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Master's Dissertation in Mental Health Policy and Services

Title:

Mental Health Service provision in remote areas in Greece: the experience of the Mobile Mental Health Units in Cyclades islands

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ABSTRACT

The aim of this study was to identify if and how the operation of the mental health mobile units in the Cyclades in Greece has had an effect on the mental health of the local population. The Cyclades islands, although very popular as a summer destination globally, had an almost inexistent system of mental health services. Due to the complete lack of such services, 2 mobile units were founded 10 years ago in order to cover for this lack. We give a short description of the structure and working mechanisms of the mobile units. We then present the current situation and how it has evolved across time. We processed the data into a unique database of the users of the Mobile Mental Health Units in a period of 10 years. We used quantitative methods and descriptive analysis to a set of variables and indicators to help us reach a conclusion of how to measure the impact of the provision of service, along with a short focus groups discussion involving the key players in the community.

The sample of the present study is the clinical population of 6,884 adults, who were referred to the mobile psychiatric units of EPAPSY in West and North-East Cyclades between the years 2003 and 2014. The current study has focused on the identification of positive effects of the service provision of the units for the local population, as well as the barriers and limitations during the 10 year experience in the Cyclades. In addition, we tackled some present obstacles (such as the socio-economic crisis and how these have affected service provision and users' mental health status. We identified the main reasons behind the fluctuation and change in the number of users per year over the decade, the number and source of referrals, the initial requests of the patients for services and how they evolved across time. We concluded that the services offered by the Mobile units had a positive impact in reducing the treatment gap and increasing awareness for mental health issues. We also identified a few indicators that could point towards a reduction of stigma in the communities. We suggested some key steps forward for the improvement of services and, eventually, their evaluation, in order to examine the overall impact on the mental health of the population of the islands.

Keywords: mobile units, service provision, community networks, mental health promotion

SINOPSIS

El propósito de este estudio fue identificar el posible efecto que podía tener el establecimiento de centros móviles para el cuidado de la salud mental en los habitantes del archipiélago de las Cícladas en Grecia. Las islas Cícladas, aunque muy populares como destino turístico a nivel mundial, poseen un sistema de salud mental casi inexistente. Con el propósito de atender esta necesidad de la población, dos unidades móviles fueron fundadas hace diez años. En este estudio presentamos una descripción de la estructura y los mecanismos que han permitido el funcionamiento de las unidades móviles, así como un análisis de cómo dicho funcionamiento se ha ido desarrollando hasta la actualidad.

Como parte de este estudio, procesamos los datos recopilados en una base de datos que contiene información de los usuarios de las unidades móviles durante sus diez años de uso. Utilizamos métodos cuantitativos, desarrollamos discusiones con grupos focales compuestos por individuos que poseen roles importantes dentro de la población de las Islas, y produjimos un análisis descriptivo que nos permitieron establecer las variables y los indicadores necesarios para llegar a una conclusión basada en la medición del impacto que los centros móviles han tenido en la población.

La muestra de este estudio está compuesta por la población clínica de 6,884 adultos que fueron referidos a las unidades de servicios psiquiátricos de EPAPSY en el oeste y noreste de las Cícladas durante los años 2003 y 2014. Nos enfocamos en identificar los efectos positivos que el ofrecimiento de servicios de salud mental mediante el uso de unidades móviles a la población local, así como las barreras y limitaciones durante sus diez años de funcionamiento en las Cícladas. Además, también analizamos algunos obstáculos vigentes (ej. la crisis socio-económica y su efecto en el ofrecimiento de servicios, el estado de salud mental de los pacientes referidos a las unidades móviles, etc.). Identificamos las razones principales detrás de la fluctuación en el número de usuarios por año, lugar de referido, y las solicitudes iniciales de servicios y cómo estas cambiaron durante un periodo diez años.

Concluimos que los servicios ofrecidos por las unidades móviles tuvieron un impacto positivo en la reducción de la brecha de servicios de salud mental ofrecidos en las Cicladas. Las unidades móviles han tenido un rol muy importante en la concienciación en temas de salud mental y en la reducción de estigmas en las comunidades. Culminamos

este estudio ofreciendo recomendaciones claves para el mejoramiento de los servicios en las unidades móviles, así como métodos de evaluación para medir progreso y la eficiencia de los servicios ofrecidos.

Palabas claves: unidades móviles, ofrecimiento de servicios, redes comunitarias, promoción de salud mental.

RESUMO

O objetivo deste estudo foi identificar se e como a atuação das unidades móveis de saúde mental nas Cíclades, na Grécia teve um efeito sobre a saúde mental da população local. As ilhas Cíclades, embora mundialmente populares como destino de verão, tinham um sistema quase inexistente de serviços de saúde mental. Devido à falta de tais serviços, 2 unidades móveis foram fundadas há 10 anos, a fim de cobrir esta lacuna. Oferecemos uma breve descrição da estrutura e dos mecanismos de funcionamento das unidades móveis. Em seguida, apresentamos a situação atual e sua evolução ao longo do tempo.

Os dados foram processados em uma única base de dados dos usuários das Unidades Móveis de Saúde Mental, em um período de 10 anos. Foram utilizados métodos quantitativos e análise descritiva para um conjunto de variáveis e indicadores, para ajudar a chegar a uma conclusão sobre como medir o impacto da prestação de serviço, bem como uma breve discussão em grupo focal envolvendo os principais atores na comunidade.

A amostra do presente estudo é a população de 6.884 adultos, que foram encaminhados para as unidades psiquiátricas móveis de EPAPSY do Oeste e Nordeste de Cíclades entre os anos de 2003 e 2014. O presente estudo centrou-se na identificação dos efeitos positivos da prestação de serviços das unidades para a população local, bem como das barreiras e limitações durante a experiência de 10 anos nas Cíclades.

Adicionalmente, abordamos alguns obstáculos atuais (como a crise socioeconômica e de que forma tem afetado a prestação de serviços e o estado de saúde mental dos usuários). Identificamos as principais razões para a variação e a mudança no número de usuários por ano durante a década, o número e fonte dos encaminhamentos, os pedidos iniciais dos pacientes aos serviços e como eles evoluíram ao longo do tempo.

Concluiu-se que os serviços oferecidos pelas unidades móveis tiveram impacto positivo na redução da lacuna de tratamento e aumento da sensibilização para as questões de saúde mental. Identificamos, ainda, alguns indicadores que poderiam apontar para a redução do estigma nas comunidades. Sugerimos alguns passos fundamentais para a

melhoria dos serviços e, eventualmente, sua avaliação, a fim de estudar o impacto geral sobre a saúde mental da população das ilhas.

Palavras-chave: unidades móveis, prestação de serviços, redes comunitárias, promoção da saúde mental.

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1. INTRODUCTION

Greek Psychiatric Reform

1984 was a year that became a worldwide landmark mainly due to the homonymous novel by George Orwell. In the Greek context, however, 1984 was also very famous for another reason: it was the year that Psychiatric Reform was introduced with the European Community Regulation 815. The reform aimed at training mental health professionals, creating a decentralised community network of preventive, specialised treatment and rehabilitation services, deinstitutionalising psychiatric patients with chronic conditions and reducing admissions to mental hospitals. As far as structures and services were concerned, the goal was to "develop a complete network of community services to ensure at a healthcare region level (mental health sector) operational capacity in terms of the needs of the local population, a goal which is clearly wider than treating illness" (Ministry of Health and Welfare, 2001).

In 1999, the most progressive Mental Health Law 2716 was passed.11 It set the basic principles of mental health practice in Greece, identified the 'units of mental health' and introduced the concept of 'social cooperative units', which would provide people with mental illness the opportunity to work and ideally live off this work.

It was, however, the Psychargos programme that advanced developments for community-based services. With EE funding of 700 million Euros, it started initially as a 10-year project (from 1997 to 2006). Its main aims included:

(a) completing the psychiatric reforms, with the deinstitutionalisation of the remaining long-term psychiatric patients in the eight mental hospitals and their closure;

(b) the resettlement of ex-patients into the newly established psychosocial rehabilitation and housing services;

(c) further development of the network of community mental health services.

The first phase started in 1997. It included training of mental health professionals, improving infrastructure and residents' daily living, and preparing patients for community living through employment skills training. Within this context, a number of non-governmental organisations (NGOs) were set up for the completion of these projects. As

the process of deinstitutionalisation began, so did the preparations for shifting patients to protected or relatively autonomous homes in the community, the improvement of hospital care and the development of new socially-focused mental health services (Tsiantis, 2004; Madianos, 2005; Karastergiou et al., 2005)

The second phase (from 2001 to 2010) aimed at the development of community based mental health services. Its main targets were the closure of mental health hospitals, the establishment of psychiatric services in general hospitals, and the development or expansion of specialist services. A major accomplishment of this phase was the sectorisation of mental health services, with care coordination and delivery in relatively small, discrete geographical areas across the country. Hospitals provide services to the several hostels, out-patient facilities and social rehabilitation units in their areas (mainly run by NGO's), and, as a result, the numbers of patients with chronic illness has substantially decreased.

We are currently in the third phase (2011-2020) and the main targets are to ensure the sustainability of the programme, establish a permanent link with Primary Health Care, promote mental health of the general population and prevent its deterioration, especially within the context of the economic crisis.

In short, over the least 3 decades some steps have been taken to improve and develop mental health services (Stylianidis, Gionakis & Chondros, 2009):
Law 2716/1999 was enacted, which is a quite comprehensive framework law, which placed the development of community services on the Greek policy agenda. The percentage of beds in psychiatric hospitals (out of all psychiatric beds) was reduced by almost half. A large number of young professionals acquired initial training and practical experience in community settings, which is the start of a change in the model used to provide psychiatric care. Examples of good practice at community level emerged, thanks to efforts to implement the principles of social psychiatric and provide comprehensive coverage for the local population.

Non-Govermental Organisations, as previously mentioned play a significant role in psychiatric reform, as most of the services developed are established and managed by

these organisations. EPAPSY (scientific association for regional development and mental health) is such an NGO that grew along with the programme and is currently operating 25 units, among which the two mobile units in the Cyclades. At this point, it is important to provide a background on the concept of mobile units

Basic Principles

Mental Health Mobile Units were developed within the framework described above, in order to serve population mental health needs in remote areas, in sectors with limited or without other mental health services. Mobile units were founded in order to operate under the main principles of community psychiatry and WHO suggested elements of mental health policies (Mechanic 2001, Tansella & Thornicroft, 2001, WHO 2002):

- transfer of basic psychiatric care from the psychiatric hospital in the community
- integration of mental health services with Primary Health Care
- transfer of mental health professionals' interest from the illness to the individual and his/her social disability
- multidisciplinary approach in care provision
- use of resources of self-help and self-support of patients
- work with patients' families
- individualised approach according to the individual's needs
- continuity of care
- respect of human rights
- working in networks
- development of mental health promotion programmes in the communities
- evaluation of care provided by services
- equity in access and provision of care
- synergy of local social policies

In general, these are the most basic principles regarding a mobile unit:

-the provision of diagnostic assessment and treatment of suffering from mental disorders in three target groups of the population (children, adolescents and adults)

-the assessment of the needs of the population targeted in the field of mental health in order to offer the most appropriate services (Slade and Glover 2001, Tansella and Thornicroft)

-the achievement of the highest possible level of integration between primary health care and mental health services

-the development of local networks between Primary Health Care Services, Social Services, as well as local authorities

-the development of a strategy towards the formation of a system of health provision locally (WHO2001, 2003) and mobilisation of local resources

Primary Health Care and Mobile Units

Mental health in primary healthcare is defined by the WHO as "providing basic preventive and curative mental health care at the first point of entry in the health system".
Primary healthcare coordinates the individual's healthcare, has direct access to the patient, and his family, ensures the continuity of case is the entry point for more specialised care (Barbato, 2008). Mental Health Mobile Units were developed to act in collaboration with Primary Health Care in remote rural areas, while the need of a model on the field of integration with PHC services was emerged.
Different models to improve mental health care in primary care have been suggested, according to the amount of responsibility taken by the primary care practitioner in managing common mental disorders, compared to the role of specialized services (Bower and Gilbody 2005). These models include:
a) the training model, emphasizing methods to improve the knowledge and skills of primary care staff to identify and manage mental health disorders (WHO 2001a, Thompson et al 2000, Gask 1998, Cornwall and Scott 2000),
b) the consultation-liaison model, with model specialists entering into an ongoing educational relationship with PHC team in order to support them in managing specific patients (Gask et al 1997, Bower and Gask 2002),

c) the collaborative care model with elements from the previous two models in addition to changes in the role of primary care professionals and mental health professionals and generally changed in the system of care (Bower and Gask 2002, Katon et al. 2001)

d) replacement/referral model focusing on management of presenting psychiatric problem by mental health professionals, although primary care practitioners have the overall clinical responsibility (Bower 2002).

The importance of treatment provision for psychiatric disorders in PHC was emphasized as a key mental health policy by WHO (2001, 2008). Key aspects of Primary Care include first contact care, direct patient access, patient-centred care with family orientation and continuity, a 'gatekeeping function to access to specialist care and generally a role in coordinating care (Bower & Gilbody, 2005; Starfield, 1992; Fry & Horder, 1994). Furthermore, there is evidence that the degree of primary care focus in a health care system (especially the gatekeeping role) is an important element leading to cost-effectiveness and efficiency of care provision (Starfield, 1992).

MU in Cyclades – the context

Mental Health Mobile Units of Northeastern and Western Cyclades Islands, which are scientifically and administratively managed by EPAPSY, were founded in 2004.

The sector served by the Mobile Units consists of 12 islands (northeastern and western Cyclades) with a population of about 80.000 inhabitants (National Statistic Service 2011).The NE Cyclades mobile unit is based on Paros and is responsible for the islands of Syros, Andros, Mykonos, Tinos, Paros and Antiparos. Likewise, the Western Cyclades mobile unit is based on Milos and is responsible for the islands of Milos, Kimolos, Sifnos, Serifos, Kea and Kythnos.

Services are provided by teams of mental health professionals (psychiatrists, child psychiatrists, psychologists and social workers) visiting the island twice a month for two or three days. Sessions take place in Health Centres or offices provided by the local authorities, while there is also the possibility of home visits. Supervision of clinical and community work as well as training seminars take place for the multidisciplinary team twice a month (Stylianidis et al., 2007; Pantelidou et al., 2010).

Both mobile units operate with specific tasks, listed underneath:

- In-time diagnosis - intervention to prevent the onset of disease or a remission.
- Home intervention to deal with and manage crises.
- Home treatment and monitoring of medication, follow-up of the course of the illness at regular intervals, and to ensure the continuity of psychiatric care for the patient.
- Help and support for the patient in meeting his practical needs with emphasis on teaching him skills and preparing him for the end goal, which is an independent life.
- Counselling – support for the family of the patient to ensure better communication, and reduce stress for both the family and the patient.
- Training key players in each setting (doctors, local authorities, volunteers, police officers, priests, teachers)
- Combating social stigma through community training programmes.

There are four major areas in which the mobile units act: assessment of needs, clinical practice, integration with primary health care and mental health promotion. However, there are special characteristics in the reality of the islands.

There is a great contrast between the way of living during summer and during the winter. As most of the islands have become among the most popular tourist attraction this period for the last 15 years, they become crowded and the local population works mainly in touristic enterprises. In contrast, during winter the islands give the image of isolated communities, many people do not work during this period, social events become less and generally social life for locals is very restricted. Weather conditions during winter in some cases do not permit travelling, giving the feeling of even greater isolation. This great change has a significant impact in the way of living, the culture, the patterns of thought and behaviour, even in the way mental health demands are formed and expressed. Most of the local communities are introvert.

Concerning health and social services in the region, in every island there is a Health Centre (except for some very small islands where there is only a Peripheral medical office

with one or two general practitioners). The capital of Cyclades is Syros (with a population of over 20.000 residents), where there is a General Hospital. In every island there are also social services for elderly people, programmes providing help at home funded by Municipalities (severe dysfunction during the last three years due to lack of funding), programmes concerning the prevention of substance use (in some islands) and some services for people with special needs in Syros and Paros (a voluntary service). These services have been developed over the last 10 years.

There are no mental health services in the islands with the exception of a psychiatrist in the General Hospital of Syros. As a result, for many years a lot of people suffering from mental disorders did not seek for help and had to travel to Athens to get psychiatric care. Stigma and prejudice toward mental health issues is also a great barrier to seeking help and should be into consideration by a community mental health team starting working in a region with no sensitization in the field.

To sum up, all of the above can be translated, in terms of mental health strategy, as the inadequate development of PHC system, the insufficient number of well-trained GPs in respect to the population needs, the low level of integration with specialist services, the devaluated role of General Practitioner in managing mental health problems and, last but not least, the isolation of the area.

As a result, these characteristics along with the framework of function of the Mobile Units, dictate the formation of specific working hypotheses of clinical and community work that need to be taken into account:

-work must be adapted to specific needs and characteristics of every island

-socio-anthropological issues are taken into consideration in order to form an ethno-psychiatric approach to the community: specific cultural codes, attitudes towards “the different”, prejudice concerning mental health issues, factors having a role in forming the “psychiatric demand”, the way symptoms are expressed differ from one community to another and should be well understood and direct work in the islands

-working towards the integration with other services, the mobilisation of local resources and the development of local health system are also necessary. Introversion of a service in

an already “introverted’ community would result in greater fragmentation of care provided and would be completely ineffective in succeeding its aims.

Research: Background, Purpose and Objectives

To begin with, it is important to note that, although the mobile units begun their operation in 2004, it was not until 2007 that a large scale epidemiological research on the prevalence of common mental disorders in general population of Paros and Antiparos was conducted. This research, in collaboration with Panteion University of Athens and the Psychiatric Clinic of University of Ioannina, with the support of local authorities (Stylianidis et al 2010), was a stepping stone in regard to needs assessment for the islands of Cyclades.

In order for this research to be feasible, the mobile units had developed through an empirical process a record providing information about chronic psychiatric conditions in the community and the most common problems in the field of mental health. Information was gathered through the records of Primary Health Care and social services, as well as community work, such as meetings with key persons in the communities i.e representatives of local authorities, doctors, professionals of social services, teachers, priests etc. This record, which was later enriched with information, has proven to be the basic tool in identifying the psychiatric and social problems managed by health and social services, as well as untreated problems referred by key persons.

The findings of the first epidemiological research, conducted with a sample of 506 persons randomly selected from the general population, showed that the prevalence of psychiatric morbidity was 22%, while the prevalence of major depression was greater in women (4,15%) than men (0,54). Alcohol misuse was found to be three times greater in men (12%) than women (3%). Generally, women, unmarried and retired were more likely to suffer from a common psychiatric disorder.

Following this first research, two more surveys were conducted. The first, assessing the prevalence of common mental disorders in 323 high-school students in Paros (aged 15-17) using CIS-R (Lewis et al 1992). Major depression was found in 1,6% of students and mild depression was found in 6% of students (almost three times greater in girls). Depressive symptoms were more common in higher levels of school. Substance use (alcohol, cannabis, smoking) was higher in students suffering from depressive symptoms. Cannabis

use (once) and alcohol use (at least once in a week) were greater in boys than girls (12% vs 4% for canabbis use and 31% vs 21% for alcohol use), while smoking (at least once a week) was higher in girls, 18% vs 13% in boys (Skapinakis et al 2010).

The second, concerning the number of compulsory hospitalisation of psychiatric patients living in Cyclades Islands during the period 2000-2005. It was found that there was an increase in the number of compulsory hospitalisations from Cyclades Islands from 2000 till 2005.

Overall, having presented a short background on the formation and function of the mobile units in the Cyclades, along with the specificities that arise in this geographical area and the prevalence of mental disorders in a representative sample of the population, we shall now try to focus on examining the evolution and impact of the services during the ten years of operation. Our main target is to examine the key areas in which the operation of the mobile units throughout the ten year period has had an effect.

The main areas around which we shall focus our research and analysis are:

a. Clinical work
b. integration with primary care
c. mental health promotion and development of community networks

As far as clinical work is concerned, we shall try to identify certain characteristics of the population treated by the mobile units, which can help us draw some conclusions upon the treatment programmes, the requests and – up to the extent to which it can be accomplished - outcomes and how they have evolved over time.

In addition, we shall try to evaluate the level of integration that has been achieved with primary care, mainly through the referral process and the cooperation between the units and the health centres.

Finally, we shall look at the most important mental health promotion activities that have taken place over the last decade and how these have contributed to the further development of the community networks established through the operation of the mobile units in the islands.

2. METHODOLOGY

Sample

The sample of the present study is the clinical population of 6,884 adults, who were referred to the mobile psychiatric units of EPAPSY in West and North-East Cyclades between the years 2003 and 2014. It is worth mentioning that almost 30% of the permanent inhabitants of the islands have been reached. At this point we should mention that the mobile units have also offered services to children and adolescents, the clinical population of which was 2,035. We shall not use this population in our main research sample, although we feel that it is worth mentioning certain data which can be of interest for our discussion.

Procedures & Data collection

The data reported in the present study are derived from a retrospective study of the medical records of all patients referred to the mobile psychiatric units of EPAPSY between the years 2003 and 2014. Data were obtained through four major sources:

A. a self-reported questionnaire administrated prior to the first session to every patient referred to the units.

B. the clinical data entered in the patient's medical record by the responsible mental health professional assigned with the case after completion of the psychiatric evaluation.

C. the records of community work and mental health promotion activities, as well as review of the articles published in the local press regarding the operation of the mobile units throughout the Cyclades

D. focus group discussion with the key players in the community, including the head of the medical centre, the head of primary and secondary education, the head of the police department and the head of the social services of the municipality.

Instruments & Variables

The self-reported questionnaire includes 20 items asking about a number of socio-demographic and socioeconomic factors, as well as basic features of the past and present medical history of the patient. This questionnaire is a useful tool in the process of gathering information during the intake and has been of great assistance to both administrative as well as clinical work of the units.

The socio-demographic variables studied were: gender, age, country of origin, family status, while the socioeconomic variables included: educational status, which was defined as the highest educational level attained, employment type, employment status.

Basic information regarding the present and past medical history includes various variables such as initial request, history of hospitalization, prior contact with a mental health professional, life events, chronic physical conditions etc.

The clinical data entered by the clinician in the patients' medical records that interest us in the present study include the following variables: diagnosis, general functioning and suggested treatment plan. The diagnosis is entered according to the criteria of the ICD-10 Classification of Diseases. In the present study we are going to investigate the diagnostic categories of "Chapter V: Mental and Behavioural disorders (F00-99)", as well as those from "Chapter XXI: Factors influencing health status and contact with health services (Z00-99)". The general functioning is assessed using the Global Assessment of Functioning (GAF) scale and the score is presented as a range.

Statistical analyses

Descriptive analyses were run in order to present our sample and the population using the mobile units of EPAPSY. We performed chi-square tests for all variables of interest.

3. RESULTS

The sample of the present study is the clinical population of 6,884 adults, who were referred to the mobile psychiatric units of EPAPSY in West and North-East Cyclades between the years 2003 and 2014. The mean number of patients served per year was 564 (the relevant figure ranged between 324 in 2009 and 949 in 2013)

Figure 1. Number of patients (adults)

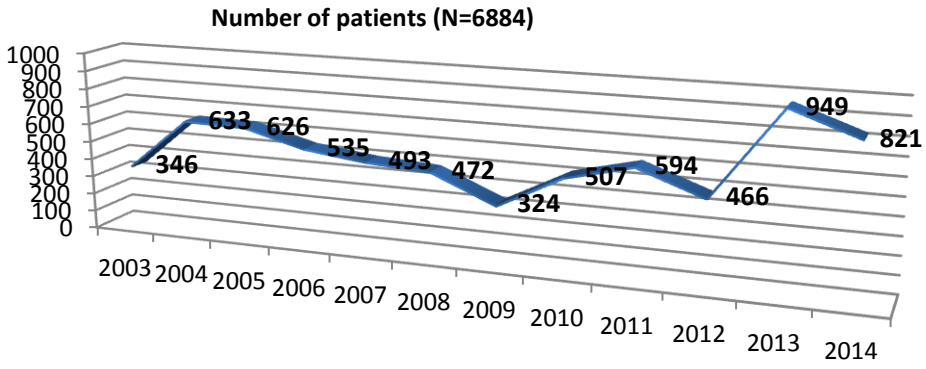
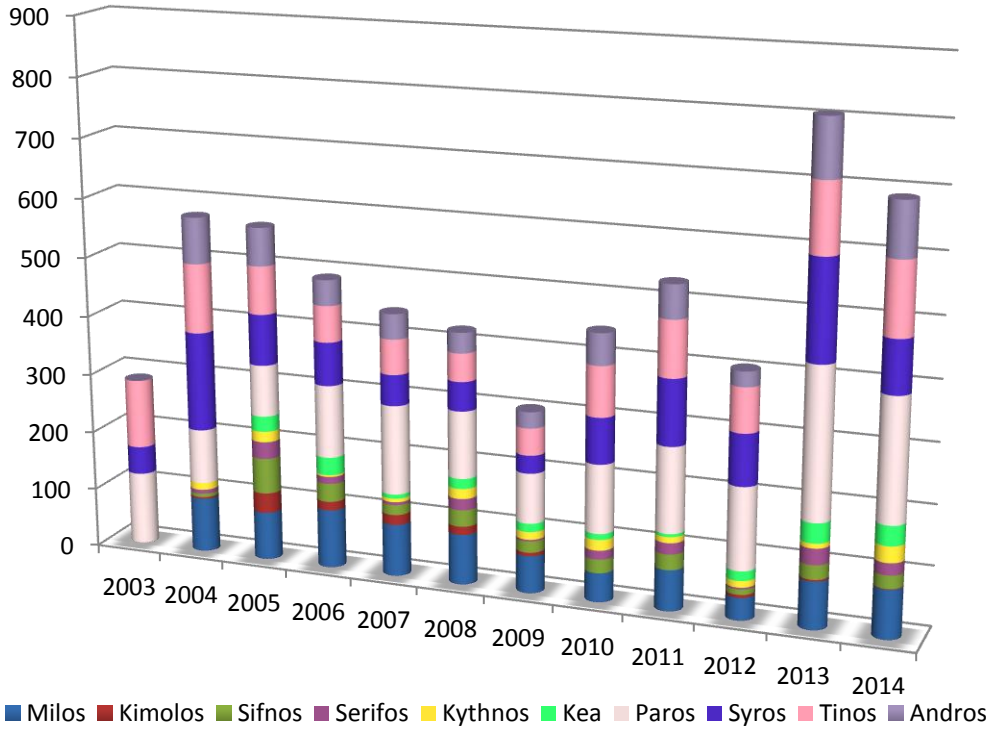


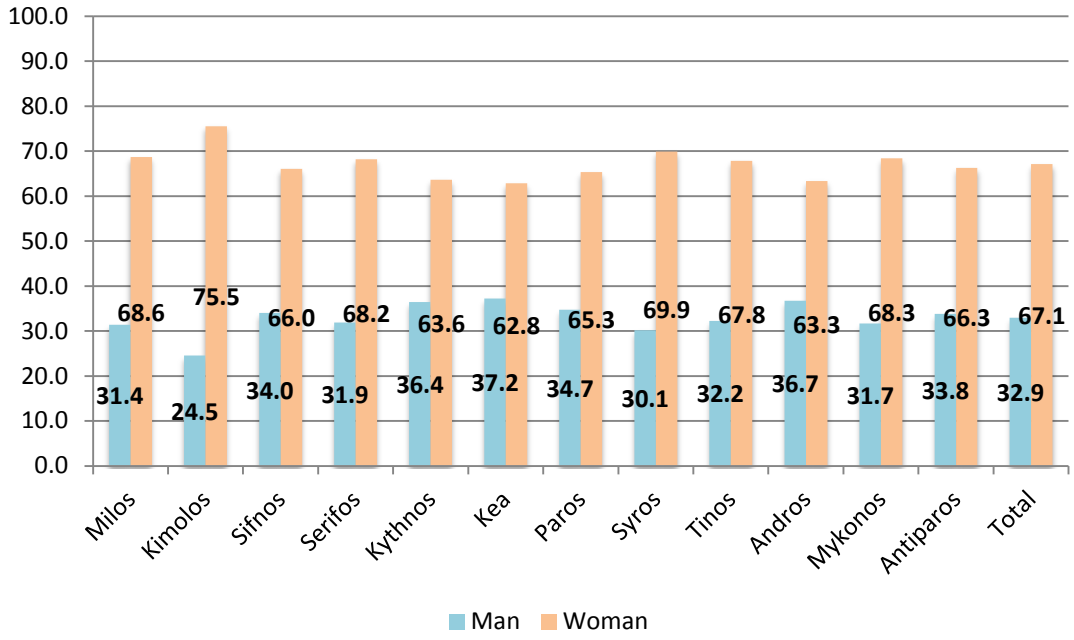
Figure 2. Number of patients per year per island



Socio-demographic characteristics of the sample

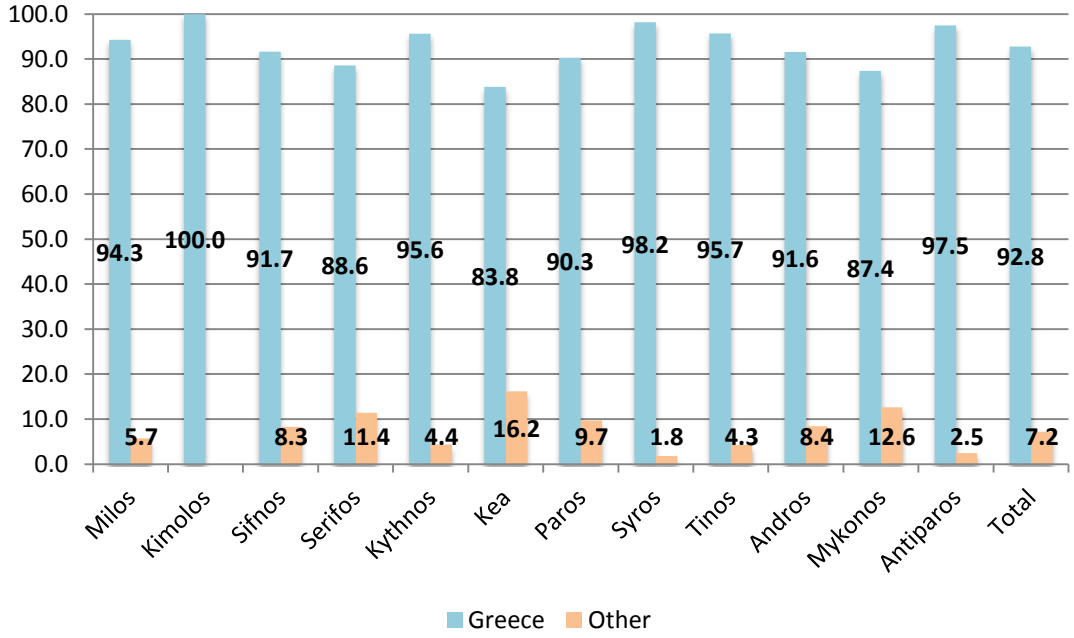
Figure 3 SEX

67.1% of the individuals were women,



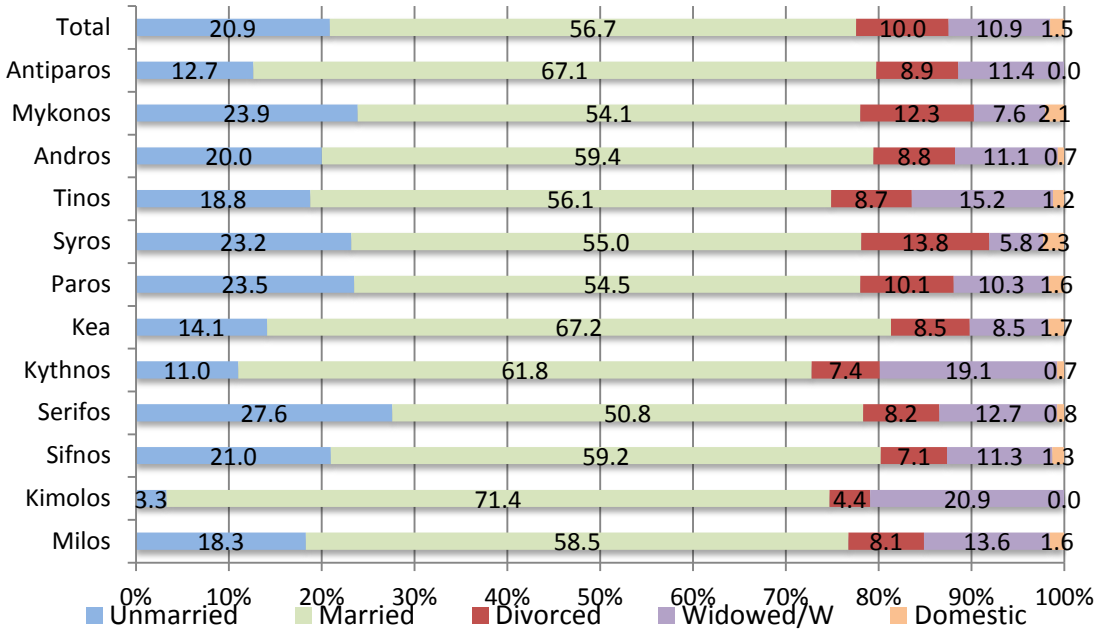
while only 7.2% of them had an origin other than Greek.

Figure 4 country of origin



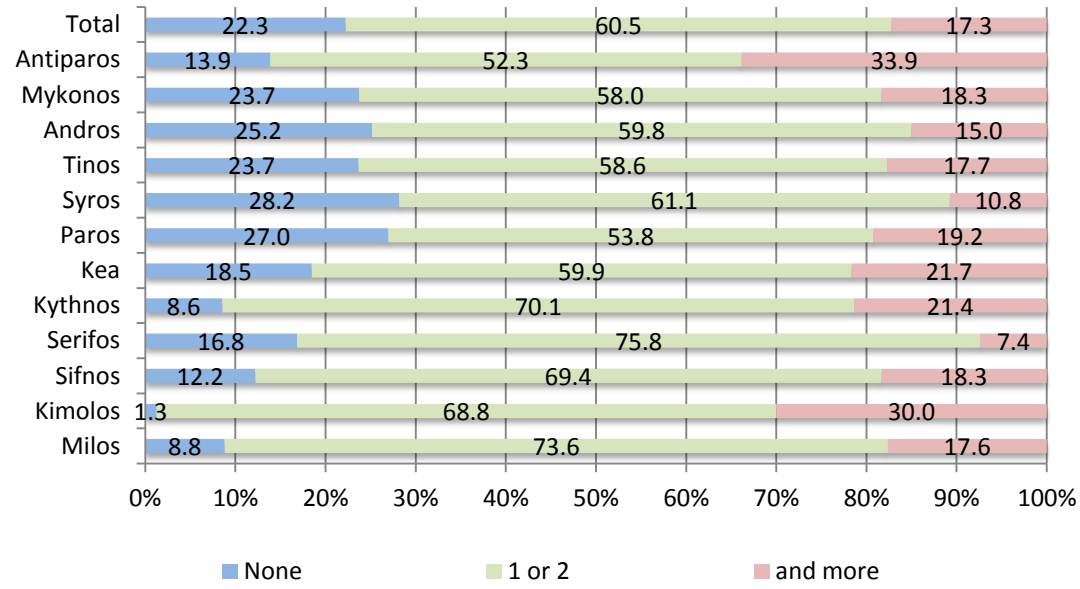
The majority were married (56.7%), while 20.9% have never got married, 10.9% were widowed, 10% divorced and 1.5% in a domestic partnership.

Figure 5 marital status



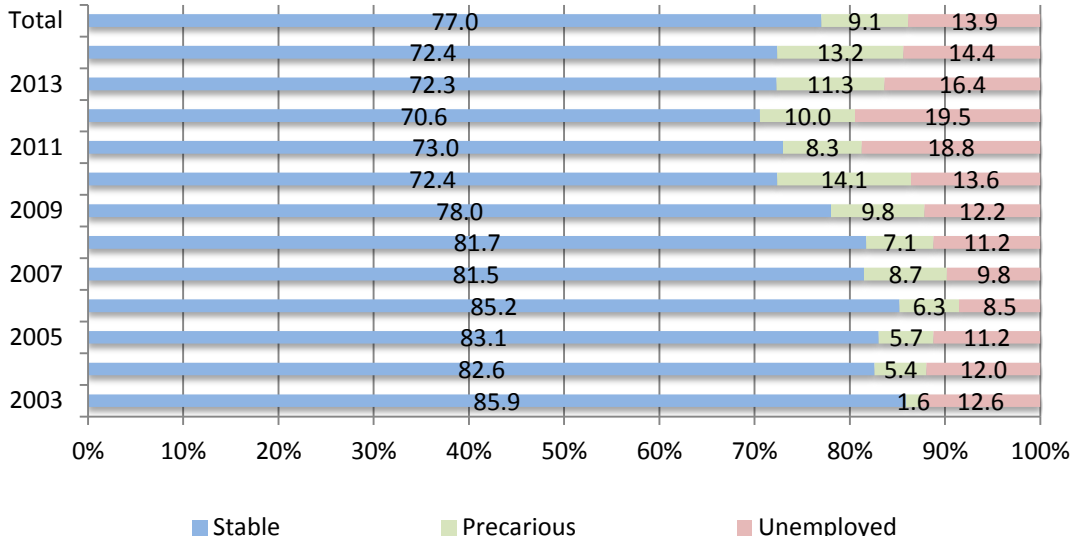
Most of the individuals (60.5%) had one or two children and 17.3% of them had 3 or more children.

Figure 6 Number of children



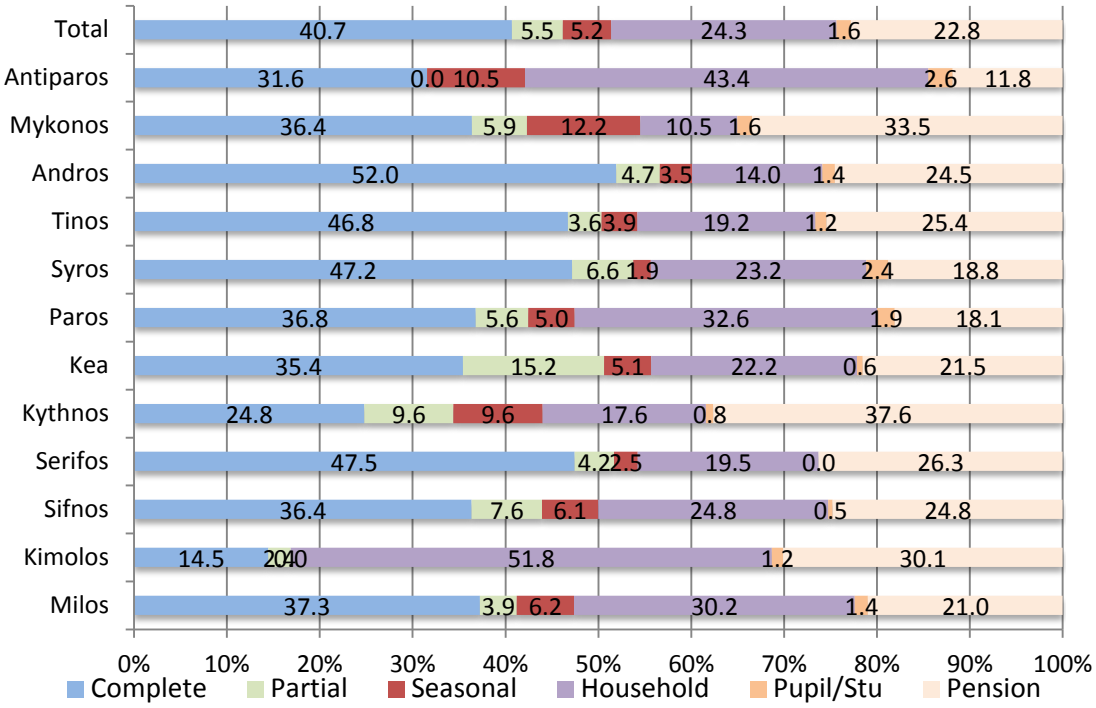
Between 2003 and 2014 13.9% of the patients referred to the mobile units were unemployed, while 9.1% of them were on a precarious employment status.

Figure 7 employment



Regarding the employment type, 5.2% individuals in our sample had a seasonal job, 5.5% worked on a part-time basis, 22.8% were pensioners, 24.3% looked after the household, while the majority (40.7%) had a full-time job.

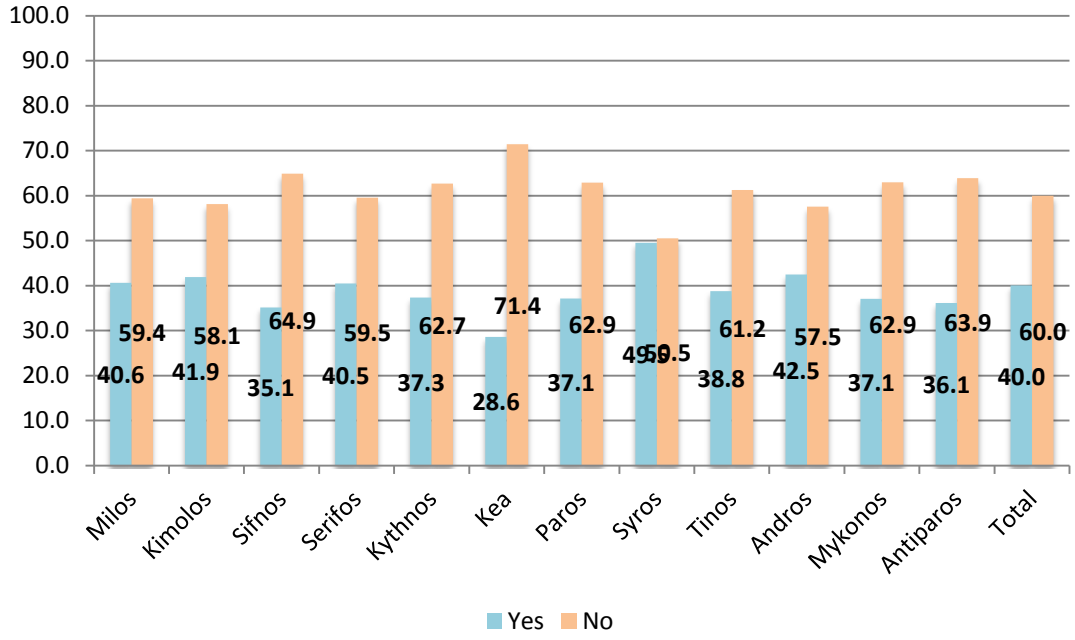
Figure 8 employment type



Health characteristics of the sample

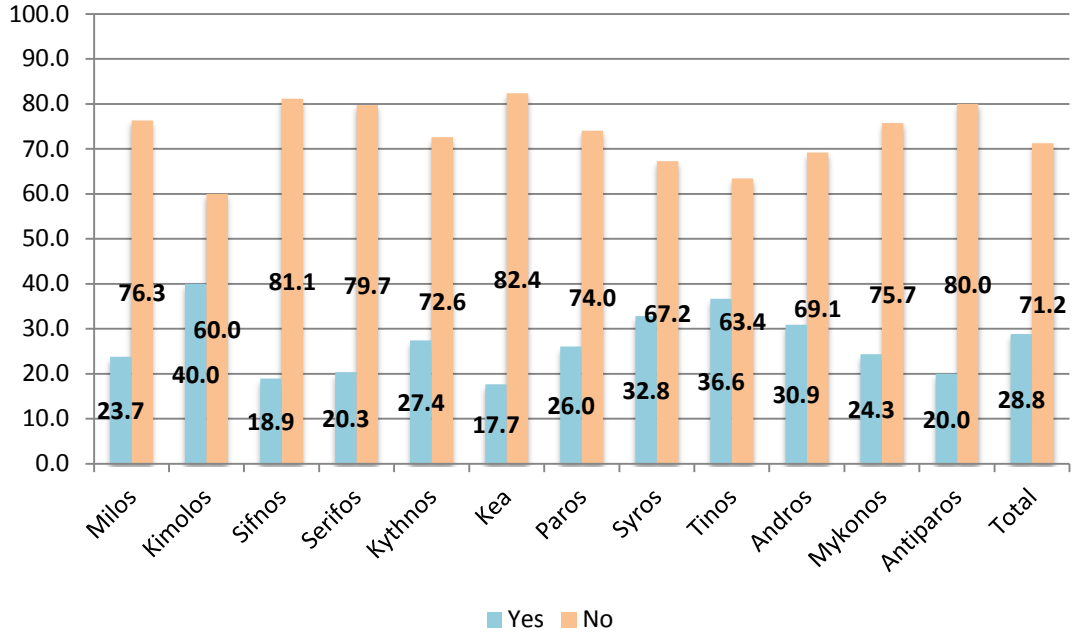
60% of the patients in our sample have never visited a mental health professional before,

Figure 9 Previous visit to mental health professional



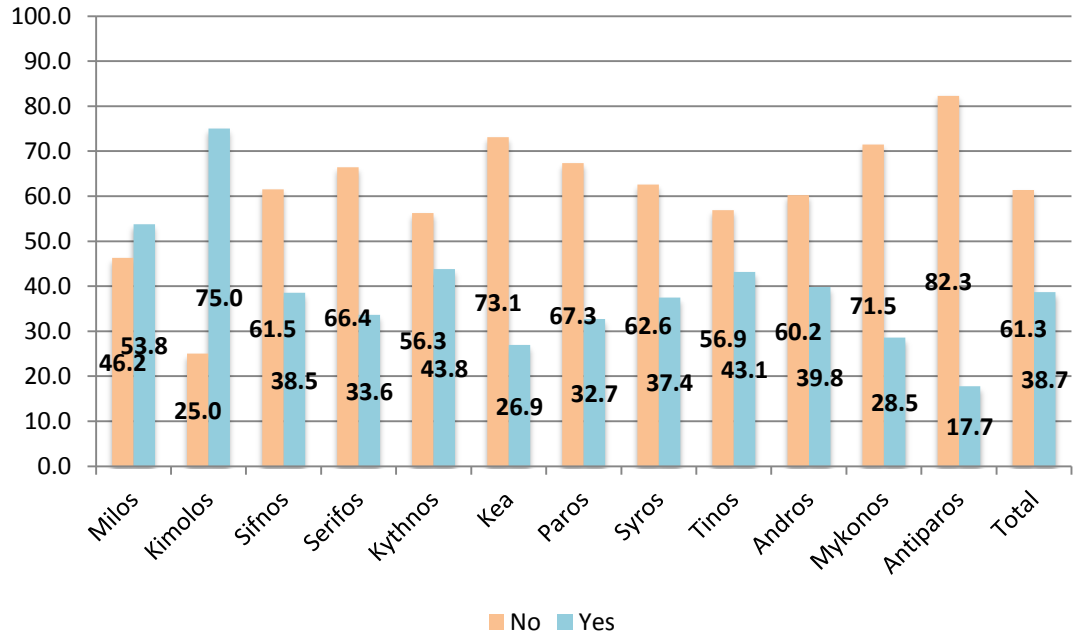
while 28.8% of them report that they are facing a serious health problem.

Figure 10 serious health problem



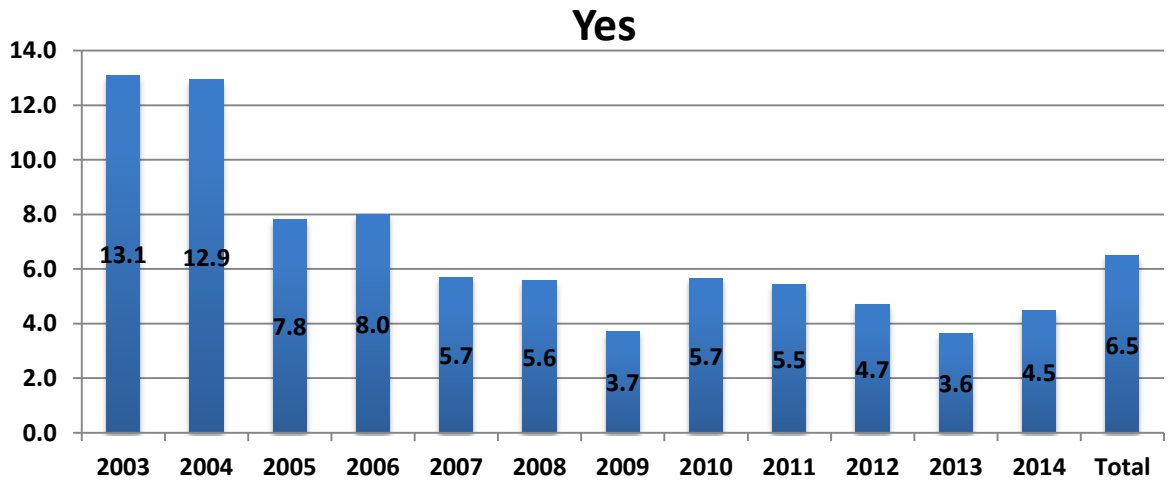
38.7% of the patients that visited the mental health mobile services of EPAPSY reported a concurrent chronic physical ailment

Figure 11 chronic physical ailments



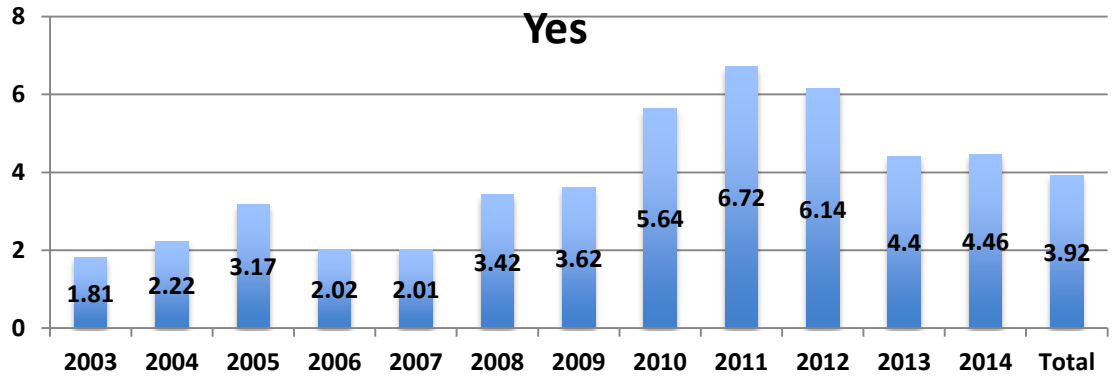
On the whole, 6.5% of the adults referred to the mobile psychiatric units reported a history of previous psychiatric hospitalization.

Figure 12 Psy hospitalization



The co-morbidity rate in our sample, defined as having received at least two different ICD-10 diagnoses, was 3.92%.

Figure 13 co-morbidity



Mean scores in the Global Assessment of Functioning (GAF) scale for each year between the years 2003 and 2014 in a sample of 6,684 adults referred to the mobile units of EPAPSY.

Figure 14 Mean scores in the Global Assessment of Functioning

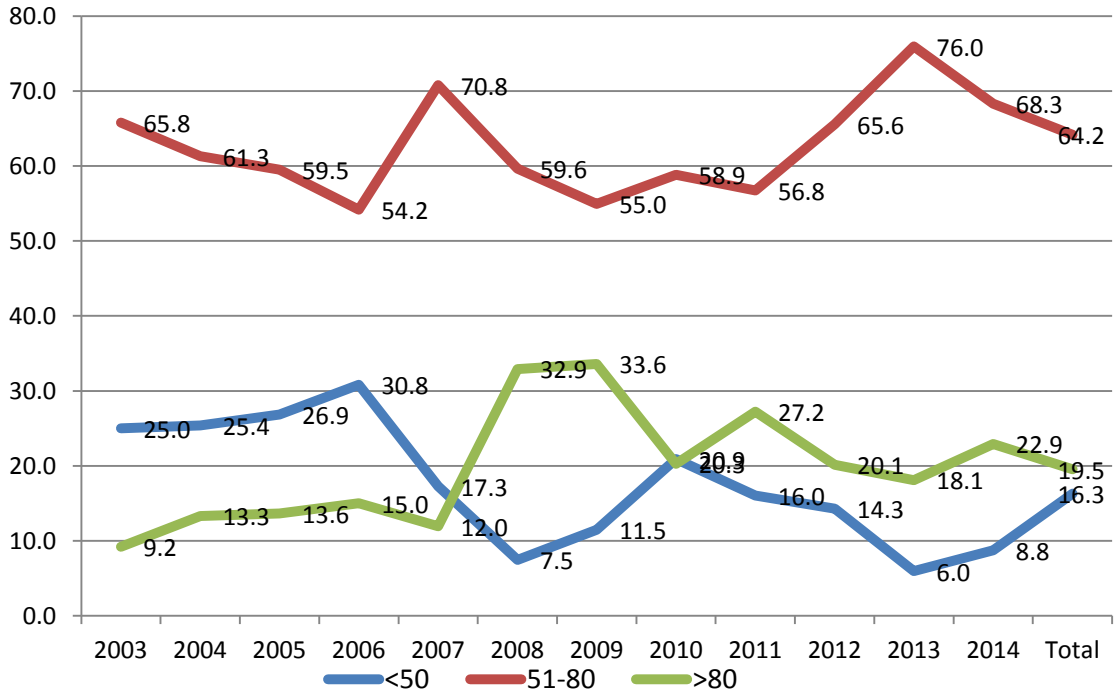
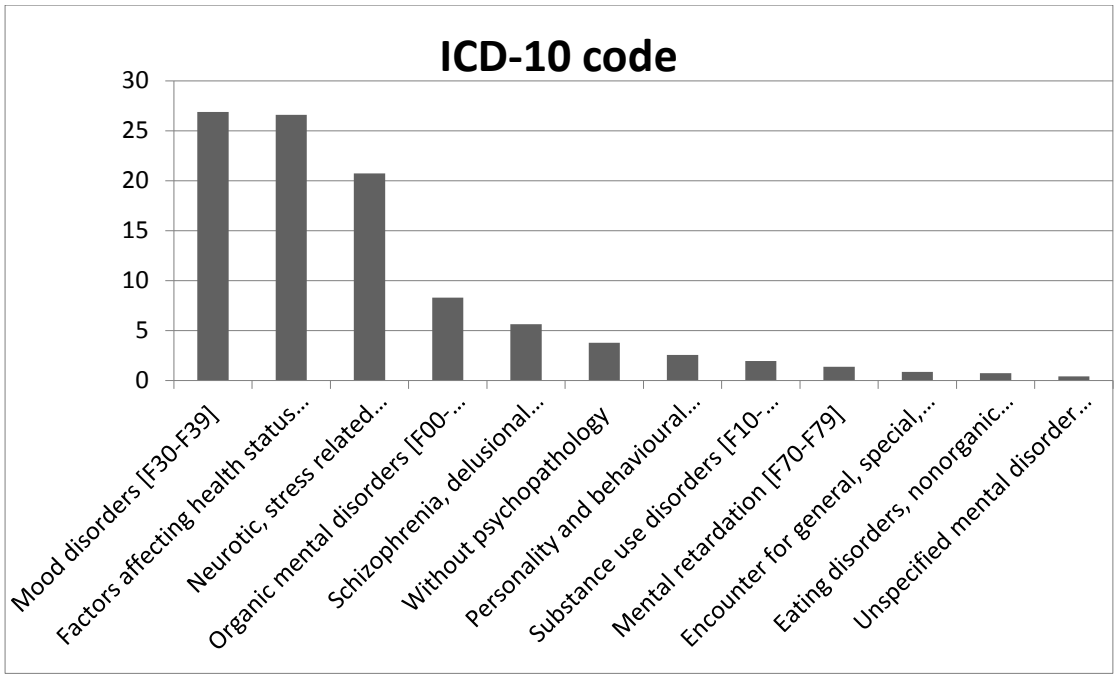
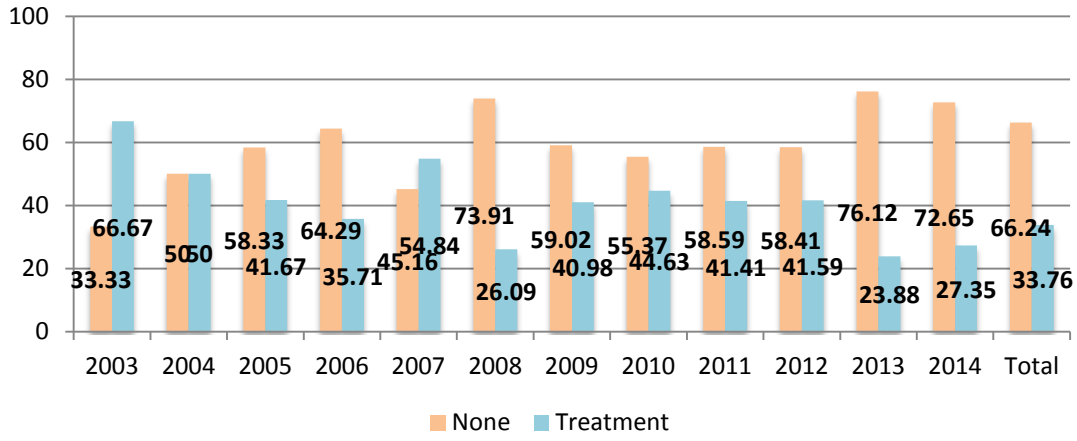


Figure 15 Diagnostic categories according to the criteria of the ICD-10 Classification of Diseases, as set by the EPAPSY psychiatrists



The diagnoses according to the criteria of the ICD-10 Classification of Diseases were set after the completion of the psychiatric evaluation conducted by the professionals of EPAPSY. “Mood disorders” (26.9%) and “Factors affecting the health status” (26.6%) were the most common and equally prevalent diagnostic categories in our sample. On the whole 27.4% of the individuals in our sample received a diagnosis from the Z codes of the ICD-10 Classification of Diseases, 68.8% from the F codes (Mental, Behavioral and Neurodevelopmental disorders), while 3.8% of the individuals referred to the mobile psychiatric units had no psychopathology.

Figure 16 treatment received



After the completion of the relevant evaluation it was decided that there was no need for any kind of treatment for 5.1% of the adults in our sample. Regarding the cases for which treatment was indicated, 49% were offered a psychological treatment, 31.9% pharmacotherapy, 14.8% psychotherapy, 1.9% were referred to another service and 2.4% received other kinds of intervention. Among those who were offered pharmacotherapy, 15% received anxiolytics, 22.4% antidepressants, 9.6% antipsychotics, 1.7% anti-dementia drugs and 3.8% other kinds of medication.

Figure 17. Number of patients per year

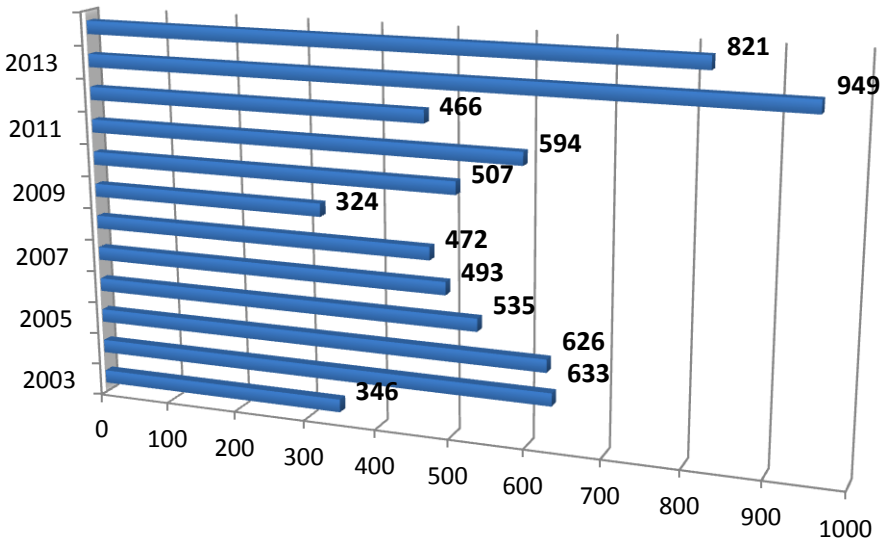


Figure 18.1 initial request

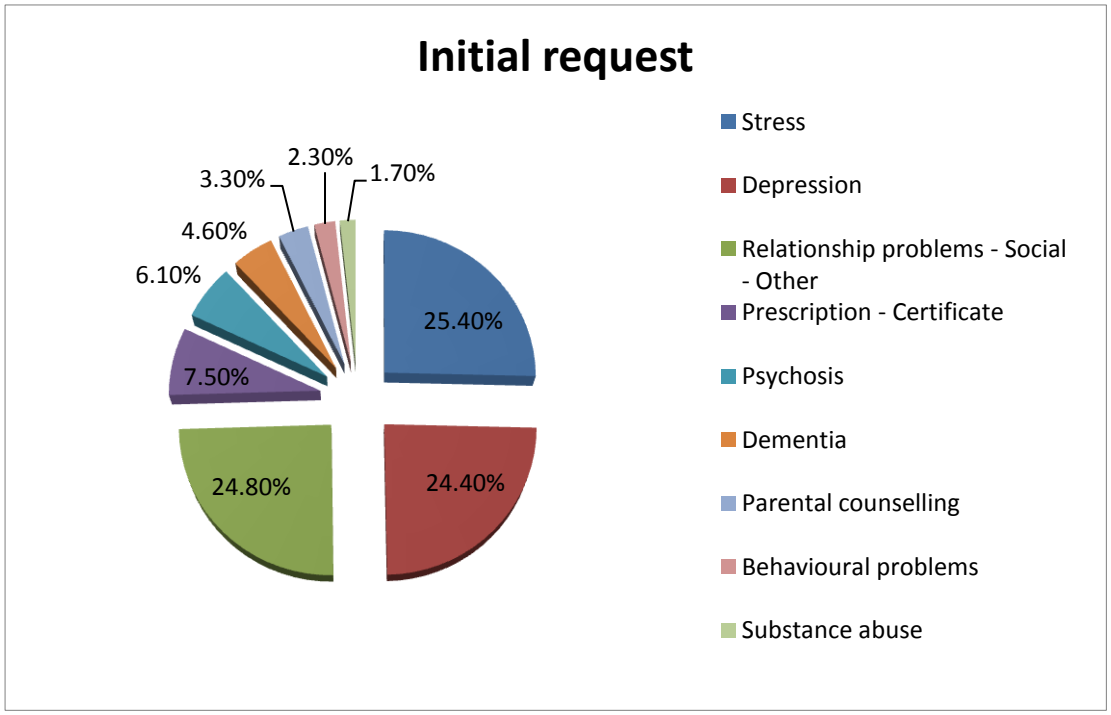


Figure 18.2 initial request per year

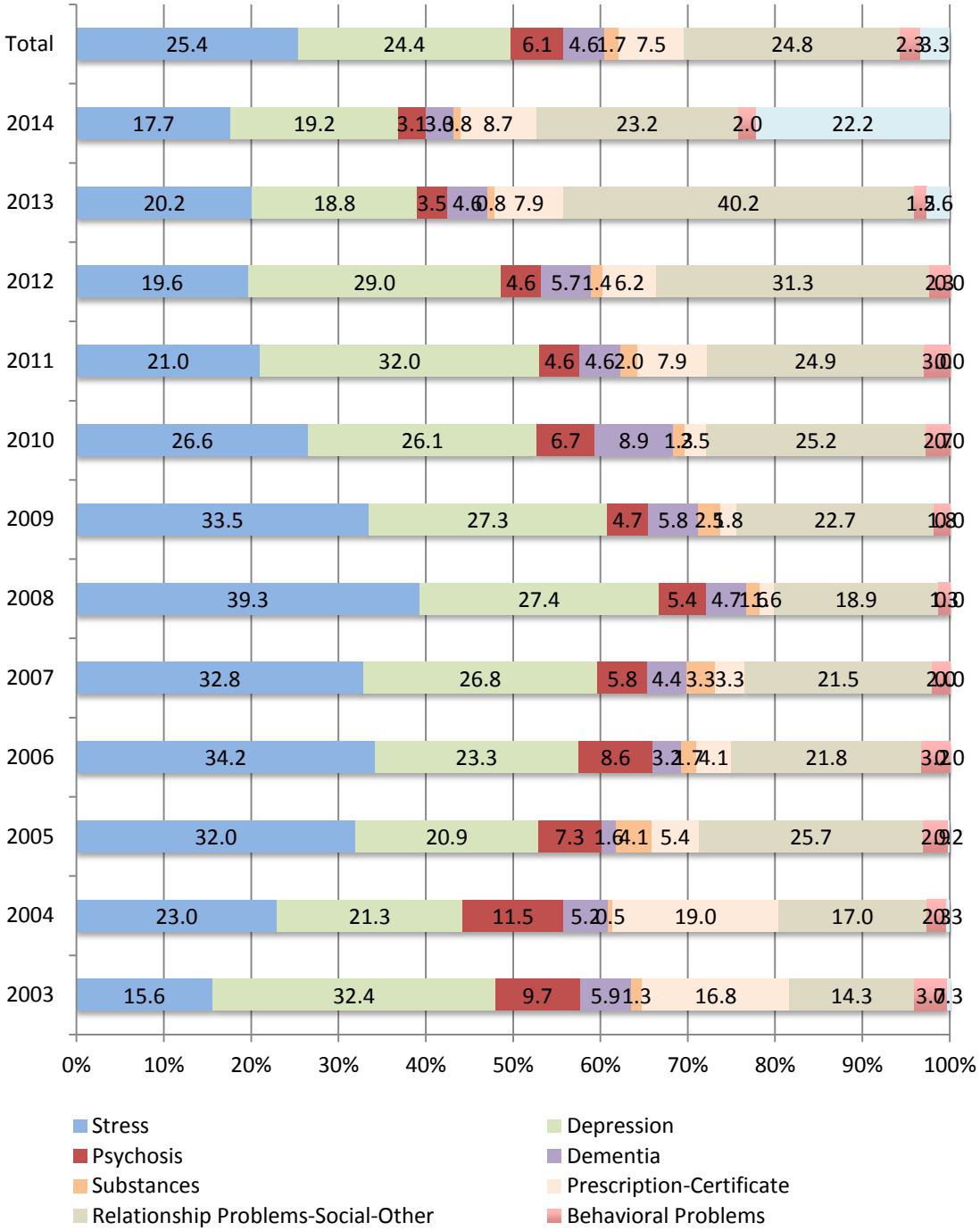


Table 5. Relevant Frequencies of the diagnoses of the adults served in the 1st decade of the NE & W Cyclades Mobile Units operation (N = 5,021 & 1,863 respectively)

Diagnosis	NE Cyclades	W Cyclades
Organic, including symptomatic, mental disorders (F00-F09)	7.8%	12%
Mental and behavioral disorders due to psychoactive substance use (F10-F19)	2.4%	1,2%
Schizophrenia, schizotypal and delusional disorder (F20-F29)	6.9%	3,4%
Mood (affective) disorders (F30-F39)	28.2%	27,9%
Neurotic, stress related and somatoform disorders (F40-F48)	18.5%	23,4%
Behavioral syndromes associated with physiological disturbance and physical factors (F50-F59)	0.7%	0,7%
Disorders of adult personality and behavior (F60-F69)	2.4%	4,7%
Mental retardation (F70-F79)	1.1%	1,9%
Disorders of psychological development (F80-F89)	0.2%	0,4%
Unspecified mental disorder (F99)	0.1%	0,1%
Counseling/Medical advice (Z71)	6.6%	4%
Problems related to social environment and to primary support group (Z60-F63)	18.1%	13,8%
No mental disorder-Certificates-Other	7.1%	6,5%

Figure 19 Relevant Frequencies of the diagnoses of the adults served during the 1st decade of the NE & W Cyclades Mobile Units operation (N = 6,884).

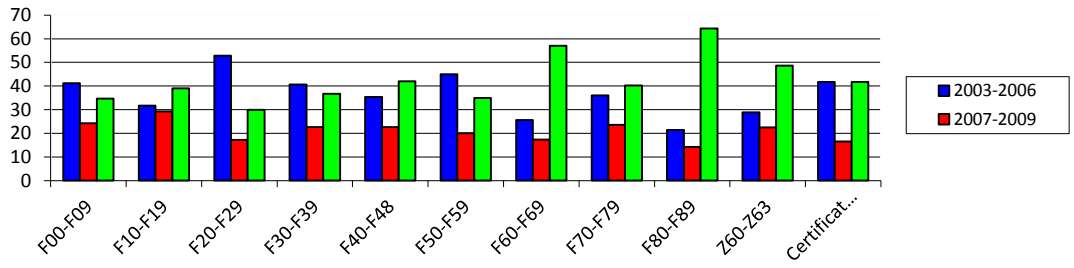
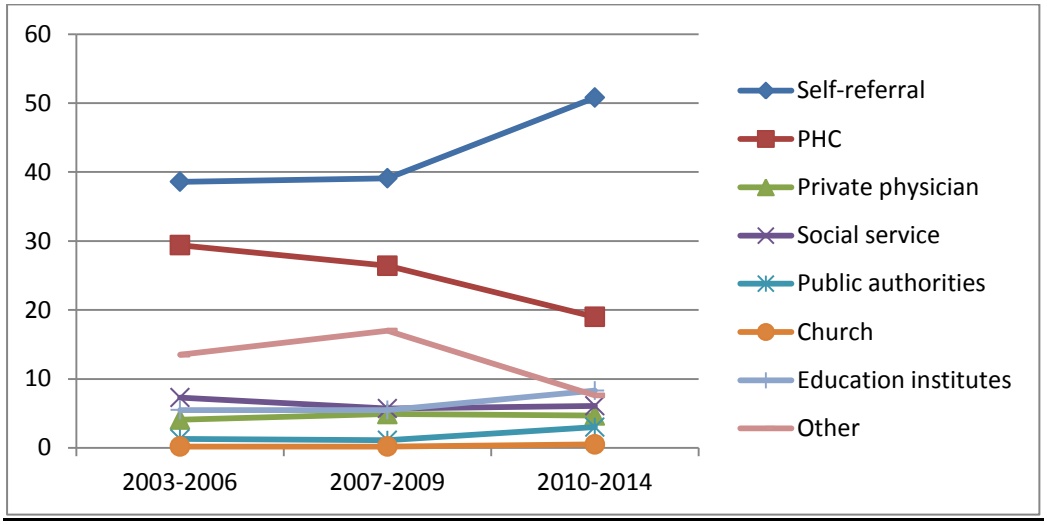


Table 6. Relevant Frequencies of the referral sources in the 1st decade of the NE & W Cyclades Mobile Units operation

Referral sources	NE Cyclades	W Cyclades	Total
Self referral	48.9%	30.6%	44.4%
Primary Health Care	23.3%	26.6%	24.1%
Private Practice Physician	5%	2.9%	4.5%
Social service	6.8%	5.1%	6.4%
Public authorities	1.5%	3.8%	2.1%
Church	0.3%	0.3%	0.3%
Educational institutes	6.1%	22.3%	6.6%
Other	8.1%	8,4%	116%

Figure 20. Relevant Frequencies of the referral sources in the 1st decade of the NE & W Cyclades Mobile Units operation



Children And Adolescents

The following 4 tables present the main demographic characteristic, requests, referrals and diagnosis for this population. As mentioned before, although not taken into account in our sample, the recent socioeconomic crisis has been the source of a rise in family problems, which, unavoidably, affect children and adolescents. We feel it is worth presenting some data in a area which will be of great interest in the near future.

During the 10 years the mobile mental health units have been in operation they served a total of 1,339 children and adolescents in the NE Cyclades and 567 in the Western Cyclades, whose average age was 9.2 years old (*SD* = 4.1, *min* = 1 *max* = 2)

Table 1. Demographic characteristics of children and adolescents who received services from the mobile mental health units in the NE and Western Cyclades in the first 10 years they were in operation (N = 1906)

Demographic variables	f	%
Gender:		
Boy	1,121	58.8
Girl	785	41.2
Country of origin:		
Greece	1,728	90.7
Abroad	178	9.3
Prior contact with a mental health expert:		
Yes	391	24.5
No	1,199	75.3

Table 2. Relative frequencies of sources of referrals to mobile units in the NE and Western Cyclades in the first decade in operation (N=1,906)

Source of referrals	NE Cyclades	Western Cyclades	Total
Self-referral	49.3%	34.3%	45.2%
Primary healthcare	11.6%	8.7%	10.9%
Private doctor	3.9%	1.3%	3.3%
Community body	4.6%	2.3%	3.9%
Public authorities	0.9%	4.6%	1.5%
Church	0.2%	0%	0.1%

Educational body	22.5%	25%	23.3%
Other	6.9%	23.7%	11.8%

Table 3. Relative frequencies of initial requests made to mobile units in the NE and Western Cyclades in the first decade in operation

Initial request	NE Cyclades	Western Cyclades	Total
Psychiatric symptoms	18.8%	15%	17.5%
Learning problems	15.3%	29.1%	19.8%
Behavioural problems	27.6%	20.6%	25.2%
Substance dependence / abuse	0.2%	0%	0.1%
Problems with family relations	16.4%	14%	15.6%
Speech problems	5.8%	6.2%	5.9%
Developmental disorders	1.9%	1%	1.6%
Eating disorders	1.1%	1.2%	1.2%
Mental retardation	0.4%	0.8%	0.5%
Certificates, etc.	1%	2.3%	1.5%
Social surveys	11.4%	9.9%	10.9%
Other	0.1%	0%	0.1%

Table 4. Relevant Frequencies of the diagnoses of the Children and Adolescents served in the 1st decade of the NE & W Cyclades Mobile Units operation. (N = 1339 and 567 respectively)

Diagnosis	NA Cyclades	W Cyclades
Organic, including symptomatic, mental disorders (F00-F09)	0.3%	0.2%
Mental and behavioral disorders due to psychoactive substance use (F10-F19)	0.1%	
Schizophrenia, schizotypal and delusional disorder (F20-F29)	0.3%	0.9%
Mood (affective) disorders (F30-F39)	4.1%	5.7%
Neurotic, stress related and somatoform disorders (F40-F48)	11.4%	13.4%
Behavioral syndromes associated with physiological disturbance and physical factors (F50-F59)	1.8%	1.4%
Disorders of adult personality and behavior (F60-F69)	1.7%	1.1%
Mental retardation (F70-F79)	2.4%	3.9%
Disorders of psychological development (F80-F89)	25.2%	19.6%
Behavioral and emotional disorders with onset usually accruing in childhood and adolescence (F90-F98)	22.2%	21.6%
Unspecified mental disorder ((F99)	0.1%	
Problems related to social environment and to primary support group (Z60-Z63)	25.9%	26%
No mental disorder-Certificates-Other	4.7%	6.2%

4. **Discussion**

The clinical work of the Mobile Units (MU) includes psychiatric and psychological assessment and diagnosis, personal, group, family and couple counseling and psychotherapy, coordination of a social club for people with severe psychosocial problems, social investigations in cases of child abuse, support of families with multiple psychosocial and medical problems, as well as home care.

As it is easily understandable, while there were no such services offered across the islands – with the exception of syros island, where there is a child psychiatrist at the general hospital – the operation of the mobile units has played an important role in the everyday day life of the population suffering from mental health problems. Before the mobile units started their operation, there were only two options: either arrange a visit at the general hospital in Syros (which can be very difficult in terms of work load of the psychiatrist, means of transport – as interisland connections are not very easy, or travel to the capital of Athens and arrange a visit at one of the psychiatric hospitals.

As a result, having the professionals offering services at the islands, was not only saving time and money for the inhabitants, but also gave people the advantage of having their "personal" therapist, at no cost and at the proximity of their home. Evidently, apart from the obvious advantages in cost and time savings, what appears to be the greatest benefit for the population treated by the mobile units is the potential "savings" in psychological cost, for them and their families, not having to endure the travel to a psychiatric hospital, which, in most of the cases, result in hospitalization. In addition, it is worth mentioning that, even if relapses were difficult to predict, it was much easier for both users of the services as well as professionals to prevent them, since there was a closer monitoring of each case (with a frequency of twice or once a month).

Monitoring the change in new cases over time, as shown in figure 17, during the first years in operation there was a gradual increase in new cases. This is rather common within any community intervention where there are no other mental health services. This rise was followed by a drop in the preceding years, which can be attributed to internal funding

problems of the Ministry Of Health towards the services. Then, one can notice a gradual rise, which is probably associated with the impacts of the socio-economic crisis as well as with the activities undertaken relating to prevention and awareness raising for the psychosocial health of adolescents and their families, triggered by the raise of initial requests.

The various types of the initial request as presented by the patients referred to the mobile units of EPAPSY. The three major reasons for referral, i.e. stress, depression and relationship/social problems, are equally common and together they represent three quarters of all types of requests.

Looking at figure (18.2), where initial requests are examined per year, it is worth taking a note of the rapid increase of social related and relationships problems during 2012 and especially 2013, when the percentage of initial request for this cause reached an absolute highest of all requests throughout the whole decade of operation of the mobile units (40,2%). As the socio-economic crisis had reached its peak, the level of unemployment was increasing, along with the difficulties faced in everyday life amongst relationships, families and community life.

Concerning the diagnoses (table 5), the most frequent ones are those related to mood disorders, neurotic and stress related disorders, as well as problems related to social environment and primary support group.

Following the same pattern, as one can notice from figure 19, the decrease of all types of diagnoses during the years 2007-09, reflects mostly the problems concerning the funding of the MU. Concerning the longitudinal occurrence of each diagnosis, psychoses and organic metal disorders are most frequent during the first years of the MU's function.

After the eruption of the socioeconomic crisis in Greece, all types of diagnoses, but in particular affect, neurotic, stress related as well as problems related to socioeconomic conditions and the primary support groups were increased. As a result and in response to this particular trend, there were a series of actions undertaken by the mobile units in order to respond to the needs of the population, which will be presented at a later stage. Overall, one could argue that the mobile units, through the evaluation of initial requests, have a strategic plan to develop activities adapted to the changes in the socioeconomic environment over time.

Taking into consideration table 6 , self-referral, being the most frequent source of referral and actually increasing over time, reflects on one hand the fact that the MU have created strong ties with the local communities so that people may refer on their own to them. On the other hand, it underlines that PHC is not being the most frequent source of referral, as expected, due to the lack of such services in rural areas in favor of extremely large Tertiary Health Care services in Athens.

What becomes clear from the table above is that self referral is the most common source by far amongst all others. Certainly, this shows not only the need that was existent but not served before the operation of the units, but also the fact that, a high level of awareness was achieved through community work and social mobilisation; people would more easily reach out to ask for assistance than before. This can also be argued if we take into account the rise in self referrals after the first few years of operation, as shown in figure 20.

The next source of referrals was primary healthcare providers. Although the second highest, as we can see in the following graph, there is a drop after the first years of operation. This can be explained in two ways: on one hand, one can argue that the operation of the mobile units offered the people the service they needed, so as not to refer to the primary health service. On the other hand, this could be a problem in the process of integration with PHC, as some people who could be treated there, preferred to refer straight to the mobile unit instead.

Looking more deeply at the issue of sources of referrals, it is clear that over time there is a clear statistically significant difference, especially in the two most common sources of referrals, as previously discussed. Nevertheless, it appears that the increase of self referrals is rather equivalent to the decrease in referrals from PHC (chi-square statistical verification (18) = 295.69, $p < 0.001$).

Overall, from a clinical point of view, although we cannot assess whether the actual mental health of the population has itself improved over the years, one could argue that the services offered from the mobile units have improved the overall quality of life of people with mental health problems living on the islands of the Cyclades.

Integration with Primary Health Care

Nevertheless, this does not seem to be the case as far as the integration with primary health care is concerned, as there are serious problems in the operation of primary healthcare in the Cyclades, mainly due to the lack of staff and resources, especially after the years of the socioeconomic crisis. Apart from the lack of staff, there is also a lack of training among doctors in the interface between primary healthcare services and mental health and chronic welfare cases.

Despite the fact that there is a system of liaisons with primary healthcare providers operating within the territorial remit of the mobile units that been built up, one cannot be satisfied with the overall level of integration with PHC. The mobile units have undertaken a series of actions within the context of achieving a satisfactory cooperation with Primary health care to the benefit of the people living on the islands.

To begin with, there have been many workshops focusing on training primary healthcare professionals in how to prevent, recognise and manage mental disorders. These workshops were held locally on each island and were aimed at all doctors and nurses involved in primary healthcare in the Cyclades. In addition, the WHO's MhGap guide (WHO, 2010) has been translated into Greek and is being used in training.

What appears to be the problem in this "relationship" is the fact that the shortage of professionals working in the PHC is creating a work-case overload for them, which, in returns, is translated as an unwillingness to become an active part of the integration model. In our discussion with the head of the Health Centre of Paros, although it was mutually recognised that there is a very good relationship that has been built during the years, it is quite common in emergency settings for a doctor to refer the patient to the mobile units, rather than offering assistance.

In addition, many doctors will not stay for more than two or three years on an island, which unavoidably creates another need for continuous training, which sometimes cannot be undertaken by the professionals of the mobile units. This circle of understaffing, lack of resources and consequently lack of training, leads to an undermined level of integration with PHC. On the other hand, we have to admit that the job turnover in the mobile units is also relatively high. As a result, it becomes even more difficult to build strong and solid ties with the professionals working in PHC.

In general, one can suggest that the already overburdened PHC staff can sometimes be rather reluctant in not only treating a patient with mental health problems, since the easy route of referring him to the mobile units exists, but also in participating in the training sessions. On the other hand, although a solid system of referral exists, we have to admit that there is lack of supervision and guidance from the staff of the mobile units, which eventually degrades the relationship established through training.

Mental Health Promotion & Community Networking

In order to make up for this low level of integration with PHC, which, as previously discussed, could be translated by the drop in referrals, the mobile units have undertaken several activities in the field of mental health promotion. These activities, listed below, were primarily community-focused services aimed at not only the users themselves, but also at strengthening the ties with the community and reducing the level of prejudice and stigma on the islands.

Such activities included:

a. workshops – seminars aimed at the residents of each island, to provide information about the mental health of children, adolescents and adults. These workshops are organised on a yearly basis on each island.

b. Special events with a less theoretical and more experiential character relating to specific population groups. Such events have lead to the creation of parent support groups, support groups for relatives of patients with dementia, and empowerment groups for women who have suffered domestic violence.

c. Programmes aimed at providing information and training for specific professionals in the community. There are specific training groups for professionals working in primary and secondary education to provide information about key psychopathology issues in children and adolescents and issues of how to deal with behavioural problems. In addition, there are yearly seminars that offer training for police officers, as there are a number of Public Prosecutor orders for involuntary hospitalisation, as well as cases of domestic violence than need to be treated.

d. Development of voluntary support groups comprised of patients, relatives and other individuals from the local community to provide information about the rights of individuals with mental disability and how to organise self-advocacy measures.

All of the activities and actions mentioned above have resulted in the development of a network of local bodies from health services, social services, educational bodies, local government authorities and public authorities.

In the focus group discussion held, where representatives of those bodies were present, it was commonly agreed that there is a quite satisfactory level of networking between local services. However, as there is an unstable socioeconomic environment, there is a continuous change of needs that arise which need to be recorded.

In particular, the head of the Police department hailed the assistance of the mobile unit in the process of cooperation for managing serious psychiatric cases in the community. Nevertheless, he stressed out the fact that, as there is serious shortage in personnel, it is becoming more difficult to deal with Public Prosecutor orders for involuntary hospitalisation. Although there has been a decrease in the number of such orders over the past years, it appears that the services offered by the mobile units cannot always prevent such orders, not to mention hospitalisation.

The head of the social services of the municipality stressed the good working relationship with the mobile unit and the high level of cooperation in both planning and implementing mental health prevention and promotion measures. After all those years of operations, the majority of municipalities are not only involved in the direct funding of such activities, but also in the process of designing, along with the mobile units, of new actions regarding mental health promotion and prevention, not only for the general community, but also for the people working in the municipalities of the islands.

As far as activities within the context of schools are concerned, the heads of primary and secondary education pointed out the importance of the presence of promoting mental health by the professionals of the mobile units, not only for the teachers but also for the students. So far, the mobile units have been involved in many educational seminars for both the targeted populations. It is worth mentioning that despite the bureaucratic obstacles that have arisen in the case of schools (such as special permissions from the ministry of Education), the good network and relationship with the local bodies of primary

and secondary education of the islands has always been a catalyst, not only in developing mental health promotional activities in schools, but also in receiving referrals for children and adolescents.

Overall, given the extent to which the operation of the mobile units in such a geographically spread area, which can even sometimes be unreachable (for example during winter periods of strong winds), has allowed them to intervene with the mental health of the population, one can argue that a lot has been done during a decade. Nevertheless, it is not a common secret that there is a need to develop further synergies along with local authorities and other bodies in each community, taking into account special cultural and social features. For example, considering the extremely low number of referrals from the church, although reasonably justifiable, it is necessary to engage in activities with regards to the training of priests about key aspects of mental health, as they are highly respectable figures in the local communities of the islands.

5. Limitations, Conclusions and Recommendations

There are certain limitations in this study that need to be taken into consideration. We must point out that this is not an evaluation study, rather a study that interprets certain data which derive from the accumulated experience and operation of the mobile units. Consecutively, there is no evaluation of the clinical outcomes of the patients, which would give us a measurement on the actual impact of the service on their mental health. Although we have various indications that users' mental health has improved, it would be rather overoptimistic to confidently assume that there has been an improvement in the mental health of the population.

In addition, user involvement in this study is limited to the self administered questionnaire, while there could be a user involved in the focus group and a further in depth research of user satisfaction, which could be measured with a Patient/Relative Mental Health Services Satisfaction Scale (based on the Verona Service Satisfaction Scale-VSSS, Ruggeri & Dall'Angola, 1993)

In general, there is a lack of an external evaluator who would not only focus on clinical outcomes and user satisfaction, but will also carry out economic studies, cost-benefit and cost-efficiency analyses into the long-term operation of mobile units.

It was not before 2012 that a process of assessing the clinical interviews on a systematic basis was launched, using the following scales: World Health Organisation Quality of Life-Bref (WHOQOL-bref) (WHOQOLGroup, 1998; Ginieri-Coccossis et al., 2009), the revised version of the Symptom Checklist-90 (SCL-90-R) (Derogatis & Savitz, 2000; Donias, Karastergiou & Manos, 1991), and the Strength and Difficulties Questionnaire (SDQ) (Goodman & Goodman, 2009; Giannakopoulos et al., 2009) for children and adolescents.

Then again, there is always the big issue of hospitalisations, especially involuntary. Although there was an early research in the Cyclades (Stouraitou et al., 2009), mainly between 2000 and 2009, showing that there was a gradual raise, more needs to be done in the area of identifying the main reasons behind involuntary hospitalizations, which are far more complicated than the patient's mental health problem. This would give a better

insight on how to better manage and prevent such situations from the perspective of the mobile units.

Current socio-economic conditions which are associated with the onset or increase in factors burdening mental health, such as financial debt, lack of resources to access private mental health services or even medication, unemployment, make individuals more vulnerable to the development of mental disorders. As recent studies have shown, there has been an increase in psychiatric problems in relation to these factors (Economou et al., 2011, Skapinakis et al., 2013). Taking into consideration the dramatically changing environment, with examples such as the recent constant flow of immigrants and refugees, the need for developing measures relating to the prevention and handling of both mental health and social problems has arisen. Local communities must be empowered and facilitated by the mobile units in order to self-organise in groups or teams for self help and prevention of relapses.

Within this decade of operation of the mobile unit, one can argue that there have been certain positive outcomes that have been identified (Prince et al., 2007; Saraceno, Levav, & Kohn, 2005) , such as the success in reducing the – nevertheless still existent - treatment gap, and a noticeable increase in the level of awareness for mental health issues. In addition, the foundation of a social club from people with mental health problems and the participation of users of mental health services in community work of the mobile units, are positive indicators that there might be a reduction of stigma in these communities and, consecutively, an overall positive impact on the mental health of the population of the islands. However, this is a field for further research that opens up the opportunity to extract more concise results upon the exact nature of this positive impact.

As one can see, there are still a lot to be done, not only in the area of research for the effect of the operation of the mobile units, but also in the evolution of the service itself Although it has been a busy decade of work for the mobile units, there are always new challenges –not only in the form of opportunities but obstacles as well – that need to be addressed.

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