Country Profile Cyprus

Community-based Mental Healthcare Networks: Key Facts and National Priorities

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Contents

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Introduction

The EU-Co-funded "Joint Action on Implementation of Best Practices in the area of Mental Health", short **JA ImpleMENTAL** has a duration of 3 years, lasting from October 2021 to September 2024. Detailed information can be found at the project's website JA ImpleMENTAL (ja-implemental.eu). It aims to promote and improve mental health structures, services, capacity and outcomes in participating countries in 2 specific areas, that are 1) mental health reform (promoting community health services) and 2) suicide prevention.

Two national best practices - mental health reform in Belgium and the Austrian suicide prevention program SUPRA - serve as best practice examples. Selected components of these should be prioritized and implemented over the course of the JA in 14 i.e. 17 participating EU-countries. JA ImpleMENTAL comprises six Work Packages (WPs), four horizontal WPS and one for each best practice. Specifically, WP1 for coordination and management of the JA, WP2 Dissemination, WP3 Evaluation, WP5 Sustainability, WP5 Transfer and pilot Implementation of the Belgian best practice on reform of the MH services, and WP6 Transfer and pilot implementation of selected elements of the Austrian Best Practice on Suicide Prevention (SP) "Supra". WP5 on community-based mental healthcare aims to implement elements from Belgian Mental Health Reform, which is based on the principle of deinstitutionalization, i.e., the transition from care primarily provided in institutions to community-based care in order to improve mental health outcomes and quality of life and avoid unnecessary hospitalizations. In addition, the reform is based on the principles of rehabilitation and inclusion, decategorization, i.e., multisectoral cooperation, strengthening care in hospitals to make stays shorter, but with more intensive treatment, and the principle of consolidation, providing funds for pilot projects.

MH services reform is a continuous long-term process as the resistance to change is a barrier not easy to overcome. The overall objective is to support adaptations in the management and organization of mental health (MH) services from institutionalized MH care towards the (sustainable) establishment of intersectoral, community-based, client-centered and integrated local MH promotion, care and prevention networks and services in the participating countries

The main objective of the Belgian reform was to reduce hospital care and to increase community-based care to improve recovery and reintegration through the creation of local networks.

The five main targets as well as fields of actions is:

- **Deinstitutionalization** which describes the limitation of hospital care combined with the set-up of ambulatory specialized and intensive psychiatric care.
- **Inclusion** entails an intensive **Inter-/multisectoral** collaboration between the mental health care services and the sectors of education, culture, labor, social housing and similar fields with a view towards rehabilitation, reintegration. and recovery.
- **De-categorization** means establishing collaborative **Inter-/multidisciplinary** procedures that enable the provision of integrated care across different sectors organized around the user rather than interventions of stakeholders in "silos".
- **Intensification of in-hospital care** should **aim at shorter hospital stays** with more intensive care while reducing disruptions in the interchange of the patients with their community.
- **Consolidation** covers the integration of already existing pilot projects into an all-encompassing concept of mental health care.

- Building, maintaining and sustaining **network structure** Including: setting the role of Network coordinator. Specifying recruitment of professionals into the network, defining roles and responsibilities, ensuring motivation and incentives in place to keep working as a network, ownership to continue working as a network, participation of users and their families.

In order to achieve the above aims our MH networks should take into consideration

- **Governance structures for mental health** Including: financing, law and policy, guidelines and protocols
- **Capacity building Including:** training, human resources availability, mentoring, supervision, continuous education for the development of local networks and their core five functions and services as well as participation of users and family's engagement of stakeholders and human rights

In order to personalize the intervention through the Individualized Care Plan (ISP), with the active participation of the user/patient, as well as the involvement of stakeholders as well as available patient's organizations and organizations of friends and relatives of the patients.
Also, services development and/or transformation or developing new services that might not exist in the mental health system, with further strengthening the care pathway by helping services work together more effectively, including:
For AMH networks

- Mobile or ambulatory teams offering intensive treatment for both acute and chronic mental health problems.
- hospitals offering residential intensive treatment for both acute and chronic mental health problems, if hospitalization is necessary.
- prevention and promotion of mental health care, early detection, screening and diagnostic activities, user centered approach.
- rehabilitation services using users centered approach aiming to recovery and social inclusion.
- Housing services and specific residential facilities allowing an offer of care, when necessary, care at home or at a home substitution is not possible.

For the CAMH networks:

- Early detection, screening and orientation: Exploration of early signals of a possible psycho-logical problem and directing individuals to an appropriate offer of help.
- Diagnostics: Multidimensional exploration based on the bio-psycho-social model.
- Treatment: Improve or maintain the level of functioning, reduce the burden of suffering and promote recovery, where possible.
- Inclusion in all areas of life: Support of activities that enable individuals to participate as fully as possible in society.
- Cooperative exchange and use of expertise: Exchange of competencies to optimize continuity of care and professionalism.

Expertise Research and Data Bases- Monitoring and Evaluation

- Data collection, monitoring and evaluation of activities and introducing KPIs.
- Dashboard use, relations with local data collection, using evidence-based approach for evaluation, sustained self-improvement of services after JA.
- Monitoring of referrals within the network structure and Individualized Care Plan.

The present country profile is one of the major deliverables of the JA, presenting key facts of the national and local mental health system. It summarizes results of the recent situation analysis and needs assessment (SANA), lists lessons learned, recommendations, challenges and opportunities as well as outlining next steps necessary to scale-up, promote national/regional community-based mental health care services. The country profile forms a basis for strategy formulation, decision-making and commitment.

This country profile is based on a situation analysis conducted in two parts and subsequent needs assessment. For the situation analysis, two questionnaires have been developed by WP5, one for the analysis of the situation regarding the overall health system and community-based mental health care at national level, and another one for the analysis at implementational level. Following the data collection, a SWOT analysis was conducted by the countries to assess the needs in terms of community-based mental health care.

1 Context and Situation Analysis (SA)

1.1 Cyprus, Health and Social System

The Republic of Cyprus joined the Eurozone since the 1st of January 2008 and latterly joined the European Union on 1 May 2004.

Cyprus or the Republic of Cyprus has a high-income economy and Human Development Index, and consists a main destination for tourists in the Mediterranean Sea as well as for other economical activities.

Healthy life expectancy at birth in Cyprus is 82.4 years overall (2020). The life expectancy of males at birth in Cyprus is 80.4 years (2020). The life expectancy of females at birth in Cyprus is 84.4 years (2020).

The Republic of Cyprus is a presidential republic, divided into six districts (Nicosia, Famagusta, Kyrenia, Larnaca, Limassol and Paphos). Nicosia is its capital and largest city of Republic of Cyprus. Cyprus is the third largest and the third most populous island in the Mediterranean Sea, with an area of 9.251 square kilometers. The total population is 904.705 inhabitants on 1 January 2022, in the Republic of Cyprus Government Controlled Areas included only (1), as the northeast portion of the island is currently governed de facto by the self-declared Turkish Republic of Northern Cyprus, a claim that is unrecognized by the international community.

Despite the fact that The Republic of Cyprus has been a member of the European Union since 2004, the application of the EU laws and regulations is suspended in the area under military occupation by Turkey, pending a solution to the division of the island.

GDP per capita (EUR) is currently 25790 euros with 17.3% of the people at risk of poverty or social exclusion. Healthy life expectancy at birth is 82.4, and 7.3 at age 65 (in 2020) (2) Income inequality, expressed as the Gini coefficient, is 29.4, and total healthcare expenditure relative to GDP is 7%.

A universal national health system, known as GESY, was implemented in Cyprus in June 2019. The new system aims to provide affordable and effective medical care to all people residing permanently in Cyprus.

Under the new General Healthcare System, health care financing will be tripartite, with the revenues coming from employee contributions, employer contributions and the state budget, in addition to co-payments. All revenues will be transferred to a central fund and be administered by the HIO, which will act as the exclusive purchaser of health care services for all beneficiaries through contracted public and private providers.

Cyprus' universal healthcare system, GESY, launched on June 1, 2019. [4] As of June 2022, 917.000 Cypriots have registered [5] with a general practitioner through the GESY system, which is roughly the current population of the Republic of Cyprus.

1.2 Population profile

Table 1: Population structure: 2020, expressed as number of persons, by age and sex

	Sex		
Age group	Male	Female	**Total**
<18	89036	83992	173028
18 - 64	282340	299845	582185
65+	69707	79785	149492
Total	**441083**	**463622**	**904705**

1.3 Mental Health System

1.3.1 Strategy and action plan

Mental health must be a priority for the health systems, due to its impacts to physical health, productivity, relationships, societal harmony, and our overall well-being. By prioritizing mental health, we can experience positive emotions, cope with stress, think organize and perform better, build healthy relationships, cooperate, prevent mental and physical disorders, and create supportive communities.

Currently there is no active Mental Health Strategy on national level in Cyprus. Nevertheless, Mental Health Services (MHS SHSO) has its own stand-alone policy, strategy and action plan as the main MHS provider of the country, under the management of SHSO. Ministry of Health makes health policy as well as the mental health policy. The MHS SHSO it is going to contribute in the forthcoming strategy on national level as needed.

Cyprus Mental Health Services (MHS) national plan for MH includes deinstitutionalization and the development of the community mental health care. In this national plan the building of the new Mental Health Center (140 beds) is included, that is going to replace the current overcrowded Athalassa Mental Health Hospital in 2024. The building of the new MH center is consisted of 2 phases, with an estimated cost of around 9 and 40 million euros respectively. The first phase includes 3 mental clinics or wards: The acute psychiatric wards for males, the acute mental ward for females, and the Drug And Alcohol Detoxification and Rehabilitation Clinic (THEMEA). The 1st phase of the new health center is currently under development and is going to be finished at the end of 2023. The second phase includes the main building of the hospital and it is not started yet.

Athalassa hospital is currently overcrowded despite a small decrease in admissions since the end of covid-19 emergency situation. The character of Athalassa Mental Hospital has changed from asylum to hospital approach, but it still offers services to 31 chronic mental patients, due to the lack of appropriate community residential facilities.

Transformation of the mental health services towards the direction of community mental health is being done with the addiction of new procedures and protocols between the mental hospital, the community mental health and the drug and alcohol detoxification and rehabilitation facilities. The field of addictions is incorporated in MHS under the national strategy and action plan. Also, some NGOs that are approved in drug counselling and rehabilitation are taking part in the network of services.

The vision of MHS is to promote mental health for all ages in an equal way, by providing quality mental health services. Our 2 main strategic goals are 1) the prevention of mental health problems and 2) the promotion of high-quality mental health services in the fields of diagnostic evaluation, therapeutic interventions and actions aimed at rehabilitation.

Regarding the first goal of prevention, the Directorate of Mental Health Services, in cooperation with the Management of SHSO and the other Directorates of the State Health Services Organization, the Ministry of Health, other Ministries and Services, NGOs and organized bodies, implements policies and develops actions and programs that promote prevention, with an emphasis on children and adolescents.

The Directorate of Mental Health Services second goal is to organize and operate services and structures according to the needs of the population, the widely accepted scientific developments in the field of mental health and the guidelines of relevant international organizations, with the prospect of upgrading and modernizing them, as well as continuous staff training.

The key principles governing the operation of the Directorate of Mental Health Services are the improvement in accessibility, the provision of a complete range of services, the coordination and continuity in healthcare, the adequate efficiency and effectiveness of services and interventions, the equality in providing care based on the needs of patients and respect for human rights.

Mental Health Services also has a national plan for the treatment of Children and Adolescents considering human rights of the minors. This plan includes that prevention, treatment and rehabilitation of children and adolescents is being done by specialized multidisciplinary teams for Children and Adolescents. This teams are coordinated by the child and adolescent psychiatrist and the members include the mental nurse, the clinical psychologist, the occupational therapist, the social worker, the teacher, the educational psychologist and the teacher when necessary. When there is a need for hospitalization, the hospitalizations of the adolescents is being done in the adolescents mental health clinic.

Currently there is no policy and/or procedures for transition age. The lack of psychogeriatric services is recognized and there is a plan for psychogeriatric clinic in the second phase of the new Athalassa Mental Health Center.

There is a priority to develop protocols for smooth transition from CAMH to AMH. During the pilot program we are working in the WP5 on the protocol for the smooth transition from adolescence to the adulthood by a newly developed multidisciplinary team. Currently there are referrals from child and adolescents' multidisciplinary team to the adult psychiatry multidisciplinary team via the software of the general health system that incorporates psychiatrists, clinical psychologists and mental nurses, but not occupational therapists and social workers. According to the current policy, the CAMH team covers patients up to the age of 18 with an extension for those haven't finish high-school yet. The adolescent's clinic accepts patients up to the age of 18 whereas elder patients are admitted in the

adult's mental health clinic of the general hospital, accompanied by a major caregiver (parent) and having care coordinated by the children and adolescent psychiatrist of the CAMH team.

1.3.2 Legislation

The legislation that regulates main mental health issues in Cyprus is currently available open access. The legislation for mental health issued in 1997 and updated in 2003 and again in 2007. The legislation covers many issues regarding patients' rights, obligatory hospitalization under court order as well as the duties of the relatives, social services and the police, and the concept of first keen regarding decision of the non-autonomous mental patient. The full text is available online (http://www.cylaw.org/nomoi/enop/non-ind/1997_1_77/full.html).

Currently there is no legislation for community treatment order in Cyprus despite the fact that a public scientific debate on this field is in progress. Another legislation for Community MH issues is currently under development.

1.3.3 Available MH services and facilities

In the pilot area of Nicosia, the available MH facilities for inpatients care is Athalassa Hospital with 124 beds, the AMH Ward of the General Hospital (14 beds) and the CAMH ward of Makareion Hospital with 8 beds, and the Drug and Alcohol Detoxification and Rehabilitation Unit (THEMEA) with 6 beds. The CAMH ward of Makareion Hospital performed 111 admissions during the year 2022. THEMEA performed 105 admissions in 2021 (72 males and 33 females) and 95 admissions during the year 2022, with a length of stay 2-3 weeks. Of these 105 admissions of 2021 there were 47 patients from Nicosia, 18 from Larnaca, 16 from Limassol, 16 from Ammochostos, and 5 from Pafos area and 2 homeless patients. Hospitalizations under section only in Athalassa Hospital currently can be performed. In the rest of the country there is only two more inpatient facilities that are located in Limassol. These are the AMH ward of Limassol General Hospital with a capacity of 16 beds and the AMH Drug Detox Unit (Anosis) of the old general hospital with 6 beds. The the AMH ward of Limassol General Hospital performed 282 admissions during the year 2022.

There is a wide network of community mental health services around the country. The capital city of Nicosia has a higher density of services.

The community services in the pilot area of Nicosia are the community mental health centers (sector A in Aglatzia and sector B in Strovolos), the mental health outpatient departments in general health centers, the drug and alcohol detoxification and rehabilitation center "THEMEA", the counselling center for adults with drug use disorders named Multiple Intervention Center as well as the Adolescents and family Drug Counselling Centre named "Perseas" that also serves young adults, a Day Center for AMH, an Occupational Rehabilitation Unit named "MERA", the Center for Prevention and Psychosocial Intervention for children and adolescents as well as the Opioid Substitution Program named GEFYRA. There is also a Mental Health Centre of the MHS SHSO located in the Prison of Nicosia, that serves only AMH prisoners as there are not imprisoned non-adults. This MHS in Nicosia prison also offers addiction therapy and counselling "DANAI unit" in outpatient basis as well as Opioid Substitution therapy.

Around the country there is also Community Mental Health Centers (Nicosia, Limassol, Larnaca, Paphos, Ammochostos) that are interprofessional staffed by Psychiatrists, Mental Health Nurses, Psychologists, Occupational Therapists. Also,Centers for Prevention and Psychosocial Intervention for children and adolescents (Nicosia, Larnaca, Limassol, Paphos), Opioid Substitution Programs (OST):

"GEFYRA" (Nicosia), "SOSIVIO" (Limassol), "DIAVASI“ (Larnaca), "EPISTROFI” (=RETURN)" (Paralimni, Ammochostos), "STROFI“ (Paphos), Adolescent and Family Drug Counselling Centers (Perseas in Nicosia and Promitheas in Limassol), Day Centers in Nicosia, Limassol and Larnaca, Occupational Rehabilitation Units (MERA) in Nicosia and Limassol only, two Centers for the Prevention and Treatment of Eating Disorders located in Nicosia for children and adolescents and adults respectively, an AMH drug detoxification center "Anosis" Detoxification Unit in Limassol and the Center for Psychological Detoxification of People with mild use "ANAKAMPSI" also in Limassol.

There is a constant collaboration between the MH authorities with ministries, services and sectors of the state. Mainly with the Ministry of Social Affairs (and the department of social welfare), the Ministry of Education, the Ministry of Justice, the Ministry of Labour. Also, there is a collaboration with local and international non-governmental organizations (NGOs) as well with service users and associations/organizations of service users as well as with organizations of friends and relatives of the users.

1.3.4 Beneficiaries and coverage of non-beneficiaries

Currently in Cyprus the care and treatment of persons with mental health conditions in included in the national health insurance system or reimbursement scheme. This coverage includes inpatient as well as outpatient care. No specific mental health conditions, diagnoses or treatments, interventions or services are excluded from the coverage. The treatment of the drug use disorders is not currently covered by the GeSY but it is still covered by the ministry of health. The treatment of patients with dual diagnoses eg depression and alcohol use disorder are covered by the GeSY General Health System scheme. Patients that are not beneficiaries of the General Health System but are legal in the country are being treated in the mental health services as needed, paying out of pocket. Patients that are legal in the countly under the status of asylum seeker they are also receiving mental health services free of charge. Patients that illegal in the country they can emergency psychiatry services as well as free of charge hospitalization in Athalassa Hospital under court order.

1.3.5 Funding of MH

According to Eurostat, the total health care expenditure in Cyprus as a percentage of Gross Domestic Product (GDP) is 7.01 (2019), compared to 9.92 (EU-27) and 10.23 (Euro area 19 countries).

The Cyprus government’s total expenditure on mental health, according to WHO Mental Health Atlas 2020 is 8.701.474 euros. As a percent of total government’s health expenditure, this expenditure on mental health equals to 0.14%

The total government expenditure on public mental health care (SHSO) in 2023 is a total 23 million euros. The total cost of outpatient psychiatric care (Health Insurance System) is approximately 13,8 million. The Share of people reporting unmet mental health care needs due to financial reasons in 2014 is 7% (WHO Mental Health Atlas).

1.3.6 Workforce of MH

Table 4: Total number of MH workers in MHS SHSO

	In MH services (all)		In child & adolescent MH services	
	Total number	Rate	Total number	Rate
Psychiatrists	32	NS	0	0
Child psychiatrists	8	20%	8	0
Mental health nurse	415	NS	NA	NA
Psychologists	68	0	NA	NA
Social workers	0	0	0	0
Speech therapists	0	0	0	0
Occupational therapists	42	NS	NA	NA
Others	1	NS	NS	NS
Total	**567**			

The workforce in mental health in Cyprus is consisted of the mental health professionals that are working for the AMH and those working for the CAMH. In each category there are those working for the MHSD SHSO, those working for GeSY under contract with HIO, and those working privately outside GeSY.

The workforce of mental health professionals in the public sector consists of 32 Adult Psychiatrists, 8 Child and Adolescent Psychiatrists, 1 Internal Medicine specialist, and 415 Mental Health Nurses, 68 Psychologists and 42 Occupational Therapists.

A large number of doctors are currently working for the health system under exclusive employment contracts with the Health Insurance Organization. These are currently 79 Psychiatrists including the 32 of the public sectors, 32 Occupational Therapists, 225 Psychologists. A number of 64 of the 32 Psychiatrists of the General Health system are registered in the pilot area of Nicosia. According to the available data a percentage of 89% (64 of 72) psychiatrists of the general health system are working in the capital city of Nicosia.

Currently, after the application of the new general health system (GeSy), every beneficiary has registered to a personal General Physician (GP). The GP refers the patient to the specialist e.g., Psychiatrist. The Psychiatrist refers to other mental health professionals, when necessary, namely Psychologist, occupational therapist and community mental nurse. These referrals are being performed electronically through the software that help medical information transfer and facilitate communication with primary care, considering all relevant GDPR issues. Nevertheless, the role of primary care doctors in prevention, diagnosis, treatment and relapse prevention of mental disorder it still remains weak.

The public sector MHS SHSO personnel that is currently working full time in community MH is consisted of 6 Psychiatrists, and 158 Mental Nurses. Also, part time Psychologists and Occupational Therapists.

The MH personnel that is currently working full time in the Mental Hospital is consisted of 8 Psychiatrists and 148 Mental Nurses. Also, part-time Psychologists and Occupational Therapists. In the 2 mental wards of the general hospitals are currently working full-time 52 Mental Nurses. In all the other 3 inpatient units (2 detox and rehab units and 1 adolescents mental ward) there are currently

working in total 61 Mental Nurses and 3 Psychiatrists, as well as part-time Psychologists and Occupational Therapists.

1.3.7 Mental Hospital

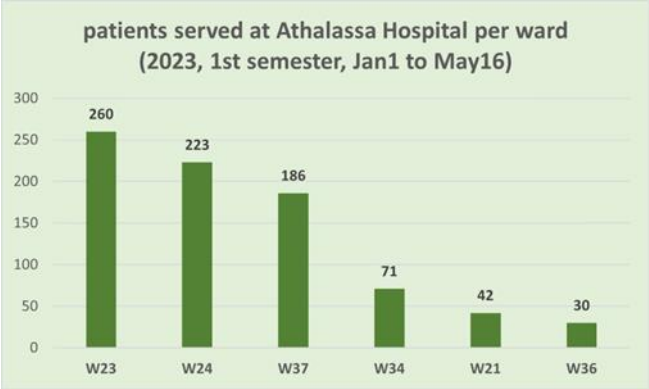
There is 1 Mental Hospital in Cyprus for the whole population of 1 million inhabitants, namely Athalassa Hospital with the ability of hospitalization of 122 patients currently, that is usually overcrowded. In addition to the 122 beds Athalassa Hospital still owns and run occasionally -as needed- a COVID-19 clinic with 7 more beds, reaching the total number of 131 beds. Athalassa hospital is located close to Athalassa forest in Strovolos suburb of Nicosia.

Table: Hospitalizations of adults in Athalassa Hospital and of Adolescents in Makareion Hospital

	2019	2020	2021	2022	2023 (1st semester)
Athalassa Hospital	860	906	970	786	405
Inpatient Unit for Adolescents	74	82	108	111	46

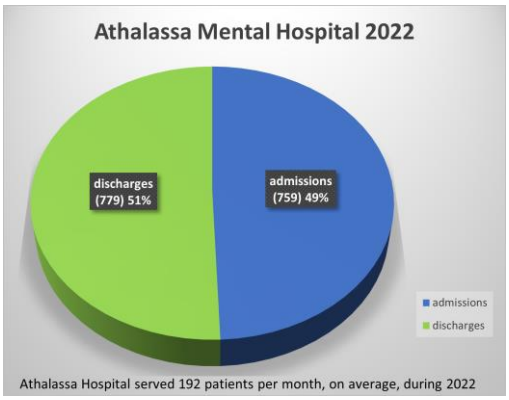
All beds of Athallassa hospital are approved for safe obligatory hospitalization under treatment order by the court, as well as for voluntary hospitalization when necessary.

In total, Athalassa Hospital manages in total 192 cases per month. There is 65 discharges per month on average.



Athalassa Hospital has 6 mental wards/clinics and 1 COVID-19 clinic. The two clinics are serve acute emergency psychiatry cases admitted under court treatment order. The one of this clinics „Ward-23“, is a male clinic with 21 beds and the other „Ward-24“, is for female patients with a capacity of 24 beds respectively. The names of the clinics have historical origin from the old asylum era. The male ward W36 (capacity 18 beds) and the female ward W21 (capacity 10 beds) treats the main number of the 31 chronic patients, where the 20 of the 31 stays in W36 (capacity 21 beds). The ward W37 serves as a brief rehabilitation ward with a capacity of 21 beds. The ward W34 treats dangerous cases of male patients as well as some difficult forensic cases.

During 2022 the total number of admissions in Athalassa Hospital were 759, and he average length of stay for the newly admitted patients were 42 days. The hospital performs 65 admissions per month. The number of discharges from the hospital were 779 for 2022, namely 65 discharges per month.



The number of long-stay patients staying in Athalassa more than 1 year is 31 or 25 % of the whole. The reason of the long-staying is the lack of adequate community residential facilities. There is a constant effort for the community rehabilitation of this patients. The average days of patient staying in the hospital is currently 42 days, not taking into account the 31 chronic long-stay patients described above.

Most of the admissions in the mental hospital are involuntary admissions under court order. The mental wards of the general hospital accept only voluntary admissions therefore most of the voluntary admissions are taking place there. The percentage of involuntary-to-voluntary admissions of the mental hospital is currently 98 % as most voluntary hospitalizations are being done in the mental wards of the general hospital and only a small number in the mental hospital. Athalassa hospital is the only safe mental hospital as described by the law, therefore gives priority to obligatory hospitalizations having currently no available space for serving voluntary hospitalizations.

In the way to decrease number of involuntary hospitalizations in the mental hospital, we have recently established a new indicator to follow-up the phenomenon, the voluntary-to-obligatory hospitalizations per year index (0.98). We consider this number as a human rights indicator and included in the set of human right indices, that currently are 1) the voluntary-to-obligatory hospitalizations per year index that it was 0.98 for 2022, 2) the number of seclusions for special observation per hospitalizations per year (for 2022 was 5.8 cases per day in special observation occupied beds, and 3) the number of restraints for patient's safety per hospitalizations per year (for 2022 was 72 cases per year)

This percentages is under surveillance also as an indicator of quality of services in the mental hospital. There is a plan for receiving some involuntary admissions in the mental ward of the general hospital of Limassol in the near future in order to decrease hospitalizations in the mental hospital. This extension of the ward is under construction with 8 general hospital beds.

1.3.8 Other inpatient hospital-oriented facilities

Apart from Athalassa Hospital, in Cyprus there are also 2 mental wards of the General Hospital that are located in Nicosia General Hospital with 14 beds, and in Limassol General Hospital with 16 beds respectively. There is also one Adolescents Mental Ward in Makarion Hospital in Nicosia, with ability of 8 beds. Also there the Drug and Alcohol Detoxification and Rehabilitation Clinic „THEMEA" with 6 beds that is located in Nicosia General Hospital and a Drug Detoxification Clinic „ANOSI" with also 6 beds located in the old hospital of Limassol.

1.4 Community-based mental health care

There is a wide network of community mental health services around the country. The capital city of Nicosia has a higher density of services.

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1.4.1 Outpatient services

All mental patients that beneficiaries of GeSY have access to mental health professional of their own choice. These mental health professionals are working in the public sector or in the private sector having contract with the health system through the national Health Insurance Organization (HIO). Public sector mental health services are managed by the Directorate of Mental Health Services of State Health Services Organization (SHSO).

The community mental health services are consisted of a wide network separated in six distinct sectors, namely two sectors for the pilot area of Nicosia and one sector for each one of the main cities and associated provinces of the Republic of Cyprus.

According to the most recent available data from community mental health service, during 2022 there were performed 2329 mental nurse home visits in Nicosia sector-A, 3432 in Nicosia sector-B, 2465 in Larnaca area, 836 in Amochostos area, 2432 in Limassol area and 2324 in Paphos area respectively.

During the discharge procedure, the patients from Athalassa Hospital are referred to the community mental health services of our organization. These referrals are written, and they are included in the discharge note. These referrals include many outpatients care with Psychiatrist, Psychologist, Occupational Therapist, and Community Mental Nurse, depending on the needs of the patient and the availably of services in his residential area. An effort is made in order to continue to use facilities of the

same organization in order to achieve better cooperation as in this case the relevant mental health professional will be members of the same multidisciplinary team increasing effectiveness of care. Of the total number of involuntary admissions in Athalassa Mental Hospital of Nicosia, the percentage referred to community mental nurse before discharge is 21.5% that is considered low. Specifically, during 2022 of the 770 admissions to Mental Hospital the 168 were referred to community mental nursing.

Community residential facilities for AMH and CAMH

Lack of community residential facilities for AMH consist a severe barrier towards the progress of deinstitutionalization and the desired decrease of mental hospital admission as well as hospital admissions. Currently for the pilot area of Nicosia there are only three small community residential facilities namely "Lara" with the capacity of 5 beds only for men, "Ledra" with 8 beds only and "Kykkos" with 12 beds. These three structures function under the management of the ministry of social affairs: "Lara" and "Kykkos" under the management of the office for social welfare and "Ledra" under the management of the office for social inclusion. Another community residential facility is under construction to be used under the management of MHS SHSO with 12 beds in the Nicosia suburb of Latsia, but it must first overcome the obstacle of lack of staffing.

There is a better availability and easier accessibility of community residential facilities for CAMH compared to AMH patients. Specifically, there are two residential facilities for children named "paidiki stegi" (Nicosia and Limassol), other two for adolescents (one male other female), that are being operated by the ministry of labor and social affairs. In addition, there are other three facilities for CAMH that are being operated by NGOs: two that are being operated from "hope for children" of which one for unaccompanied minors and the other for CAMH drug users. Also, one more community residential facility for CAMH patients with addiction use disorder and comorbid conduct disorder, that is being operated by the NGO "Agia Skepi".

Table 2: Facilities, number of beds and hospital admissions related to mental health

Indicator at national level		Number	Rate per 100.000 adult/minor population
Mental health hospitals	Facilities	1	15.8
	Beds	100	
	Admissions	759	
Psychiatric wards/units of general hospitals	Wards/units	2	
	Beds	34	
	Admissions	NA	
Mental health community residential facilities	Facilities	4	
	Beds	NA	
	Admissions	NA	
Mental health inpatient facilities specifically for children and adolescents	Facilities	1	
	Beds	8	
	Admissions	NA	
Mental health community residential facilities specifically for children and adolescents	Facilities	8	
	Beds	NA	
	Admissions	NA	

1.4.2 Community residential facilities

Regarding the main forms of government social support available for persons with severe mental health conditions, currently there is a great shortage of community residential facilities for the mentally ill that leads to difficulties for discharging patients from the mental hospital that cannot follow an autonomous community living or move to common nursing homes. Many patients of the Mental Hospital are affected by this shortage of community residential facilities, due to prolongation of length of stay in the hospital.

During 2022, 780 admissions and 779 discharges took place at the Athalassa hospital, not including chronic patients hospitalized for more than 1 year due to a lack of suitable housing in the community (community residential setting). The average length of hospitalization was 42 days (not including patients hospitalized for more than 1 year).

It should be noted that most admissions (763) for 2022 were compulsory (with a hospitalization order) and only 17 were optional (98% compulsory hospitalizations). The number of bed days for these patients for 2022 was for 45x780=35100.

At this moment (07.07.2023) 31 chronic patients are hospitalized in our hospital with a hospitalization time of more than 1 year, due to a lack of suitable sheltered/semi-sheltered housing in the community, which is equivalent to 31 x 365 = 11315 hospitalization bed days per year. This number (31) remains roughly constant throughout the previous year. Therefore, approximately the total number of bed days for 2022 is 35100 + 11315 = 46415.

The Athalassa hospital treats patients with serious mental health disorders who, after stabilizing their mental state, continue their treatment in the community. As a rule, after discharge, patients return to their previous place of residence, but as an exception, there are homeless patients and patients who need post-hospital rehabilitation in protected accommodation (semi-protected hostels or special houses for semi-independent living), the number of which is not sufficient.

The lack of appropriate post-hospital care structures and the delay in finding housing for homeless patients are sometimes a reason for prolonged hospitalization, since it is often not in the patient's therapeutic interest to discharge him without having arranged a suitable accommodation, much more so for vulnerable patients who are hospitalized with decree of compulsory hospitalization.

The mentioned post-hospital rehabilitation structures are an intermediate stage before the full integration into the community of patients who, due to their psychopathology, are not currently ready for independent living in the community, but do not need to extend their hospitalization at the Athalassa Hospital. The further mandatory stay of these patients in the psychiatric hospital is unnecessary and does not serve the patient's rights (unnecessary detention). Particularly:

- Homeless people with serious mental health problems

Few such cases were hospitalized at the Athalassa Hospital, mainly during the period of the COVID-19 pandemic, due to their mental state they did not understand the need for protective measures (physical distance, mask, hand washing, restriction of movement) and could not cooperate in the community at risk to themselves and to public health, resulting in the issuance of a hospitalization order. The incidents recorded in our statistics as homeless are 8 for 2021 and 4 for 2022.

- Mental patients who were stabilized but whose rehabilitation was delayed for various reasons and were eventually rehabilitated.

The reasons are the inability/unwillingness of the patient's representative to receive the patient immediately due to difficulties in caring for him. The patient's representative is usually a first-degree relative, and in fewer cases the representative is the state. These patients should be transferred immediately to intermediate structures of post-hospital care but for the time being the availability of such structures and the accessibility of the patients there is very limited. In any case, these are patients who could sooner continue their treatment outside the psychiatric hospital since this would better serve their rights and their therapeutic interest.

Bed days due to delayed recovery cannot be measured retrospectively since the information on delayed discharge is currently not collected as an indicator for each patient. An indirect record of the phenomenon is made by the correspondence of the hospital with the YKE and the communication with relatives. Nevertheless, an indicator has already been designed for systematic quantification of the phenomenon.

- Chronic patients who remain for more than 1 year at the Athalassa Hospital due to lack of a suitable housing structure (protected hostel) in the community.

These are mainly patients of ward-36, but also some patients of ward-21 and ward-34 of the Athalassa Hospital. These patients at this time (07.07.2023) in our hospital are 31 chronic patients with a hospitalization time of more than 1 year, due to a lack of suitable sheltered/semi-sheltered accommodation in the community, which corresponds to 31 x 356 = 11315 hospital bed days per year . In any case, these are patients who could continue their treatment outside the psychiatric hospital since this would better serve their rights and their therapeutic interest.

1.4.3 Mental Health Information System:

Currently there is no integrated IT system in the health system that covers all health system. The software of the Health Insurance Organization (HIO) serves mainly for diagnoses, claims, and referrals. This software is also sed by the community MH services, but not covers MH hospital nor addiction treatment services. There is plan for the next few years for a new integrated IT system included medical folder of the patients that will includes all hospitals and all medical professionals, MH included.

Athalassa hospital as well as all other inpatient facilities, namely Psychiatric Clinics of the General Hospitals, Drug and Alcohol Detoxification and Rehabilitation Center (THEMEA) and Detoc Clinic (Anosis), use another spreadsheet software in order to collect many indices all year long. These indices are related to admissions, discharges, length of hospitalization, stuffing, etc. This spreadsheet does not relate data to each patient but to wards.

1.4.4 Stakeholder environment:

Mental Health Services of the SHSO is the main stakeholder for Mental Health in the pilot area of Nicosia, owing the biggest network of services and coverage, serving the MH policy of the Ministry of Health. There is constant cooperation with the department of Social Services of the Ministry of Labour and Social Affairs that is the main employer of Social Workers. Unfortunately, currently there are no Social Workers based on the Mental Hospital nor the other MH structures, facilities or services of the Community MH and CAMH. There is also a cooperation with the Ministry of Education for the prevention and promotion of MH in the school environment.

Other stakeholders include NGOs working for Mental Health including the prevention and treatment of substance abuse and behavioral addictions, for the care of the elderly, and for serving social services.

Also, there are patients organizations as well as organizations of friends are relatives of the patients that serve a supportive role as well as working on decreasing the stigma of mental disorder.

There is harmonical cooperation of the stakeholders in the field of MH, where the MHS SHSO constantly promotes networking.

2 Needs Assessment (NA)

2.1 SWOT analysis

Table 5: SWOT Analysis

Factor	Contents				
Strengths	1. experience	2. national networking	3. accesibility	4. muldisciplinary culture	5. international cooperation
Weaknesses	1.understaffing	2.lack of protocols	3. lack of continues education	4. lack of social workers in the hospital	5. lack of community residential settings
Opportunities	1. human rights	2. GDPR	3.networking	4. MHS SHSO remains leader in AMH and CAMH	5. protocol for smooth transition from AMH to CAMH
Threats	1. burm out of professional	2. quality decrease due to increased population needs	3.cost of services	4. low funding for MH	5. stigma of mental disorder

We performed a SWOT analysis workshop in order to concentrate the opinions and unmet needs of the stakeholders. The results This is a synopsis of the main results. Regarding the "Transition from child and adolescent mental health services to adult services".

STRENGTHS

- Relatively easy access to the patients' record by specific groups of mental health professionals. This access is facilitated through the different structures and centres of the Mental Health Services Directorate, provided that the patients have given their consent.
- The operation of Quality assurance offices situated in hospitals, tasked with creating and upgrading procedures and documents on various topics; such as referrals and protocols, aim to unify and uniform the way the Organisation operates
- Establishment and promotion of patients' human rights
- Protection of individuals' personal data
- Availability of education opportunities and expertise building through local or EU funding
- Interprofessional connection of specialties is sought both in outpatient and inpatient facilities.
- Mental Health Services are nowadays low cost or even free of charge due to the introduction of the General Healthcare System (GHS) in Cyprus.
- There is a 24-hour emergency medical service for mental crisis management all over the island
- The Directorate offers specialised services that are unique around Cyprus such as Occupational Therapy and community - based services
- Mental Health Services can be accessed everywhere around Cyprus
- The State Health Organisation has a marketing department that promotes mental health facilities, reducing stereotyping and enabling access to mental health facilities

- The good Interpersonal relations among staff facilitate communication and cooperation
- Clear organisational structure (chart) of the Directorate and its different departments, as well as clear scope of work
- Participation of Mental Health professionals in several external committees and services, both governmental and non-governmental ones
- Provision of services to the entire population, including non - GHS beneficiaries and vulnerable groups of people such as asylum seekers and prisoners
- Organisation of multidisciplinary groups and activities at schools for prevention and treatment purposes
- Cases of severe mental illness in Cyprus can only be treated and monitored at the Directorate facilities
- The State Health Services Organisation is promoting digital transformation of its operations, incorporating a new management system, and an electronic medical record keeping, as well as digitalisation of the existing one. This project is going to be implemented in the following two years.

WEAKNESSES

- Cumbersome bureaucracy
- Short of staff in many disciplines - understaffing
- Lack of protocols that would facilitate transition and lack of joint coordination between professionals, or the establishment of a joint programme that would facilitate smooth transition
- Limited communication between child psychiatrists and adult psychiatrist regarding transition
- Lack of procedures that would determine the transition steps between children and adolescent departments to adult services e.g., no reference or contact person, delays in choosing a health professional, different approaches in treatment, mismanagement of patient's need for autonomy, and lastly, no clear age distinction and categorisation of patients
- Lack of purposeful training of health professionals in the management of transition, including new trainees and residents
- Lack of stakeholders' involvement in the transition period such as social services and welfare
- Lack of transition groups to organise and manage change
- Exclusion of patients' feedback in the way of implementing transition. Patients in general do not have a say in the reform of the system
- Due to the introduction of the General Healthcare System (GHS), arranging an appointment with a psychiatrist can take a long time and delay therapy and transition
- Lack of informal meetings between professionals for coordination purposes. The reason for this is that meetings of interprofessional groups are not compensated by the General Health System, thus lessening time spent on conducting those sessions
- Transfer of employees or resignations lead to loss of expertise and valuable knowledge sharing
- Lack of electronic medical record keeping
- Increased length of time in the psychiatric facilities
- Poor financial management that threatens sustainable investments in mental health programmes

OPPORTUNITIES

- Adoption and application of good practices that could result in better case management, as well as prevention and treatment, adjusted to the respective needs of both the organisation and other bodies involved

- Prevention and reduction of relapses, lowering the need for hospitalisation, enabling patients to have an effective rehabilitation, and better quality of life
- Active involvement in international research
- Revision of legislation regarding the regulation of the Mental Health Directorate and mental health treatment, updating law on parental consent for the examination of a minor child
- Establishment of regular inter-professional meetings and improvement of interdepartmental communication with multi - professional cooperation and teamwork, both on national and international level.

THREATS

- Difficulty of adolescents and young adults in gaining autonomy from their family
- Prejudice and social stereotyping affecting the treatment of young adults, reducing accessibility to the mental health services, interrupting, or delaying transition
- State indifference in the mental health care and unwillingness to proceed with essential investments
- Unstable financial environment and external competition hinder the steady growth of the organisation and threatens its future existence (after the year 2024 and onwards), leading to work insecurity or reluctance, and frequently leading to complete job abandonment
- Lack of proficient mental health specialists in the work market avert the enhancement of the human resource dynamics of the Directorate
- legal issues see the light every day, attracting negative publicity, voicing concerns and complaints regarding healthcare issues, spotting and emphasising mental health weaknesses
- Lack of regulated patient advocacy
- Global trends in favour of flexible employment and gig culture, threaten job security and create different status in employment (e.g., permanent staff, contact-based employees, external consultants, or lease of employment), lead to disengagement and poor performance
- Army service interrupts smooth transition from adolescence to adult mental health treatment.

2.2 Reflection on SANA results

According to our SANA analysis, the process of steering towards community MH can be facilitated with the pilot implementation of the main factors described in the suggested Belgian model of MH care reform. Starting from the pilot area of Nicosia, with the strategic goal the main objective of the Belgian reform that is to reduce hospital care and to increase community-based care to improve recovery and reintegration through the creation of local networks. Namely, by constructing a network around the service user on a comprehensive and integrated approach, enabling resources to be used efficiently in line with the needs and with a recovery-oriented vision.

The overall objective is to support adaptations in the management and organization of mental health (MH) services from institutionalized MH care towards the (sustainable) establishment of intersectoral, community-based, client-centered and integrated local MH promotion, care and prevention networks and services in the participating countries. The main networking during the pilot phase will be between the hospital and the community MH services, as well as between AMH and CAMH. Regarding the

network between AMH and CAMH we focus on the smooth transition by adding procedures for continuity of community care in order to avoid relapses and unnecessary hospitalizations.

Box 1. Prioritized measures for pilot implementation

- Measure 1: networking between Mental Hospital and Community MH
- Measure 2: networking between AMH and CAMH
- Measure 3: procedures and protocols

POTENTIAL SUCCESS FACTORS

- ✓ Success factor 1: stakeholders involvement
- ✓ Success factor 2: multidisciplinarity

3 Priorities

- Step 1: continue the implementation and evaluation of pilot actions according to the proposed plan
- Step 2: Develop more the community mental health facilities
- Step 3: Develop new mental health facilities that are currently missing
- Step 4: Work the culture of deinstitutionalization
- Step 5: work against the stigma of mental disease

3.1 1st Strategic Area – Core Element: Ensure (strong) governance structures/mechanisms

Sub-strategic area 1.1.: Governance conditions

- Activity 1.1.1a: procedure and protocol on smooth transition CAMH to AMH
- Activity 1.1.1b: procedure and protocol on smooth transition hospital to mobile teams
- Activity 1.1.1c: procedures for decrease unnecessary hospitalizations

Sub-strategic area 1.2: Building (consolidating or extending) and sustaining networks based on intersectoral, multidisciplinary and recovery-oriented approach (at pilot site)

- Activity 1.2.1a: building multidisciplinary hospital-community network assure 1.2.1b
- Activity 1.2.1b: building multidisciplinary CAMH-AMH network

3.2 2nd Strategic Area: Development or transformation of MH services and interventions (incl. multidisciplinarity approach)

2nd Strategic Area – Substrategic area 1: Developing new (non-existing) OR transforming/adapting existing MH services (incl. reinforcement of multi-disciplinarity and improvement of evidence-base, quality, efficiency and continuity of services) in the areas of (five functions of the Belgian BP):

- Activity 2.1.1a: clinical procedure for smooth transition from CAMH to AMH
- Activity 2.1.1b: clinical procedure for smooth transition from MH hospital to mobile teams

2nd Strategic Area – Substrategic area 2: Developing/strengthening a human-rights based and user-centered recovery approach in service delivery

- Activity 2.2.1a: insert human rights indicators in MH hospital
- Activity 2.2.1b: procedure from smooth discharge from hospital to community services

3.3 3rd Strategic Area: (Extensive global) training & capacity building programme of stakeholders (in support of the reform & cultural change in service provision)

- Activity 3.1a: training of the stakeholders in smooth transition and therapeutic continuity
- Activity 3.1b: establishing groups to change the therapeutic culture

3.4 4th Strategic Area: Intensive continuous communication, information and awareness raising among/towards stakeholders and users (in support of the reform and a culture of change)

- Activity 4.1a: seminar on good practices
- Activity 4.1b: online promotion on good MH practices

3.5 5th Strategic Area: Data collection, monitoring & evaluation

- Activity 5.1a: data collection
- Activity 5.1b: insertion of new indicators

4 Next steps

- Share and communicate the proposed strategy and action plan with the local stakeholders.
- Implement the pilot actions and evaluate the implementation.
- Analyze more the findings from the needs assessment analysis to find and set priorities for improvement, based on the implemented pilot implementation.
- Organize a national conference during fall 2023 to present and discuss with stakeholders.
- Make a proposal of mental health transformation proposal to be included in national mental health strategy, based on Joint Action Implemental conclusions

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