiatric Services for Elderly People**

Mental health disorders are also common with the elderly people. This is especially true concerning depression, which is predicted to be increasing during the coming years. The syndromes of depression in the elderly can be very different from the syndromes of depression in younger persons. Dementia will be another increasing disorder and problem with the elderly people. There must be special skills in diagnosing and treating the psychiatric problems of the elderly. It needs to be decided if the elderly people are treated in the general health and mental health services or should they also have their own community based mental health services.

**Psychiatric Services for Ex-combatants**

Mental well-being of the ex-combatants (total number is about 400,000) is and will be – during the coming years – a big problem. An assessment of the mental health situation and the needs of the ex-combatants should be done, for example by a survey, and the needed services should be planned on the basis of this. It needs to be decided should the services be offered through the general services or as separate services. The present services for ex-combatants should continue and be widened. The general mental health service providers should be aware of the special needs of ex-combatants. This is true even if the ex-combatants should have separate services.

**Psychiatric Services for Immigrants**

Libya has more than 1,000,000 immigrants and the number will possibly still increase. Many immigrants might have experienced traumatic circumstances in their native country, including extreme poverty, human trafficking, exposure to war, and natural disasters. Exposure to traumatic conditions, coupled with difficulties in acculturation, can lead to severe and long-lasting psychological and behavioral problems, including depression, anxiety, posttraumatic stress disorder, and a risk for suicide. This is why it is important to decide how the mental health care of the immigrants will be taking care of. The ideal model could be that the immigrants have the same right to use all the mental health services than Libyan citizens.

**Psychiatric Services in Prisons**

The prevalence of psychiatric disorders among the prisoners is higher than among the general population. Therefore it is important to decide how the mental health care of the prisoner will be taking care of. One possibility is to establish a psychiatric ward in one of the prisons.

4.4. Treatment practices

In general level, the so-called comprehensive need-adapted and integrated treatment is recommended to be used in everyday clinical practice. The main elements in the need-adapted treatment are:

1. Therapeutic activities are planned and carried out flexibly and individually in each case, so that they meet the real, changing needs of the patients, as well as the people close to the patient (most often family).
2. Examination and treatment are dominated by a psychotherapeutic attitude.
3. The different therapeutic activities should be seen as complementary to each other instead of an either/or approach.
4. The treatment should attain and maintain the quality of a continuing process.
5. Follow-up is important both at the level of individual patients and at a more global level, directed to the development of treating units, and the treatment system as a whole.

The guiding principles in developing integrated mental health services should be the following: The treatment mix available should be comprehensive and of high quality, providing evidence-based treatment to persons in need. Psychotherapy or at least psychotherapeutic approach and other psycho-social interventions should be an essential part of that mix. Systematic psychotherapy training for professionals working within the mental health services should be established. Additionally, all members of the personnel treating patients should have access to appropriate supervision provided/purchased by the employer. Also crucial elements of the integrated care are the following:

- Patients' voice should be heard in all planning and development of the mental health care system including its financing.
- Meetings along the principles of therapeutic community (including both staff and patients) should be organized on regular basis.
- Significant others, especially the family, should be included in the treatment. A joint meeting with the family and the patient should always be organized, especially concerning persons with a first episode of psychotic disorder.

Particular attention must be paid to ensure the continuity of care and that nobody will fall in any gap between the services. This requires good co-operation between different service providers. A good way to ensure the continuity of care would be to divide the country into responsible catchment areas for mental health care. All catchment areas would provide a broad range of different specialty mental health services (from mental health promotion to psycho-social rehabilitation), preferably under a common administration. Another clear requirement is to ensure continuous financing of treatment for those patients who need long-term care.

A covering network of community based nurses with good psychiatric training to take care of the long-term patients living in the community (case management) should be established. Their special task would be to act as supporter and coach for certain number of chronically ill patients living in the community. They have to make home visits and to make sure that the patient gets all the services which are needed and available. It is important to ensure that these persons are connected to the main psychiatric treatment unit in that region (Community Mental Health Centre) to ensure that they have enough support from colleagues.

Team work approach is clearly an area where there is still need for development in the Libyan mental health service system. A psychiatric team should usually consist at least of the following professionals: psychiatrist, psychiatric nurses, psychologists and social workers. For working effectively and successfully continuous collaboration and support to each other is needed from all team members.

In many countries multidisciplinary mobile teams have been established to support the community based care of severely mentally ill patients. The required activities can include for example:

- Assertive outpatient care,
- Rapid intervention in psychotic crises,
- Home visits,
- Family support.

In the realm of psychiatric care, the main tool that professionals have is to use their own personality. In order to maintain this tool as fit to the serve the job as required, supervision is needed. It allows professionals to have the possibility to examine their own feelings and solutions in a trustful atmosphere with an outside expert (supervisor). This is especially needed and useful.
when working with severely ill patients. An adequate group or individual supervision should be available to all members of the treatment staff.

In order for establishing a real integrated community based mental health service system, a stepwise rehabilitation model should be considered seriously in Libya. The stepwise rehabilitation model is presented in Annex 2.

**Timetable:** These activities should be started immediately but gradually; the main timeframe for improving these could be the years 2013-2020 but still continuing 2020-2025.

The main authorities responsible are the Ministry of Health, National Center for Disease Control, regional and local authorities.

### 4.5. Mental health information system

#### 4.5.1. Introduction

A well-functioning, comprehensive mental health information system must fulfill several purposes. Information system is needed:

- To support the care of individual patient,
- To assess quality of care,
- For service evaluation:
  - evaluation of structures,
  - evaluation of processes,
  - evaluation of outcomes.
- To estimate population needs,
- To support planning and development,
- For mental health services research.

There are different needs at different levels of the health system:

- Patient level,
- Care unit level,
- Regional/Catchment area level,
- Country/national level.

#### 4.5.2. Patient and care unit level

Adequate case-note system is first of all serving the treatment and care of the patient. On the other hand, the basis for any relevant and reliable mental health information system lies in the adequate patient record keeping. The whole system cannot be more reliable than is the data in patient records.

An old-fashioned and insufficient patient book keeping system is still in use in Libya in all psychiatric facilities.

Additionally, at the care unit level there is need for statistics on patient flows, outcomes and costs, serving management and planning of the activities of the unit. Actually, this kind of information is seen as a very important tool for the administration and as a relevant feedback to the staff responsible for the treatment of patients. Therefore, it is important that within the Libyan mental health services, the analysis of statistical information on their own functions is should be started soon.
The best solution would be an electronic patient record system that should gradually be taken into use in all mental health care units collecting patient data on-line on a continuous basis in all mental hospitals, psychiatric outpatient units, and day care centre's in the future. To be useful and practical, a minimum set of common items to be included in the patient records of all relevant care units should be agreed on. These should be adapted to the needs of the Libyan context. They also should be unanimously and clearly defined to ensure the comparability of the data.

The implementation of this kind of new system requires:

- That all stakeholders and actors are included (also the patients) and take part in its development;
- A binding decision by the Ministry of Health to take the system in use;
- Clear guidelines for its implementation and use;
- Systematic training for all mental health care providers;
- Building up a useful and feasible system to analyze and report the collected Information (feedback to the care providers).

4.5.3. Regional level

The information system at this level should provide statistics serving management, financing, resource allocation, planning and co-ordination in that region or catchment area.

4.5.4. National mental health statistics

This system is needed for national mental health monitoring, national quality assurance, as well as for developing national mental health policy and strategies.

- National mental health statistics should be part of the general national health statistics.
- The appropriate institution for national health statistics and registers could be NCDC.

The future mental health information database should be as far as possible individually identifiable. This requirement concerns especially those most seriously mentally ill (the so-called patients with specific needs). This would greatly enhance the possibility to monitor that their needs are adequately met. Data protection regulations should be strictly followed in running such a register. All mental health service providers should be included in one single information system gathered by the NCDC. If all mental health care information is collected by the same governmental administration it would certainly enhance fulfillment of this requirement.

4.6. Human rights framework

Human right issues are of specific importance in psychiatric care and especially in institutional psychiatric care where it's possible to restrict the personal freedom of patients and also use seclusion or restriction belts. There must be clear guidelines how to take care of the human rights of the psychiatric patients. The Ministry of Health should establish a system of regular human rights inspections of all mental health inpatient facilities according to the recommendations of WHO Regional office in the "Regional strategy on mental health and substance abuse" published 2012.

The guidelines on human rights issues in psychiatric care, prepared by the Committee of Ministers of the Council of Europe, are presented in Annex 4.
4.7. Inter-institutional collaboration at different levels

The integrated organisational system is recommended to be the basis of the future Libyan optimal model for mental health services, as described above. In comprehensive integrated systems the inter-institutional collaboration, inter-agency cooperation and involvement of major stakeholders – users and families included – can be the sources of added value for the benefit of service users and create ideas for further development of services. The real challenge for the managers and leaders at all levels is to getting these possibilities realised. The capacity-building training programme should be continued and targeted at all categories of staff throughout the administrative structures and sectors.

National level

In order to implement really the inter-institutional collaboration the future legislation could list the Ministries and other central government agencies, which in principle are taking part in the implementation of the law at national level. According to the discussions with experts the collaboration between the Ministries and agencies needs urgent attention. As part of the optimal model for organising mental health services, a national inter-ministerial coordination body should be established as soon as possible.

In addition, at national level there are several mental health policy and legislation areas which require “bi- or trilateral” collaboration between Ministries, e.g. Ministry of Health, Ministry of Justice and Ministry of Interior, Ministry of Social Affairs, and Ministry of Employment, as well as between Ministry of Health, Ministry of Education and the Ministry of Higher Education. Also the national NGOs in mental health field and other interest organisations, such as social partners, should be involved in the national dialogue on priorities and enforcement of mental health policy.

Without intensified collaboration practices at national level between all relevant stakeholders it is hardly possible to get enough resources to be allocated for mental health field, needed to realise the national mental health action plan during the ongoing decade.

Some examples of mental health topics for different Ministries:
- Ministry of Social Affairs
  - in developing the social benefit system in future in Libya people with mental disorders should be noticed,
  - the psychosocial support for ex-combatants.
- Ministry of Education
  - supporting the mental well-being of the pupils by teachers, school doctors and nurses and social workers
- Ministry of Higher Education
  - updating the curricula of mental health professionals and health professional, in addition to other relevant professionals
- Ministry of Employment
  - supported employment for people with mental disorders
- Ministry of Justice
  - mental health in prisons
  - human rights and mental health legislation
- Ministry of Defence
  - mental health of draftees'

Regional catchment area level
The same activities than implemented on national level should be implemented also on regional and local levels.

4.8. Strengthening the roles of regions and municipalities

For a couple of decades an international trend has been to decentralise and delegate responsibilities from central administration to the regional, county and municipal levels. However, in many countries experts have noted that too small municipal entities or cities are not able to manage "too heavy" load of responsibilities.

This is the reason why in some countries municipalities are merged into larger and economically stronger entities. Also at the regional level similar mergers are the reality in order to create more sustainable regional administration.

In relation to the future optimal organisation of the mental health services the counties and municipalities should have more responsibilities for their contributions in organising and partly financing the mental health activities. In any case, it is important to strengthen the cross-sectorial collaboration at regional, municipal and community levels between mental health units and other service agencies (e.g. employment, social welfare, housing, adult education, cultural, police and courts, vocational training etc.).

In addition, all CMHCs should hire either a community nurse or social worker for organising the advocacy work at county, municipal and community levels. The idea is to use all available resources in local communities to support the recovery of persons with mental disorders.

4.9. Involvement of users, families and voluntary NGOs

Integration of services is understood to be a range of approaches for achieving greater coordination and effectiveness between different services in order to achieve improved outcomes for service users, for example, by coordinating different services the user needs parallel or consecutively. The coordinating worker is e.g. authorised and qualified case manager, personal advisor, community nurse or social worker.

Community based psychosocial rehabilitation (CBR) is a strategy within general community development for the rehabilitation, equalization of opportunities and social inclusion of all people with disabilities, including people with mental disorders. In Libya the integrated mental health services are recommended to follow the principles of the CBR.

The principles are implemented through the combined efforts of people with mental illness themselves, their families, organisations and communities, and the relevant governmental and non-governmental health and mental health organisations and agencies working together with the regional and local education, housing, vocational and employment, as well as, with social, cultural and other community services.

In countries where mental health services are shifted from psychiatric hospitals to community level organisations, mental health professionals have taken a more active role in protecting service users' rights and raising awareness for improving services. The similar advocacy tasks should be part of the clinical work, as well as support to users' participation in the voluntary associations or, in the case these are not available, to encourage users and families to create new NGOs of and for people with mental disorders.
In ideal cases, the role of users, families and their voluntary associations are developing in the optimal service organisations towards "a co-producer's position" in the community service networks or in integrated service pathways.

4.10. Human Resources

4.10.1. General

The most urgent needs in improving the Libyan mental health service system are increasing rapidly the volume and also quality of all professions. In order to be successful in this all the possible activities should be considered for example:

- Developing a comprehensive, national training and recruitment plan for mental health professional for Libya,
- Recruiting professionals from expatriates and from Arabic-speaking countries. In this case the volumes are small and this can't be a sustainable solution,
- Using incentives in recruiting the employees,
- Improving the undergraduate curricula for all professions working in mental health care,
- Implementing postgraduate training with an accredited certificate/diploma or recognition from clinical board for all professionals working in mental health care,
- Improving the specialization processes for all professions working in mental health care.
- Recruiting professionals by giving them training abroad, avoiding, however, as much as possible the brain-drain of trained professionals from Libya to other countries.

The number of professionals in the basic unit in the future, the Community Mental Health Center, for population 100,000, should be in 2025 the following:

- Two to three senior psychiatrists and one junior psychiatrist,
- Four to six clinical psychologists,
- Six to eight (psychiatric) nurses,
- Two to three social workers,
- One occupational therapists.

Timetable: These activities should be started immediately but gradually; the main timeframe for improving these could be the years 2013-2020 but still continuing 2020-2025.

The mainly responsible authorities for increasing the volume of mental health professionals in Libya are the Ministries of Health and Higher Education, National Center for Disease Control, Universities and Secondary grade training units.

4.10.2. General Practitioners

In the future in long term, the general practitioners should play a central role:

- In treating common mental illnesses,
- In referring severely mentally ill patients to special psychiatric care, and
- In follow-up treatment of severely mentally ill patients in their stabilized periods

To be able to fulfill these tasks the following is required:

- Improve the undergraduate curriculum in psychiatry,
- Extend psychiatric training in the specialization in general medicine,
- Organize postgraduate courses with diploma for the general practitioners,
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August 2012

- Build a well organized system for psychiatric consultation including possibilities to participate in a Balint or similar group.

Timetable: in year 2015 30 GPs have a diploma from a psychiatric postgraduate course, in year 2020 the number is 100 and in year 2025 150.

The main authorities responsible are the Ministries of Health and Higher Education, National Center for Disease Control.

4.10.3. Psychiatrists

The curriculum for doctors specializing in psychiatry should be developed. The clinical experiences during the specialization period should be shifted from institutions also to outpatient and community based facilities. During specialization period it would be useful to address also specifically to the topics related to:

- Psychosocial rehabilitation,
- Delivering services to a defined population,
- Liaison with primary care,
- Detailed multi-axial assessment,
- Care planning,
- Routine clinical audit.

Psychiatrists are the core professionals in community based mental health care and they will work as leaders in working teams in different mental health facilities. There is a huge shortage of psychiatrists in Libya. The number of psychiatrists and the appreciation of psychiatry as a specialty should be increased. The salaries and other incentives should be at least equal or better ones compared to the doctors in other medical specialties. The psychiatrists working in community based mental health care should have an opportunity for regular supervision paid by the employer. This is especially important for doctors during their specialization period in psychiatry.

Child psychiatry should be a subspecialty of psychiatry and the training of the child psychiatrists should be started before the year 2020. Before that, specialization training abroad should be supported, avoiding, as much as possible, the immigration of trained specialists from Libya to other countries.

Timetable for increasing the number of psychiatrists: In year 2015 the number of psychiatrists should be 50 and the number of child psychiatrists should be from one to two. In year 2020 the number of psychiatrists should be 100 and the number of child psychiatrists should be from five to ten. In year 2025 the number of psychiatrists should be 200-300 and the number of child psychiatrists should be about 20.

The main authorities responsible are the Ministries of Health and Higher Education, National Center for Disease Control.

4.10.4. Other medical specialists

All other medical specialists should be able to diagnose psychiatric diseases and provide the required treatment themselves or, if appropriate, to refer the patient for further psychiatric treatment. The specialists for example in neurology, internal medicine and paediatrics meet these patients quite often.
4.10.5. Nurses

The training of nurses should be developed rapidly. Accredited training for psychiatric nurses should also start as soon as possible in Libya. The content regarding the mental health issues should be improved in the training of general nurses. In the training of specialized psychiatric nurses, in addition to medical psychiatric issues, also the following topics should be emphasized:

- General and psychiatric nursing theory,
- Psychotherapeutic attitude,
- Case management,
- Psychosocial rehabilitation,
- Teamwork.

The nurses already working in mental health care should have an opportunity for postgraduate training at different levels: university courses, shorter courses organized by different training authorities and associations and on-the-job training. The main topics in these trainings should be the same as mentioned above in connection of the training of psychiatric nurses.

A great challenge is to increase the number of psychiatric nurses in all mental health care facilities: in inpatient care, in outpatient care, and in psychosocial rehabilitation services. Also, the role and job description of nurses should be changed. In addition to the present activities when nurses are predominantly taking care of orders from the psychiatrists, nurses should also act as independent nursing experts being responsible for the case management and for the rehabilitation activities within the psychosocial rehabilitation. It is obvious that this new role of nurses is not possible without investment in the number of nurses and their training as well. Still, this is a major prerequisite for improving the psychiatric care in Libya. Otherwise it would be difficult, if not impossible, to improve care.

Timetable: The number (psychiatric) nurses should be 500 in year 2015, 700 in year 2020, and 1,000 in year 2025.

The main authorities responsible are the Ministries of Health and Higher Education, National Center for Disease Control.

4.10.6. Psychologists

The role of clinical psychologists should be defined and approved. The natural functions for the psychologists could be:

- Psychological tests and evaluations,
- Psychotherapeutic interventions,
- Group supervision for teams,
- Individual supervision for different professionals: psychologists, social workers and nurses,
- Involvement in interdisciplinary teamwork in child psychiatry and in planning preventive and promotive activities in different contexts,
- Planning, conducting, and evaluating development projects,
- Involvement as experts in forensic activities concerning minors.

The psychologists already working in mental health care should have opportunities for postgraduate training with a focus on psychotherapeutic and supervision skills.

Timetable: The number clinical psychiatrists should be 60 in year 2015, 100 in year 2020, and 150 in year 2025.
The main authorities responsible are the Ministries of Health and Higher Education, National Center for Disease Control.

4.10.7. Social workers

The social workers should have more mental health topics in their undergraduate training, which means that the curricula for undergraduate training should include more knowledge about mental health and mental disorders. The social workers already working in mental health care should also have opportunities for postgraduate specialization in mental health. In the training of social workers the following topics should be emphasized:

- The social and health legislation,
- The disability benefits in the future,
- Psychosocial rehabilitation,
- Team work,
- Family work in mental health care.

Timetable: The number social workers working in mental health care should be 45 in year 2015, 75 in year 2020, and 100 in year 2025.

The main authorities responsible are the Ministries of Health and Higher Education, Ministry of Social Affairs, National Center for Disease Control.

4.10.8. Occupational therapists

The training of the occupational therapists should be started in Libya. Occupational therapists are needed especially in psychosocial rehabilitation activities.

Timetable: the training of occupational therapists should start in Libya at least year 2020 and the number of the occupational therapists should be 30 in year 2025.

The main authorities responsible are the Ministries of Health and Higher Education, Ministry of Social Affairs, National Center for Disease Control.

4.11. Combating stigma

The fight against stigma is very culturally linked, but it should be implemented in all levels: national, regional and local. Best practices and pilots from other Northern African countries should be implemented also in Libya.

Mental health promotion and prevention activities are potent in decreasing stigmatization. Certain prerequisites are needed in order to be successful in implementing mental health promotion and prevention activities for supporting the de-institutionalization process. The most essential of them are administrative prerequisites and education and training of professionals.

As administrative prerequisites both at national and regional level a professional specialist with administrative responsibility and authority should be named to develop, coordinate and support promotive and preventive mental health activities in the country and in the regions. For developing promotive activities a professional body is needed, such as NCDC.

Professional training and guidance ought to be arranged on multi-professional basis due to the set of qualifications required in that field. Practical experience and professional interaction between
experts is a valuable resource, therefore, national networking ought to be organized. Networks are essential as first steps in development and often encourage implementation of new activities.

Strategically, in all programmes, lessons learned and models from existing functioning networks can be utilized, adapting them to national and cultural circumstances. The know-how, ongoing activities and networks of NGOs are invited and integrated to suitable programmes.
ANNEX 1. The institutions and persons met during the process of preparing the document

<table>
<thead>
<tr>
<th>Date</th>
<th>Institution</th>
<th>Persons</th>
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</thead>
<tbody>
<tr>
<td>9.4.2012</td>
<td>WHO</td>
<td>Dr. Fahmy Bahgat</td>
</tr>
<tr>
<td>10.4.2012</td>
<td>National Center for Disease Control</td>
<td>Dr. Amjad Shagrouni (Director of Mental Health Department) and many other experts</td>
</tr>
<tr>
<td>11.4.2012</td>
<td>Tripoli Mental Hospital,</td>
<td>Dr. Ahmed Kara (Medical Director),</td>
</tr>
<tr>
<td>11.4.2012</td>
<td>OPD in Tripoli General Hospital</td>
<td>Personnel of OPD</td>
</tr>
<tr>
<td>12.4.2012</td>
<td>OPD for psychosocial support for children in General Hospital</td>
<td>Director of the OPD</td>
</tr>
<tr>
<td>14.4.2012</td>
<td>Tripoli Medical Hospital</td>
<td>Director of the hospital</td>
</tr>
<tr>
<td>14.4.2012</td>
<td>Ministry of Health</td>
<td>Dr. Ahmed Sewehli, Mental Health Coordinator of MoH</td>
</tr>
<tr>
<td>15.4.2012</td>
<td>NCDC, Primary health care unit</td>
<td>Representatives of unit</td>
</tr>
<tr>
<td>16.4.2012</td>
<td>Tripoli Mental Hospital</td>
<td>Dr. Adel Abu Aza (Director of Hospital), Dr. Ahmed Kara (Medical Director)</td>
</tr>
<tr>
<td>8.7.2012</td>
<td>WHO and NCDC</td>
<td>Dr. Fahmy Bahgat (participated the whole mission), Dr. Amjad Shagrouni</td>
</tr>
<tr>
<td>9.7.2012</td>
<td>NCDC, Mental Health Department,</td>
<td>Dr. Ali Abdalla Abdusamad, Dr. Nadia Mohammed, Dr. Khyria Salem Elsaadi (expert for elderly people), Dr. Nabil Abuamer (Expert in drug addiction), Dr. Fahmy Bahgat (participated in all meetings)</td>
</tr>
<tr>
<td>9.7.2012</td>
<td>Tripoli Mental Hospital</td>
<td>Dr. Adel Abu Aza (Director of Hospital), Dr. Ahmed Kara (Medical Director)</td>
</tr>
<tr>
<td>10.7.2012</td>
<td>EU-Delegation</td>
<td>Juan Zaratiegui Biurrun (Attache), Dr. Stuart Morgan (management consultant)</td>
</tr>
<tr>
<td>10.7.2012</td>
<td>Tripoli Mental Hospital</td>
<td>Dr. Ahmed Kara (Medical director)</td>
</tr>
<tr>
<td>10.7.2012</td>
<td>Ministry of Education</td>
<td>Dr. Omar Reda (an expatriate psychiatrist)</td>
</tr>
<tr>
<td>11.7.2012</td>
<td>Ministry of Education</td>
<td>Dr. Suleiman Khoja (Undersecretary)</td>
</tr>
<tr>
<td>11.7.2012</td>
<td>Tripoli Mental Hospital</td>
<td>Representatives of nurses, social workers and psychologists</td>
</tr>
<tr>
<td>11.7.2012</td>
<td>National Warriors Organization</td>
<td>Mr. Abdulrahman El Mansouri (Head of the organization), Dr. Mohamed Shelamari (the Leading Social Worker and Professor of Social Psychology), Dr. Fahmy Bahgat (participated in all meetings)</td>
</tr>
<tr>
<td>12.7.2012</td>
<td>Ministry of Health</td>
<td>Dr. Osama Al Sharif (Head of PHC Unit), Dr. Mahmoud Usta Omar, (Head of the Pharmacy Section)</td>
</tr>
<tr>
<td>12.7.2012</td>
<td>Ministry of Higher Education</td>
<td>Prof. Fathi R. Akkari (Deputy Minister)</td>
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<tr>
<td>12.7.2012</td>
<td>International Medical Corps</td>
<td>Representatives</td>
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<tr>
<td>12.7.2012</td>
<td>International Organisation for Migration</td>
<td>Representatives</td>
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<tr>
<td>11.8.2012</td>
<td>WHO</td>
<td>Dr. Fahmy Bahgat (participated in all meetings)</td>
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<tr>
<td>12.8.2012</td>
<td>WHO</td>
<td>Dr John Jabbour (WHO representative in Libya)</td>
</tr>
<tr>
<td>Date</td>
<td>Institution</td>
<td>Members</td>
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</tr>
<tr>
<td>14.8.2012</td>
<td>Benghazi Mental Hospital</td>
<td>Dr. Mohammed ELKWAFI (Medical Director), Dr. Tarek Alareby (Acting Director), Dr. Tarek F Bader (Child Psychiatrist - the only one in Libya), Dr. Abdelziz S. Elneihoum (Senior Psychiatrist), Mr. Naser Omar Salem (Head Social Worker), Mrs. Nagib Ebrahim Elagory (Head Psychologist), Head of the Addiction Unit</td>
</tr>
<tr>
<td>14.8.2012</td>
<td>Ministry of Social Affairs</td>
<td>Mr. Ahmed Fathe Rageb, (Head and Coordinator in a country wide psychosocial service for the ex-combatants and ex-prisoners)</td>
</tr>
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</table>
ANNEX 2. International frameworks for integrated mental health services

Concept of integrated services

According to the Council of Europe (CoE) guidelines (Integrated Social Services in Europe. Brian Munday, 2007) the term integrated services is understood to be a range of approaches or methods for achieving greater coordination and effectiveness between different services to achieve improved outcomes for service users. These approaches include e.g. coordination of different services the user needs parallel or consecutively, regular cooperation between agencies, partnerships, inter-organisational collaboration, multi-professional or joint working. Therefore the integration process is conceptualised as a continuum of inter-organisational collaboration which can at the end lead to a fully integrated service system under a single decision-making body.

Based on the CoE guidelines a number of examples from different countries are described below:

Integration at different levels. Public services may be integrated with one or more major services at the national, regional or local level. In this case the separate organisations at the level concerned are integrated horizontally across the administrative boundaries. In another case the integration could be arranged vertically by reorganising or combining responsibilities of separate agencies between different levels of administration. The most important level for integration is at the level of the individual service user.

Structural integration. This can be seen as the most complete or radical form of integration as it involves bringing together staff and resources from different services into a new organisation under a single unified structure. An advantage of successful structural integration is that it can provide a lasting, stable solution to problems of service coordination, resulting in a more effective use of staff in the interests of service users.

Whole systems working. The whole system may be defined as: not simply a collection of organisations that need to work together, but a mix of different people, professions, services and buildings which have patients and users as their unifying concern, and deliver a range of services in a variety of settings to provide the right care, in the right place at the right time.

Process-centred collaboration. This is one of several approaches designed to improve cooperation or collaboration between services and their staff. This approach focuses on caring activities rather than their organisational context. A key feature is the introduction of incentives for closer working between professionals across professional boundaries e.g. new forms of funding such as client budgets, long term care allowances.

Inter-disciplinary working. This is a form of process-centred collaboration as it involves staff from two or more professions working as a multi-disciplinary team, for example in a community mental health centre. It can be a particularly effective form of service integration if it is carefully planned with full consultation and preparation of staff concerned.

Partnerships. This is a form of integration in which service organisations and their professionals agree to participate in specific and ad hoc collaborative relationships. Partnerships can be formal with associated costs or informal where organisations act as partners without structural changes.

One-stop shops or single service centres. This approach to the integration of several separate services at the local level is becoming increasingly popular, for example in France, Armenia, Malta.
and UK. Basically, the one-stop shop enables users to access in one building various different services previously housed in geographically different centres. The convenience to users is obvious, together with the strong potential for greater collaboration, information sharing and joint working between staff of the different services. One-stop shops vary in the extent of service integration.

**Case management.** The importance of integration of services at the level of delivery to the individual user is strongly emphasised in international work on integration. The notion of ‘seamless care’ indicates how ideally the user should experience the delivery of, say, health and social services for their particular needs. Case management is a well developed model for integrating services for individual users, especially for those with complex long term needs. Integrated social and medical care with case management may provide a cost effective approach to reduce admission to institutions and functional decline in people living in the community.

The Libyan integrated mental health service system is expected to be arranged mainly at regional and local community level, which means on the first hand the horizontal and, inside the catchment areas, partly vertical integration processes. The most relevant framework for this development work is the Community Based Rehabilitation (CBR) approach, jointly recommended by the United Nations organisations ILO, UNESCO and WHO (WHO 2004). CBR is a strategy within general community development for the rehabilitation, equalization of opportunities and social inclusion of all people with disabilities, including people with mental disorders. In Libya the integrated mental health services are recommended to follow the principles of the CBR.

These are implemented through the combined efforts of people with mental illness themselves, their families, organisations and communities, and the relevant governmental and non-governmental health and mental health organisations and agencies working together with the regional and local education, housing, vocational and employment, as well as, with social, cultural and other community services.
ANNEX 3. Stepwise rehabilitation model

Basic ideas and practice

1. The stepwise rehabilitation model does not mean that the patient proceeds step by step according to the model, but appropriate services are selected together with the patient. The model must support the progress but it must also allow setbacks.

2. The basic idea is to train the staff to use the rehabilitative approach in their work. Important point is that the training process is long enough and well supervised.

3. The best order to start a new activities, or to change the activities which are already in function could be:
   - Choose the most suitable patient group,
   - Select the staff group which has the knowledge to do the work and if needed organize suitable training for the staff,
   - Part of the training could be organized together with the patients,
   - Guarantee the administration’s support,
   - Let patients take part in the planning process,
   - Start with one new activity or with one big change of activity. When it is working well you can build up the next step.

4. The optimal number of patients in the rehabilitation ward or unit is 20 – 25 patients.
5. Found a support group of volunteers who can give practical help and influence the attitudes in their own surroundings.

6. Day activities can be divided into hobby activities or more target oriented rehabilitation activities. In day care centre the basis should be in target-oriented rehabilitation activities if the aim is to help the patient regain self-worth, purpose and confidence and to learn the skills needed in ordinary life.

7. Co-operation with family members is very important and staff members’ role is to offer identificatory model also to family members how to adapt an attitude towards family member with mental illness. In rehabilitation activities work objectives are planned and estimated jointly with the patient.

8. In supported housing, the inhabitants carry on most of the responsibilities of their daily routines. Peer support and staff members support is available but the emphasis is on client's own will who should make an effort to try to do certain things.

9. Relevant information should be given to both patients and their families. What kind of help is possible to get: rehabilitation home activity, regular appointments with the psychiatrist, appointments with the social worker, medication, welfare support, etc.

10. Written information to patients and their families with their own language dealing with psychiatric problems/illness and the possibilities to get help and recover.

11. Regular contacts with primary care or outpatient clinic to check the status and for example the appropriateness of medication.

12. If the patient has no potential for the open labor market, suitable day centre activities should be available for her/him to maintain recovery.
ANNEX 4. Guidelines for human rights issues in psychiatric care

The guidelines are based on the guidelines the Committee of Ministers of the Council of Europe have approved in 2004.

**Object and scope:** The recommendation aims to enhance the protection of the dignity, human rights and fundamental freedoms of persons with mental disorder, in particular those who are subject to involuntary placement or involuntary treatment. The provisions of recommendation do not limit or otherwise affect the possibility for a member state to grant persons with mental disorder a wider measure of protection than is stipulated in this recommendation.

The recommendation applies to persons with mental disorder defined in accordance with internationally accepted medical standards. Lack of adaptation to the moral, social, political or other values of a society, of itself, should not be considered a mental disorder.

**Non-discrimination:** Any form of discrimination on grounds of mental disorder should be prohibited. Member states should take appropriate measures to eliminate discrimination on grounds of mental disorder.

**Civil and political rights:** Persons with mental disorder should be entitled to exercise all their civil and political rights. Any restrictions to the exercise of those rights should be in conformity with the provisions of the Convention of Human Rights and Fundamental Freedoms and should not be based on the mere fact that a person has a mental disorder.

**Information and assistance on patients’ rights:** Persons treated or placed in relation to mental disorder should be individually informed of their rights as patients and have access to a competent person or body, independent of the mental health service that can, if necessary, assist them to understand and exercise such rights.

**Principle of least restriction:** Persons with mental disorder should have the right to be cared for in the least restrictive environment available and with the least restrictive or intrusive treatment available, taking into account their health needs and the need to protect the safety of others.

**Environment and living conditions:** Facilities designed for the placement of persons with mental disorder should provide each such person, taking into account his or her state of health and the need to protect the safety of others, with an environment and living conditions as close as possible to those of persons of similar age, gender and culture in the community. Vocational rehabilitation measures to promote the integration of those persons in the community should also be provided. Facilities designed for the involuntary placement of persons with mental disorder should be registered with an appropriate authority.

**Professional standards**

Professional staff involved in mental health services should have appropriate qualifications and training to enable them to perform their role within the services according to professional obligations and standards. In particular, staff should receive appropriate training on:

- Protecting the dignity, human rights and fundamental freedoms of persons with mental disorder;
- Understanding, prevention and control of violence;
- Measures to avoid the use of restraint or seclusion;
• The limited circumstances in which different methods of restraint or seclusion may be justified, taking into account the benefits and risks entailed, and the correct application of such measures.

**General principles for treatment of mental disorders**

Persons with mental disorder should receive treatment and care provided by adequately qualified staff and based on an appropriate individually prescribed treatment plan. Whenever possible the treatment plan should be prepared in consultation with the person concerned and his or her opinion should be taken into account. The plan should be regularly reviewed and, if necessary, revised.

Treatment may only be provided to a person with mental disorder with his or her consent if he or she has the capacity to give such consent, or, when the person does not have the capacity to consent, with the authorisation of a representative, authority, person or body provided for by law.

When because of an emergency situation the appropriate consent or authorisation cannot be obtained, any treatment for mental disorder that is medically necessary to avoid serious harm to the health of the individual concerned or to protect the safety of others may be carried out immediately.

**Involuntary placements in psychiatric facilities and involuntary treatment**

The provisions of this part of recommendations apply to persons with mental disorder who have the capacity to consent and are refusing the placement or treatment concerned, or who do not have the capacity to consent and are objecting to the placement or treatment.

A person may be subject to involuntary placement only if all the following conditions are met:

- the person has a mental disorder;
- the person's condition represents a significant risk of serious harm to his or her health or to other persons;
- the placement includes a therapeutic purpose;
- no less restrictive means of providing appropriate care are available;
- the opinion of the person concerned has been taken into consideration.

The law may provide that exceptionally a person may be subject to involuntary placement for the minimum period necessary in order to determine whether he or she has a mental disorder that represents a significant risk of serious harm to his or her health or to others.

**Involvement of the criminal justice system**

Involvement of the police: In the fulfilment of their legal duties, the police should coordinate their interventions with those of medical and social services, if possible with the consent of the person concerned, if the behaviour of that person is strongly suggestive of mental disorder and represents a significant risk of harm to him or herself or to others.

Where other appropriate possibilities are not available the police may be required, in carrying out their duties, to assist in conveying or returning persons subject to involuntary placement to the relevant facility.

Members of the police should respect the dignity and human rights of persons with mental disorder. The importance of this duty should be emphasised during training. Members of the police should receive appropriate training in the assessment and management of situations involving...
persons with mental disorder, which draws attention to the vulnerability of such persons in situations involving the police.

**Penal institutions**

Persons with mental disorder should not be subject to discrimination in penal institutions. In particular, the principle of equivalence of care with that outside penal institutions should be respected with regard to their health care. They should be transferred between penal institution and hospital if their health needs so require.

Appropriate therapeutic options should be available for persons with mental disorder detained in penal institutions. Involuntary treatment for mental disorder should not take place in penal institutions except in hospital units or medical units suitable for the treatment of mental disorder.

An independent system should monitor the treatment and care of persons with mental disorder in penal institutions.

**Quality assurance and monitoring**

Member states should ensure that compliance with the standards set by this recommendation and by mental health law is subject to appropriate monitoring. That monitoring should cover compliance with legal standards and compliance with technical and professional standards. The systems for conducting such monitoring should have adequate financial and human resources to perform their functions, be organisationally independent from the authorities or bodies monitored, involve mental health professionals, lay persons, persons with mental disorder and those close to such persons, and be coordinated with other relevant audit and quality assurance systems.

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