

2nd European Regional Training Programme

Advanced Institute for Psychosocial Rehabilitation for Families and Carers:

From Theory to Practice

Psychosis: Patient and Family

**International and Greek Examples
of Psychiatric Rehabilitation**



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**Hellenic Branch of the World Association for Psychiatric Rehabilitation
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Hellenic Branch of the World Association for Psychiatric Rehabilitation
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PREFACE

It has long been acknowledged that the goal of psychiatric rehabilitation is to promote the highest possible level of social and vocational functioning and well-being for people with severe and enduring mental illness, so that they may live a full life in the community, with the least amount of professional support¹. To this end, people with serious mental illness should develop the necessary emotional, social and cognitive skills; while at the same time, environmental changes should also occur in order to foster the optimal integration of people with mental disorders^{2,3}. Nonetheless, in spite of the long tradition of psychiatric rehabilitation and the voluminous research surrounding it, its principles and practices display low penetration to clinical routine and educational settings⁴. In this rationale, the mission of the World Association for Psychiatric Rehabilitation (WAPR) has been to facilitate their dissemination in all parts of the world through research, education and consultation.

In Greece, psychiatric rehabilitation is often a downgraded topic in psychiatry training, while on a clinical level it suffers the shortcomings of the incomplete psychiatric reform. Moreover, psychiatric rehabilitation necessitates a shift away from an illness-centered model towards a model of functional disability⁵, an advancement that has not yet occurred in the country. In parallel with these, the general public is highly stigmatizing and distancing from people with severe mental illness, as compared to the general population in other countries, such as Canada or Germany⁶. Things are expected to get worse in the ensuing years, as the sustained financial crisis in Greece has resulted in elevated prevalence rates of psychiatric morbidity, a reduced capacity on the part of the mental health care system to address the needs of the population and in low levels of tolerance for diversity^{7,8}.

In this context, the Hellenic Branch of WAPR established in 2014 the European Regional Training Programme: Advanced Institute for Psychosocial Rehabilitation for Families and Carers: From Theory to Practice in an endeavour to stimulate interest in psychosocial rehabilitation in times of uncertainty. The first scientific event was on “Psychiatric Rehabilitation in Greece during the financial crisis” and it was held in Athens on the 10th of May 2014. After the appeal of this first congress, on the 9th of May 2015, the second scientific event was organized. This congress was centered on “Psychosis: Patient and Family: International and Greek examples of Psychiatric Rehabilitation” with the participation of the President of WAPR, Dr Afzal Javed, as well as of Dr Frank Holloway and Dr Lorenza Magliano as invited international speakers. The event was deemed very successful and fostered a fruitful discussion on points of convergence and divergence between the international and Greek examples as well as among the interests of the various stakeholders. All speakers were asked to

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prepare an article based on their presentation, which is included in the current booklet.

On the first part of the booklet, international examples of psychiatric rehabilitation are delineated. Dr Frank Holloway elaborates on difficulties in defining and conceptualizing recovery, Dr Afzal Javed emphasizes on establishing a strong alliance among mental health staff, patients and their families and Dr Lorenza Magliano discusses the effectiveness of a rehabilitation program with a psychoeducation orientation delivered in residential facilities in Italy.

On the second part of the booklet, psychiatric rehabilitation is viewed through the lens of the Greek mental health care system. Dr Michael Madianos shares his own field experience of psychosocial initiatives and programs implemented in the country since 1979, while Dr Dimitris Ploumpidis highlights the stark difference between the vision regarding psychiatric reform - psychosocial rehabilitation in the country and its reality throughout the years. Finally, Panagiotis Chondros discusses the special case of non-governmental organizations in the realm of mental health and their efforts to empower patients and their families.

On the third part of the booklet, and moving from the macro-level (global) to the micro-level (the caregivers), emphasis is given on the role of mental health professionals and relatives, as formal and informal caregivers, on the successful rehabilitation of people with persistent mental illness. It is an essential aspect of psychiatric rehabilitation to have people with mental illness set personally relevant life goals and in this task; the involvement of their relatives and other supporters is of utmost importance⁹. Consistent with this, Dr Marina Economou, after serving as a Guest Editor for a special issue on Psychoeducation¹⁰, she elaborates on family psychoeducational interventions for severe mental illness and on potential barriers during their implementation. Eleni Louki based on her long experience on support groups of relatives of people with severe mental illness echoes their concerns and difficulties with regard to their caring role, especially amid the recession. Finally, Dr Alexandra Palli, discusses a case of a woman suffering from severe mental illness and the ways by which family psychoeducation facilitated her course to recovery.

On the grounds of these different standpoints, one needs to keep in mind the complexity of severe mental illness and the imperative need for synergy among all involved parties in enabling people who suffer from it to claim a full life in the community.

We are already in the process of organizing future European Regional Training Programmes to be held in Athens in the ensuing years. In light of various incidents that have taken place in Greece during the last months, involving the death of 4 patients who were mechanically restrained during their hospitalization as well as data indicating alarmingly high levels of compulsory admissions in the country, the

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upcoming scientific event will be centered on the “dangerousness” of the person with severe mental illness. Striking a balance between the rights of the individual with mental illness and those of the community is often a gray area in routine practice of psychiatric rehabilitation with enormous ethical, clinical, legal and social dilemmas faced by the multidisciplinary teams.

We look forward to meeting you all in a future event

Marina Economou

Afzal Javed

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References

- [1] Anthony W, Cohen M, Farkas M, et al. Psychiatric rehabilitation. Boston: Centre for Psychiatric Rehabilitation, Boston University, 2002.
- [2] Craig T, Killaspy H. What is psychiatric rehabilitation? In: F. Holloway, S. Kalidindi, H. Killaspy & G. Roberts (eds). Enabling Recovery: the Principles and Practice of Rehabilitation Psychiatry. London: RCPsych Publications, 2015.
- [3] Corrigan PW. Towards an integrated structural model of psychiatric rehabilitation. *Psychiatr Rehabil J* 2003; 26: 346-348.
- [4] Liberman RP. Recovery from disability: Manual of psychiatric rehabilitation. Washington: Americal Psychiatric Publishing, 2008.
- [5] Royal College of Psychiatrists. Psychiatric Rehabilitation: Revised. London: Gaskell, 1996.
- [6] Economou M, Gramandani C, Richardson C, et al. Public attitudes towards people with schizophrenia in Greece. *World Psychiatry* 2005; 4(S1): 40-44.
- [7] Madianos M, Economou M, Alexiou T, et al. Depression and economic hardship across Greece in 2008 and 2009: two cross-sectional surveys nationwide. *Soc Psychiatry Psychiatr Epidemiol* 2011; 46: 943-952.
- [8] Economou M, Madianos M, Peppou L, et al. Major depression in the Era of economic crisis: A replication of a cross-sectional study across Greece. *J Affect Disord* 2013; 145: 308-314.
- [9] Liberman RP, Hilty DM, Drake RE, et al. Requirements for multidisciplinary teamwork in psychiatric rehabilitation. *Psychiatr Serv* 2001; 52: 1331-1342.
- [10] Economou MP. Psychoeducation: A multifaceted intervention. *Int J Ment Health* 2015; 44: 259-262.

ENABLING RECOVERY: THE STATE OF THE ART AND THE SCIENCE

Frank Holloway

ABSTRACT

“Recovery” is a fashionable term in mental health care. The word features prominently in the national mental health strategy documents developed in recent years in Australia, Canada, England, Ireland, Ireland and numerous individual US States. There has long been a problem with the term when applied to mental health in that it means different things to different people and is often used in ways that differ markedly from its ordinary meaning in English: getting better from some (physical) illness or trauma. Recovery in mental health has been variously described as a “model”, an “approach”, a “paradigm” and a “movement”. This presentation explores contemporary understanding of Recovery.

Approaches to Recovery

Outside mental health care we talk of “recovery” in the context of finding lost data on a corrupt computer hard drive, services that “recover” broken down vehicles, the “recovery position” for people who have collapsed and, in the context of the Twelve Steps Programme for addictions, “being in recovery”.

In the context of mental health two recently published books illustrate contrasting approaches to the construct. *Enabling Recovery*¹ is a textbook that describes, as its subtitle suggests, *The Principles and Practice of Psychiatric Rehabilitation*. Mike Slade’s *Personal Recovery and Mental Illness*², published in a series entitled *Values Based Medicine*, explores very different territory. It argues for a conceptualization of “Recovery” that is largely independent of traditional approaches to service provision based on addressing the symptoms and disability associated with mental illness.

The literature on mental health recovery is vast and confusing. Roberts and Boardman³ make a distinction between “Clinical Recovery”, responding to treatment, and “Personal Recovery”, recovering “a valued pattern of life and living”. They describe “recovery-oriented approaches and services” as “pattern of care, support and professional practice based on learning ‘what works’ for people in recovery”. For them the “recovery movement” is a “values-led collaborative endeavour... to develop and transform mental healthcare and treatment”. Recovery itself has attracted

multiple definitions over and above mere abatement of symptoms and/or the disease process. Roberts and Boardman quote some of the most notable definitions including William Anthony's⁴ definition of recovery as "a deeply personal, unique process ... a way of living a satisfying, hopeful and contributing life ... [it] involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness". Patricia Deegan⁵, who has lived experience of mental illness, offers an alternative and more radical perspective that hints at transcendence: "The goal of recovery is not to become normal. The goal is to deeply embrace the vocation of becoming more deeply, more fully human".

Narratives of recovery in mental health

The Recovery literature is very taken by the narratives of people who are "recovered" or "in recovery". An early example is "A Gift of Stories", compiled by the New Zealander Julie Leibrich⁶. These narratives can include stories by people who continue to experience significant symptoms of psychosis but still identify themselves as being in recovery⁷. These stories provide anecdotal evidence of, to quote Roberts and Boardman 'what works'. Larry Davidson has published an important book that takes a systematic approach to studying these narratives – Living Outside Mental Illness⁸. He expands on themes he first explored in a seminal paper published in the British Journal of Medical Psychology "Sense of self in recovery from severe mental illness"⁹. Living Outside Mental Illness describes the psychological processes surrounding both the descent into mental illness and subsequent recovery as a person moves from inside the black hole (I think that's the metaphor being used) of severe mental illness to living "outside" the illness.

The pathway involves developing a sense of belonging and hope, experiencing pleasure, developing a sense of agency (which means I think being in charge of your life) and becoming fully involved in a community. This model accords with the anecdotal experiences recorded in the literature, which interestingly often emphasize engaging in creative activities.

Recovery is often understood as a "journey". A systematic review of the literature on personal recovery conducted by Mike Slade's group describe the recovery journey as an active process, which is unique to the individual, often gradual and helped by a supportive and healing environment¹⁰. A couple of other ideas crop up – it's possible to experience recovery without being cured and it's possible to attain recovery without professional help. The review then goes on to identify five recovery processes, given the acronym CHIME. Experiencing Connectedness, developing a sense of Hope and optimism, recovering an experience of personal Identity, identifying Meaning and purpose in one's own life and feeling Empowered – which I think means being in control of your own destiny. This is entirely consistent with Davidson's model, though using slightly different words. Looked at in more detail these processes involve support from others, the instillation of hope, tackling stigma and self-stigmatization, developing social roles and experiencing a sense of agency or control over one's destiny. Taken together these recovery processes can provide a "recovery-promoting" agenda for services and individuals.

The art and science of Recovery

How to encourage English mental health services to adopt “recovery-promoting” principles and practices is the focus of a large-scale organizational initiative hosted by the Centre for Mental Health IMRoC (Implementing Recovery through Organizational Change) (<http://www.imroc.org>). One key task is to get the Recovery message through to opinion-formers, managers and front-line staff¹¹ Academic papers may not be the most effective medium to achieve this.

If you look up “Mental Health Recovery” on Google Images you get a striking variety of images, quotes and slogans.

Arresting images representing important trends in Recovery thought include:

- A signpost directing us to Hope.
- A quote about mental health as a process not a destination.
- A sign banning stigma.
- A slogan “I am a person, not a mental health problem”.
- An advert for a peer-led education course, run by the American National Alliance on Mental Illness – NAMI.

The complex language or rhetoric to Recovery is well captured by word-based graphics that have been developed to illustrate the construct. These can also readily be found using Google Images. Words that very commonly appear prominently are “support”, “collaboration”, “respect”, “advocacy”, “peer involvement” and “rights”. There is an important strand in recovery thinking that derives from a human rights perspective – with an aim of the recovery project being to tackle the often extreme exclusion that people with “mental health conditions” experience.

In a recent article in *World Psychiatry* Mike Slade and others identified ten “pro-recovery interventions” which are, they tell us, evidence-based¹². They are quite a mixed bunch and include two completely mainstream psychosocial interventions: Individual Placement and Support, which is a form of work rehabilitation, and Supported Housing. There is growing evidence that Peer Support Workers are a valuable element of services, offering as they do role models of successful living with mental illness.

Three of the interventions described are variations on a theme – basically involving patients in treatment planning – both how to stay well and how to manage relapse. Advance directives are plans written with the patient to cover what should happen when their mental health deteriorates. The Wellness Recovery Action Plan (WRAP) was developed by Mary Ellen Copeland – another recovery pioneer. WRAP includes what are described as “wellness tools” and plans for managing any crisis that occurs. Illness Management and Recovery is similar to WRAP but explicitly professionally-led.

Slade and colleagues strongly advocate the Strengths Model – moving away from focusing on deficits towards the strengths and resources of consumers of mental health services. They introduce the concept of Mental Health Dialogues¹³, which bring together users carers and professionals in an open forum.

An increasingly influential intervention is the Recovery College¹⁴. The idea is to move from the provision of mental health treatment for patients to education for people with a mental health problem about how to manage themselves and in Larry Davidson's nice turn of phrase move to living "outside mental illness".

The final intervention Slade describes is REFOCUS, a large-scale research study that has developed "an intervention aimed at increasing the focus of adult mental health teams on supporting personal recovery". There is a manual, freely available on the internet. The aim is to get staff to: Understand the values and preferences of patients; Assess and amplify patients' strengths; and Support goal-striving. Disappointingly the large-scale controlled trial of the training intervention failed to show any impact on their main outcome measure – client Recovery¹⁵. The REFOCUS website supports a wide range of material on Recovery (<http://www.researchintorecovery.com/refocus>).

Making sense of recovery?

It is impossible to do full justice to the complexities surrounding recovery in a brief presentation. However it is clear that the construct offers important insights that add to traditional therapeutic approaches. Enabling Recovery¹ is one attempt to synthesize "clinical" and "personal" recovery in the practice of psychosocial rehabilitation.

References

- [1] Holloway F, Kalidindi S, Killapsy H, et al. Enabling Recovery. London: BJPsych Press, 2015
- [2] Slade M. Personal Recovery and Mental Illness. Cambridge: CUP, 2009
- [3] Roberts G, Boardman J. Understanding Recovery. *Advances in Psychiatric Treatment* 2013; 19: 400-409.
- [4] Anthony W. Recovery from mental illness: the guiding vision of the mental health service system in the 1990's. *Psychosoc Rehabil J* 1983; 16: 11-23.
- [5] Deegan P. Recovery as a journey of the heart. *Psychiatr Rehabil J* 1996; 19: 91-7.
- [6] Leibrich J. *A Gift of Stories*. Dunedin: University of Otago Press, 1999
- [7] Cordle H, Carson J, Richards P, et al. *Psychosis: Stories of Hope and Recovery*. London: Quay Books, 2011
- [8] Davidson L. *Living Outside Mental Illness*. New York: NYU Press, 2003
- [9] Davidson L, Strauss JS. Sense of self in recovery from psychosis. *Br J Med Psychol* 1992; 65: 131-145

- [10] Leamy M, Bird V, Le Boutillier C, et al. Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *Br J Psychiatry* 2011; 199: 445-452
- [11] Shepherd G, Boardman J, Slade M. *Making Recovery a Reality*. London: Sainsbury Centre for Mental Health, 2008
- [12] Slade M, Amering M, Farkas M, et al. Uses and abuses of recovery. *World Psychiatry* 2014; 13: 12-20
- [13] Amering M, Mikus M, Steffen S. Recovery in Austria: mental health dialogue. *Int Rev Psychiatry* 2012; 24(1): 11-8
- [14] Perkins R, Repper J, Rinaldi M, et al. *Recovery Colleges*. London: Centre for Mental Health, 2012
- [15] Slade M, Bird V, Clarke E, et al. Supporting recovery in patients with psychosis through care by community-based adult mental health teams (REFOCUS). *Lancet Psychiatry* 2015; 2: 503-514.

PATIENTS, CARERS & FAMILIES AS STAKE HOLDERS IN MENTAL HEALTH

Afzal Javed

Abstract

Current treatment programmes in mental health are witnessing a comprehensive approach in many areas of care. There is a growing interest supporting active participation of patients & their families in their care management programmes. The evidence supporting personal experiences of users and their families and friends in planning and organizing future care is an area of interest by many researchers and clinicians. This paper describes some of the current trends and focuses on the importance of involvement of patients, carers and families during the process of different treatment & management options. The paper also highlights some of the barriers that may affect this process and also gives an account of activities of WHO, WPA, WAPR and other international organizations in facilitating the input of patients & users in different areas including research, teaching and service planning.

There has been an increase in the prevalence of mental health problems all over the world and general estimates state that around one quarter of general the population will suffer from some type of mental illness at any given time¹. Worldwide, community-based epidemiological studies² have estimated rates of lifetime prevalence of mental disorders among adults ranging from 1.2% to 48.6% and 12-month prevalence rates ranging from 8.4% to 29.1%. World Health Organisation (WHO) has estimated that approximately 450 million individuals suffer from neuropsychiatric disorders in their lifetime in both developed and developing countries and mental health problems represent five of the ten leading causes of disability amounting to nearly one-third of the disability in the world^{2,3}.

Whereas these mental health problems vary in severity and intensity, their impact on day to day functioning is substantial. These disorders add a high emotional, personal and economic cost on individuals, families, and society⁴. The sufferers experience detrimental effects on their quality of life; while in similar view, the psychosocial consequences of the illness n ain further their suffering. This burden also leads to

further misery, distress, disabilities and a number of functional impairments. While mental disorders affect people in all groups of society in all countries, the poor are disproportionately afflicted more significantly. As people live longer and populations get older, the number of people with mental disorders also will be on the rise over the next few decades, and these trends indicate that the burden will significantly increase in the future⁵.

It is true that needs of treatment of mental illnesses have taken a long time to gain wide recognition and acceptance; however, there have been some remarkable developments that have shaped the vision and image of mental wellbeing over the last decades. Last century has witnessed a number of refinements in understanding of the importance of mental illnesses and had seen major conceptual shifts in dealing with mentally ill. The earlier practice of custodial care has gradually changed to community care and mentally ill who were kept in isolation, have now been moved out of mental hospitals and big asylums. This has revolutionised the care of the mentally ill and especially the second half of 20th century is accounted for a number of changes in policies and practices in the entire field of mental health⁶.

While these changes were taking place in improving the understanding of mental illnesses and the acceptance of innovative for mental disorders, there was also a major shift in the care of mentally ill with reference to professional roles. The authoritarian nature of the relationship between the patient and the mental health professional has changed to a more compassionate and humane one and the custodial nature of the management of mentally ill slowly moved to independent living and reintegration of patients in the community, with promising results. The paternalistic attitude of professionals also displayed a shift towards independence and empowerment of patients along with movements of recovery, as hope and wellbeing took a new shape in making radical changes in concepts and practices. Similarly the shift of the focus of care from institutions to the community also marked another big change as an increasing number of professionals were responsible for looking after the mentally ill. The need for managing the psychosocial aspects of treatment emerged as an essential component of care and the role of non medical health professionals – psychologists, nurses, occupational therapists, social workers, accommodation & employment workers and advocacy agents – became equally important as of physicians and psychiatrists.

Growing interest of carers and families in the overall management of mentally ill was another landmark in the history of community psychiatry that received a lot of acknowledgement during the 20th century⁷. While community care started becoming a priority, awareness about the role and responsibilities of carers also emerged as a new advance, which shaped our current practices in a tremendous way. This also resulted in enhancing the awareness of patient groups whose involvement became an essential component of treatment programmes, especially with regard to treatment options and formulating policies for mental health services. Although such initiatives

were taking place mainly in the developed countries, various groups of carers and families started raising their voice to advocate for the mentally ill in other countries as well as allowing for these movements to gain a worldwide recognition⁸.

Current psychiatric literature is now full of reports corroborating the need for developing partnership with patients, users, carers and families, supporting a better outcome with their involvement. World Health Organisation and many professional organisations are supporting such initiatives by endorsing the beneficial effects of this partnership. There is now ample evidence that working with carers and families is not only helpful and beneficial for short term outcomes but also leads to long lasting improvements as well⁹. These findings have been well documented in the literature and highlight the importance of developing and sustaining partnerships with patients and carers throughout psychiatric treatment.

Despite the benefits and strong empirical basis in favour of the user's and families' involvement, there are a number of limitations that may hinder such initiatives. Although this new equation of having families and carers on board yields various beneficial effects, there have also been some areas of concerns that require understanding of these issues in a more detailed way.

Looking closely the family and caregivers problems, it has been observed that the burden of illness impinges on carers as well. Living with and caring for a mentally ill, may lead to a number of problems for the family with a member suffering from a chronic mental disorder. Various studies have explored these difficulties and have confirmed various effects on the families, calling therefore for attention on this particular issue¹⁰.

Mental disorders have clear economic costs. Sufferers and their families or caregivers often experience reduced productivity at home and in the workplace. Lost wages, combined with the possibility of detrimental health care costs, can seriously affect patients' and their families' financial situation, creating or worsening poverty. Wherever economic costs of mental disorders have been studied in different countries, the most comprehensive set of estimates come from the United States, with the total economic burden calculated at US\$ 148 billion per year. A considerable proportion of these total costs was attributable to work disability and associated productivity losses. In total, the costs of mental disorders have been accounted for about 2.5% of the USA's gross national product^{5, 11}.

It has been consistently observed that while caring for the mentally ill, relatives may also suffer from mental health issues^{12, 13}. The response of the carers to the illness onset may also take different forms ranging from denial to frustration and pessimism to helplessness. Once the acute phase of the problem is over, the family's life goes back to normal and they believe that this was just a temporary phase and it does not need any further follow up. In addition to the financial impact, a recent review of the

literature by Shah and colleagues¹⁴ on carers' burden in mental disorders has shown that families who bear the main responsibility for the care of their relative with mental disorder face mental ill health themselves as a direct consequence of this caring role and that the rates of mental disorders among them is higher than that of the general population (Table 1).

Table 1

The impact of caring for different mental disorders and associated risk factors		
Mental Disorder	Risk factors	Impact on the carer
Schizophrenia	High disability, very severe symptoms, poor support from professionals, poor support from social networks, less practical social support, violence.	Guilt, loss, helplessness, fear, vulnerability, cumulative feelings of defeat, anxiety, resentment, and anger are commonly reported by caregivers.
Dementia	Decline in cognitive and functional status, behavioural disturbances, dependency on assistance.	Anger, grief, loneliness and resentment.
Mood disorders	Symptoms, changes in family roles, cyclic nature of bipolar disorder, moderate or severe distress.	Significant distress, marked difficulties in maintaining social and leisure activities, decrease in total family income, considerable strains in marital relationships. Psychological consequences during critical periods also persisting in the intervals between episodes in bipolar disorder, poorer physical health, limited activity and greater health service utilization than non-caregivers.

Taken from Aadil Jan Shah, Ovais Wadoo and Javed Latoo (2007) Psychological Distress in Carers of People with Mental Disorders. [BJMP 2010; 3\(3\):a327](#)

Similar findings from a study conducted by Basic Needs in Sri Lanka (Table 2) show that stigma, discrimination, exclusion, livelihood hardship and difficulties in meeting basic needs emerge as salient features of some of the problems expressed by carers¹⁷.

Table 2

Common Problems experienced by Carers		
	Frequency mentioned	%
Stigma, discrimination and exclusion	71	33%
Livelihood hardships/ Economic burdens	33	15%
Carers' burden	29	13%
Mental illness related problems	29	13%
Family relationships	17	8%
Mental health service issues	16	7%
Lack of Rehabilitation	9	4%

Findings from a study on Organizations of Mental Health Service Users and Carers: A Mapping in Sri Lanka Conducted by basic needs 2012-13

Despite these limitations, it is however, worth noting that a lot of work has been accomplished in this area. Professionals' and patients' and families groups have come up with a number of initiatives that are shaping current thinking in a more positive manner. Some of the work by major professional organisations endeavours to set standards and encourage professionals to look at this aspect of patients care more seriously. World Psychiatric Association (WPA), an umbrella organisation of psychiatrists, has raised the profile of this particular issue by formulating global guidelines for developing partnership with service users and their relatives. These recommendations of the WPA task force has fostered implementation of these initiatives in the respective countries¹⁷. World Association for Psychosocial Rehabilitation (WAPR www.wapr.info), another organisation that works in the field of psychiatric rehabilitation, has emphasized the importance of patients', carers' and families' participation in the treatment and rehabilitation programmes. WAPR established an ongoing task force that is formulating and reviewing guidelines for future work in this particular area and the WAPR Seoul Congress has also included a

special Presidential Symposium on this theme, in an attempt to highlight this issue in a more operative way. Similarly, the Royal College of Psychiatrists (UK) has also taken up working with both patients and carers and in fact it has involved local carers' and users' groups in formulating college policies and training programmes for psychiatrists¹⁸. This has increased the knowledge, awareness and responsiveness of trainee psychiatrist, which is critical for their future work in the field. Moreover, the Royal College of Psychiatrists in collaboration with the Prince's Royal Trust for Carers has also undertaken a number of initiatives and campaigns on advocating the triangle of care as an approach for improving patient management and carer's engagement with treatment services. The findings of the report underline the importance of early identification of carers, effective carer support, health promotion, monitoring high-risk groups, and timely implementation of appropriate interventions. This work undoubtedly outlines key elements for achieving a substantial partnership between mental health staff, patients and their relatives and provides examples of good practice in an attempt to motivate other organisations to plan accordingly their future work^{19,20}.

In summary while it is well acknowledged that mental health problems are associated with isolation, deprivation, low income, unemployment, poor education, poorer physical health and increased health-risk behaviour, mental illnesses do not only lead to human and social cost, but also yield economic burden. However, despite the impact of mental illnesses on a wide – range of functional, economic and social outcomes, and regardless of ample evidence indicating that good mental health underlies health, mental health issues are still not prominent in the area of public health policy and actions. As recommended by Royal College of Psychiatrists in their Position Statement (PS4/2010) “As there is no health without public mental health there is no public health without public mental health”²¹. Investment is therefore needed in order to strengthen mental health services. This position statement will certainly enhance population well-being and reduce the impact of mental illnesses to a large extent.

We need to bear in mind that carers do face mental ill health as a direct consequence of their caring role and this experience higher rates of mental ill health than the general population. This results in experiencing poor quality of life, while there is also a negative effect on the standard of care. As the impact of caring for someone with mental illness increases the risk of mental ill health, it would be expected that this issue would gain more recognition in our mental health services. Efforts to identify and treat caregiver psychological distress needs to be multidisciplinary, should focus on multiple risk factors simultaneously and should take into consideration the cultural context of the patients and his/her caregiver.

Hopefully, in the foreseeable future, recognition of the importance of involving patients and carers will be witnessed in relevant treatment programmes. This will certainly require more acceptance on the part of mental health professionals and

policy makers, who will contribute to developing empathetic attitudes towards these issues and implementing pertinent programmes for patients, families and carers.

There is thus a strong need to look at ways for making families and carers active members of the health care teams and use their valuable experiences in training programmes for various groups of mental health care professionals. It is imperative to involve them as employees, trainers and researchers in our future work in this area^{22, 23}.

References

- [1] Kessler RC, Üstün B. *The WHO World Mental Health Surveys: Global Perspectives on the Epidemiology of Mental Disorders*. New York: Cambridge University Press; 2008
- [2] WHO International Consortium in Psychiatric Epidemiology. Cross-national comparisons of the prevalences and correlates of mental disorders. *Bulletin of the World Health Organization* 2000;78:413-25
- [3] Wittchen HU, Jacobi F. Size and burden of mental disorders in Europe: a critical review and appraisal of 27 studies. *European Neuropsychopharmacology*, 2005; 15: 357-376
- [4] Schulze B, Rossler W. Caregiver Burden in Mental Illness: Review of Measurement, Findings and Interventions, 2004-2005. *Current Opinion in Psychiatry*, 2005; 18: 684-691
- [5] World Health Organization. *Global Burden of Disease Report*. WHO; 2008. (http://www.who.int/healthinfo/global_burden_disease/estimates_country/en/index.html)
- [6] Magliano L, et al. Carers and families of people with mental health problems. In: Knapp M, McDaid D, Mossialos E, Thornicroft G (eds). *Mental health policy and practice across Europe*. Berkshire: McGraw-Hill; 2007
- [7] Thornicroft G, Tansella, M (2005). Growing recognition of the importance of service user involvement in mental health service planning and evaluation. *Epidemiologia e Psichiatria Sociale* 2005; 14:1-3
- [8] Crawford MJ, et al. Systematic review of involving patients in the planning and development of health care. *BMJ* 2002; 325: 1263–1265
- [9] Tait L, Lester H. Encouraging user involvement in mental health services. *Advances in Psychiatric Treatment* 2005; 11:168-175
- [10] The Cochrane Database of Systematic Reviews. Patient involvement in mental health care: one size does not fit all. *Journal of Evidence-Based Medicine* 2010; 3: 130–131
- [11] Collins, PY et al. (2011). Grand challenges in global mental health. *Nature* 2011; 475 (7354): 27-30

- [12] Cormac I, Tihanyi P. Meeting the mental and physical healthcare needs of carers. *Advances in Psychiatric Treatment* 2006; 12: 162–172
- [13] Ennis E, Bunting P. Family burden, family health and personal mental Health. *BMC Public Health* 2013; 13:255
- [14] Shah AD, Wadoo O, Latoo J. Psychological Distress in Carers of People with Mental Disorders. *BJMP* 2010; 3: a327
- [15] Basic Needs. Organizations of Mental Health Service Users and Carers : A Mapping in Sri Lanka Conducted by basic needs 2012-13. Basic Needs 2013. www.basicneeds.org
- [16] Gonzalez EW, et al. Family caregivers at risk: who are they? *Issues in Mental Health Nursing* 2011; 32:528–536
- [17] Wallcraft J, et al. Partnerships for better mental health worldwide: WPA recommendations on best practices in working with service users and family carers. *World Psychiatry* 2011; 10: 229-236
- [18] Royal College of Psychiatrists Social Inclusion Scoping Group. *Mental Health and Social Inclusion: Making Psychiatry and Mental Health Services Fit for the 21st Century. Position Statement PS01/2009*. London: Royal College of Psychiatrists; 2009
- [19] NHS Health Advisory Service. *Voices in partnership: involving users and carers in commissioning and delivering mental health services*. London: Stationery Office; 1997
- [20] Wallcraft J, Schrank B, Amering M. *Handbook of service user involvement in mental health research*. West Sussex:Wiley-Blackwell; 2009
- [21] Royal College of Psychiatrists. *Position Statement PS4/2010. No health without public mental health: The case for action Position*. London: Royal College of Psychiatrists; 2010
- [22] Wykurz G, Kelly, D. Developing the role of patients as teachers: literature review. *BMJ* 2002; 325:818–821
- [23] Simpson EL, House AO (2004). User and carer involvement in mental health services: from rhetoric to science. *British Journal of Psychiatry* 2004; 83: 89-91

IMPLEMENTING INDIVIDUAL AND PSYCHO-EDUCATIONAL INTERVENTIONS IN PSYCHIATRIC RESIDENTIAL FACILITIES: DESCRIPTION OF AN ITALIAN EXPERIENCE.

Lorenza Magliano

Abstract

This text describes a rehabilitative empowerment-oriented program, the CIGI - Combined Individual and Group Intervention - specifically developed to be used in residential and semi-residential psychiatric facilities. The program includes a modular training course for staff, based on a “learn-and-do” approach, and it is open to users’ voluntary participation. It has already been implemented in residential facilities in Italy for two years and preliminary results of the effort support its feasibility as well as its effectiveness for people with poor functioning and long term mental disorders.

Italy is one of the countries with the longest experience in community mental health care. Since 1978 - when Psychiatric Reform Law n. 180 was promulgated - mental health care is delivered by Mental Health Departments, that are in charge of the management and planning of medical and social activities related to prevention, treatment, and rehabilitation in a defined catchment area. Within the departments, people with severe mental disorders and very poor levels of independent life skills and social resources may be housed in Residential Facilities.

According to National Mental Health Plans criteria, these facilities have to be easy accessible, located in urban contexts, and to include 20 beds max. Italian residential facilities constitute a heterogeneous system of rehabilitation facilities, varying in terms of intensity of staff assistance (from few hours a week to 24-hour staff assistance), and organizations. Italy is one of the countries with the longest experience in community mental health care. Since 1978 - when Psychiatric Reform Law n. 180 was promulgated - mental health care is delivered by Mental Health Departments, that are in charge of the management and planning of medical and social activities related to prevention, treatment, and rehabilitation in a defined catchment area. Within the departments, people with severe mental disorders and

very poor levels of independent life skills and social resources may be housed in Residential Facilities. According to National Mental Health Plans criteria, these facilities have to be easy accessible, located in urban contexts, and to include twenty beds maximum Italian residential facilities constitute a heterogeneous system of rehabilitation facilities, varying in terms of intensity of staff assistance (from few hours a week to 24-hour staff assistance), and organizations.

Data on the process of care in Italian residential facilities¹ found that evidence-based rehabilitative interventions are rarely available in residential facilities, particularly for people with long duration of severe mental disorders. Findings from a National study² revealed that a standardized assessment of rehabilitative needs was performed in only 38% of cases; while individual rehabilitation programs were planned in 74% of cases. Discharge rates in residential facilities are low. In many circumstances, psychiatric residential facilities represent “houses for life”², where residents live together for many years. Finally, as reported in a national survey of 1370 non-hospital residential facilities in Italy², approximately 40% of residential facilities staff had no specific professional qualification for working with people with severe psychiatric conditions.

In my contribution, I will describe a rehabilitative program, the combined Individual and Group Intervention (CIGI), to be used in residential and semi-residential psychiatric facilities. The program – designed by a researcher of the Department of Psychology of the Second University of Naples, Italy (LM) - includes a modular training course for the staff based on a “learn-and-do” approach, and guidelines on how to use the intervention in the residential facilities.

The CIGI program was developed in line with the World Health Organization (WHO) / World Association for Psychiatric Rehabilitation (WAPR) principles of Psychosocial Rehabilitation³, and the WHO/EU statement on Users’ Empowerment in Mental Health. In particular, WHO/WAPR³ defined Psychosocial Rehabilitation (PR) as “a process that facilitates the opportunity for individuals [...] with a mental disorder – to reach their optimal level of independent functioning in the community. It implies both improving individuals’ competencies and introducing environmental changes [...], and “It aims to provide the optimal level of functioning, stressing individual choices on how to live successfully in the community”. As regards users’ empowerment in mental health⁴, WHO/EU defined empowerment as “the level of choice, influence and control that users of Mental Health Services can exercise over events in their lives”, and outlined that “[...] promotion of users’ empowerment are considered as preliminary steps for psychosocial rehabilitation”.

To strengthen users’ empowerment, WHO also recommended “involving users as equal partners at all stages of training, planning, delivering and evaluation services”, and “designing and delivering mental health professional training in systematic partnership with users and families”. According to “Users’ empowerment”

principles” reported above⁴, CIGI program is based on users’ voluntary involvement in all its phases, including users’ voluntary attendance of modular training course for staff.

As far as the rehabilitative techniques, the CIGI includes elements of the VADO Individual rehabilitative approach (in English, Skills Assessment and Definition of Goals;⁵) - and of Falloons’ psychoeducational group intervention ⁶.

VADO⁵ is a cognitive-behavioural approach developed in line with WHO/WAPR psychosocial rehabilitation principles³ and inspired by the Boston Rehabilitation Center’s approach ⁷. It is based on an assessment of the client’s capacities and disabilities, the negotiation of goals achievable in few months, and monitoring of progress towards the planned goals. The efficacy of VADO on personal and social functioning of people with long-term and severe mental disorders has been repeatedly displayed in clinical settings⁸⁻¹⁰. In the CIGI, VADO techniques are used to set individual goals with each user.

Family Psychoeducational Approach developed by Falloon⁶ is a well know cognitive-behavioural family intervention whose clinical and social efficacy in severe mental disorders, such as schizophrenia, has been repeatedly supported^{11,12}. In the CIGI, the psychoeducational intervention is used with users as a group.

The CIGI program has been implemented in 8 residential facilities of the Mental Health Department of Modena, Italy for two years. Preliminary results of this initiative are encouraging: all professionals who received the CIGI training used the intervention in residential settings, while residents who received the intervention showed a significant improvement in global functioning at two-year reassessment.

The preliminary results suggest that this intervention – based on the combination and adaptation of two evidence-based interventions - may be useful to improving functioning in users with long history of mental disorders and poor functional autonomy.

The program is currently ongoing – as a part of a larger training program in psychosocial interventions for community staff – in residential and semi-residential facilities of the Mental Health Department of Lecco, Italy.

References

- [1] Santone G, de Girolamo G, Falloon I, et al. The process of care in residential facilities - a national survey in Italy. *Soc Psychiatry Psychiatr Epidemiol* 2005; 40 (3): 540–550
- [2] De Girolamo G, Picardi A, Micciolo R, et al. Residential care in Italy. National survey of non-hospital facilities. *Br J Psychiatry* 2002; 181: 220–225

- [3] WHO/WAPR Psychosocial Rehabilitation Consensus Statement. 1996
http://www.wapr.info/World_Association_for_Psychosocial_Rehabilitation_WAPR/Documents_files/WHO_WAPR_ConsensusStatement_96.pdf
- [4] WHO. 2010 User empowerment in mental health: a statement by the WHO Regional Office for Europe
(www.euro.who.int/data/assets/pdf_file/0020/113834/E93430.pdf)
- [5] Morosini P, Magliano L, Brambilla L. VADO Valutazione di Abilità e Definizione di Obiettivi. Trento: Edizioni Erickson, 1998
- [6] Falloon I, Boyd J, McGill C. The Family of Care of Schizophrenia. London: Guildford Press, 1984
- [7] Anthony W, Rogers ES, Farkas M. Research on evidence-based practices: Future directions in an era of recovery. *Community Ment Health J* 2003; 39: 101-114
- [8] Gigantesco A, Vittorielli M, Pioli R, et al. The VADO approach in psychiatric rehabilitation: a randomized controlled trial. *Psychiatr Serv* 2006; 57:1778-1783
- [9] Pioli R, Vittorielli M, Gigantesco A, et al. Outcome assessment of the VADO approach in psychiatric rehabilitation: a partially randomised multicentric trial. *Clin Pract Epidemiol Ment Health* 2006; 3: 2-5
- [10] Vittorielli M, Pioli R, Brambilla L, et al. Efficacy of the "VADO" approach in psychiatric rehabilitation: a controlled study.. *Epidemiol Psichiatria Soc* 2003; 12, 43-52
- [11] Magliano L, Fiorillo A, Malangone C, et al. Patient functioning and family burden in a controlled, real - world trial of family psychoeducation for schizophrenia. *Psychiatr Serv* 2006; 57, 1784-1791
- [12] Xia J, Merinder LB, Belgamwar MR, Psychoeducation for schizophrenia. *Cochrane Database Syst Rev*. 2011 Jun 15; (6):CD002831. doi: 10.1002/14651858.CD002831.pub2

DEVELOPING COMMUNITY PSYCHIATRY AND PSYCHOSOCIAL REHABILITATION IN GREATER ATHENS AREA: 1979-2009

Michael G. Madianos

Abstract

In 1979 Greece there were no decentralized mental health services in Greece and thus delivery of care was based on the nine large mental hospitals. In this context a Community based Mental Health Center (CMHC) was established in order to provide psychosocial care in two designated boroughs in Greater Athens area. Over the thirty years of its operation the Byron – Kessariani CMHC became a model for: (i) the systematic assessment of local mental health needs, (ii) the delivery of a broad spectrum of psychiatric services including psychosocial rehabilitation for chronic mentally ill people, (iii) community participation in prevention programmes and activities. The foundations of these lie on the solid community mental health ideology characterizing the centre, the mental health team's morale and the application of evaluative methods, in order to establish the effectiveness of CMHC.

In 1979, psychiatric care in Greece was based on nine overcrowded public mental hospitals which were mostly asylum-like and inadequately staffed, as well as on a number of private mental hospitals providing mainly biological therapies including Electroconvulsive Therapy (ECT). Moreover, several psychiatric epidemiological cross-sectional surveys revealed a considerable gap between untreated morbidity and help-seeking¹. There was a complete lack of community-based mental health care services, psychiatric beds in general hospitals and no planning for the development of psychosocial rehabilitation services for those who suffer from severe or chronic mental illness. All in all, the delivery of mental health care was totally inadequate to meet the mental health needs of the population.

In this rather anachronistic atmosphere, Professor C. Stefanis and I took the initiative to introduce an “experiment” of social and community psychiatry in two Athenian boroughs by developing the first Community Mental Health Center (CMHEC) in Greece. The particular centre provided services to a total of 80.000 people residing in Byron and Kessariani boroughs. The selection of these two boroughs was based on

specific criteria. The basic assumption for designing the delivery of care was that 15% of the local population was found to comprise of psychiatric cases which needed to be reached by our teams.

The ideological foundation of our work was based on the dialectical relationship of the mental health worker with the community: The community comes close to the Center while the Center is involved with the community. This is the only way to fill the gap concerning the 'untreated cases'.

For this reason, the Community Commission for Mental Health consisting of key-persons, volunteers and representatives of local authorities was established. Several small mental health projects were undertaken based on local demands (parents, school teachers, teenagers, elderly etc). Our clinical approach was the immediate intake of any case who would reach the CMHC on a daily basis, and the development of an early referral network including local pharmacists, physicians as well as social care agencies. Mental health team members shared a team-spirit, with a democratic and inspiring leadership, giving feedbacks and preventing burnout.

Finally, the administration applied a built-in evaluation system providing crucial data on the effectiveness of the delivery care. For example there was a constant out-reach evaluation of possible "lost cases". This tracing method brought back to the CMHC the majority of these cases for continuation of treatment and follow-up, preventing therefore potential relapses.

During the years of the Center's operation, its services were expanded, including an Open Psychosocial Care Clinic with an out-reach program, as well as a walk – in clinic monitoring high risk individuals, a Day Care Center and an Evening Social Club.

The Psychosocial Rehabilitation Unit was another specialized service providing services for 90 people with chronic mental illness. As part of their rehabilitation treatment plan, these patients were placed either in the Vocational Training Workshop or in the "Lotus" Cooperative. In 1983, a Mental Health Service for Children and Adolescents was also established. The pressure exerted by the growing demands and the need for bridging the gap between providers and consumers subsequently prompted the opening of five satellite clinics in five local socio-medical agencies.

The Center's services are staffed by four multi-professional teams. The Center went through several developmental stages: the initial stage (1979-1980); the implementation of the consumer participation stage (1981-1984); the expansion phase of mental health intervention-prevention activities and staffing (1985-1990); and finally the current stage of operation.

Several small-scale studies have explored the effectiveness of the Center's treatment and community interventions. One striking finding was the reduction by 60% of psychiatric admissions of local residents (90% in compulsory admissions) during the

period of 1978-1995². It is worth noting that every mental health care activity explored the use of community resources (housing, athletics, subsistence, public facilities, etc).

Based on the model roughly described above, another Community Mental Health Center was developed for serving the neighboring borough of Zografou with a population of 120,000 people. This new CMHC provided a walk-in clinic, an out-reach service and personal, group, and family psychotherapies, as well as a small-scale psycho-social rehabilitation unit, which also included a day care as well as an evening social club.

Evaluation data provide evidence that effective community based mental health and rehabilitation services offer a real alternative to in-patient care^{3,4}.

In Greece today there are forty (40) Community Mental Health Centers while the estimated number of needed Centers for the country is at least ninety (90).

Concluding, I would like to stress that the delivery of community-based psychiatric care facilitates and promotes the re-integration of people suffering from mental illness in the society, treating them as citizens with equal rights.

References

- [1] Madianos M. Community Psychiatry and Community Mental Hygiene. Athens: Kastaniotis, 2006
- [2] Madianos M, Economou M. The impact of a community mental health center on psychiatric hospitalizations in two Athens areas. *Community Ment Health J* 1999; 35: 313-323
- [3] Economou M, Palli A, Peppou LE, et al. Recovery from schizophrenia: a four-year study of an inner city cohort. *Community Ment Health J* 2011; 47:660-667
- [4] Economou M, Palli A, Falloon IRH. Violence, misconduct and schizophrenia: outcome after four years of optimal treatment. *Clin Pract Epidemiol Ment Health* 2005; 1: 3

REFORM OF THE PSYCHIATRIC SERVICES IN GREECE AND PSYCHOSOCIAL REHABILITATION: ACHIEVEMENTS AND OPEN QUESTIONS.

Dimitrios Ploumpidis

Abstract

The reform of psychiatric services in Greece began nearly over three decades ago but its progress is gravely hindered by the ongoing financial crisis. The main focus should have been on deinstitutionalization and development of more community based services (outpatient treatment, residential facilities etc). However those efforts have been hampered due to the lack of funds amid the economic crisis. Furthermore, it has become more difficult than ever to maintain accessibility of the public health care system, while an increasing number of citizens have no access to social security. Concomitantly, it seems that the current economic crisis fosters the emergence of new forms of social exclusion. It is therefore more crucial than ever to follow and strengthen the example of existing psychosocial rehabilitation programmes by involving families and carers into the recovery process. These efforts continue to display promising and cost – effective results.

The reform of psychiatric services in Greece

Since the middle of 1980's, a significant reform on psychiatric services has been taking place in Greece. The progress of this reform was moderate during the past few years and its future has been uncertain since the wake of the economic crisis in Greece in 2009. The 1397/1973 law for a National Health System has been the foundation of the reform in the country. The aforementioned law includes the transformation of traditional psychiatric hospitals, the creation of psychiatric units in general hospitals and the establishment of outpatient units. However, a shortcoming of this law has been the lack of a specific design for the organization of primary health care.

Two major projects of the European Union, the 815/1984 regulation and the Psychargos I & II project offered important funding and expert assistance in the

reform projects of Greece. The 815/1984 regulation permitted the large program of deinstitutionalization of Leros' psychiatric hospital for chronic patients and the "Psychargos" projects, which promoted a network of community based services and founded new psychiatric units all over Greece. Since the termination of the abovementioned projects, funding from the E.U. has enabled the operation of a large number of psychiatric units, mainly non – governmental organizations (NGOs), even during the last five years of recession in the country.

A brief presentation of the reform actions and its difficulties will follow:

1. **Strategies and priorities have been decided by policy makers.** The reform has been gradually well received by mental health professionals.
2. **The main focus should be on deinstitutionalization and housing units (which are thought to be the core of future community psychiatry units).** Deinstitutionalization has not been associated with sufficient community based units. However, a "generous" parallel program of housing units led to a vast reduction of the number of psychiatric beds occupied by chronic patients, by transferring them into residential facilities. Despite the fact that three psychiatric hospitals have been shut down, the health care system remains hospital-centered and continues to deal with patients who need multiple forms of assistance and rehabilitation, including housing.
3. **Sectorization (Law 2716/1999).** The major innovation of the 2716/1999 law was sectorization. "Large" sectors of 250-300.000 inhabitants were established and priority was given to community based psychiatric units, encouraging a close collaboration of inpatient and outpatient units. However, this success was partial and uneven.
4. **Feeble development of community based services.** The number of community based services is still insufficient. Many outdoor units are only limited to providing a simple hospital - related consultation.
5. **Priorities often follow the urgency of a necessarily rapid use of E.U. Funds.** Perhaps the urgency to use existing funds within a limited period of time favored the programs of deinstitutionalization and housing at the expense of the establishment of community – based units, which need more time in order to operate properly.
6. **A "semi – completed reform".** Generally speaking, the right way of describing psychiatric reform in Greece is as a "semi – completed reform", since a

considerable number of its goals have been achieved; however, it does not yet consist of a consolidated system of care^{1,2}.

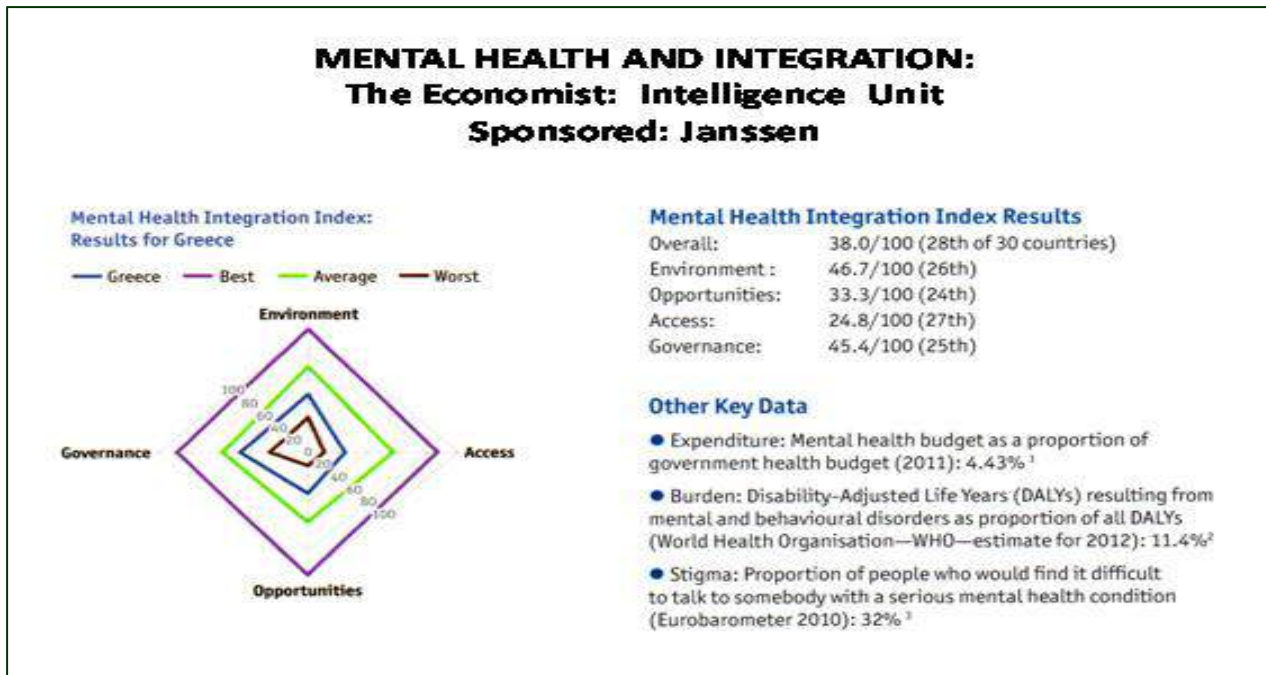
Since 2010: The years of economic and social crisis

Building a new system of mental health services has shown visible signs of deceleration in priorities and funding the years before the economic crisis. Amid the economic crisis, however, we have to subjoin the following problems:

1. **A parallel – subsequent crisis in the social security system.** An increasing number of citizens have no access to social security. Consequences are equally visible, both in the public and private sector of care.
2. **Major reduction in funding of public mental health services.**
3. **No job openings for new staff members.**

Consequences of the crisis are also visible in:

- The level of the provided health services is in complete disagreement with the universally admitted principles on human rights and on the priorities of mental health care. Furthermore, Accessing health care services became much harder for a large number of citizens³.
- The rates of suicidality and suicide have increased^{4,5}. During the crisis, the main problem of maintaining an accessible public system of health care and social security became evident. The outcome of mental health care system depends on specialized health care but also on actions of solidarity and social networking. The current economic crisis has fostered the perpetuation of traditional forms of social exclusion, as well as the emergence of new ones. Previous practices of psychosocial rehabilitation and actions of social inclusion in mental health care allowed users to access our services as a result of social solidarity. A recent study on evaluating mental health services in many European countries shows that Greece holds a low, intermediate position in a self-constructed Mental Health Integration Index, which encompasses not only at medical provision but also at factors pertaining to human rights, stigma, the ability to live a fulfilling family life and employment, among others⁶.



Psycho – Social Rehabilitation

The 1990's were considered the “golden age” of rehabilitation in Greece, due to the multiple European funding programmes, which allowed for the recruitment and training of staff as well as implementing various rehabilitation activities. These programs, however, do not exist anymore. Furthermore, the rapidly increasing number of unemployed people constitutes of another negative factor, while gainful of users of mental health services has become even more difficult, as the labor market can only offer a very limited number of supported employment schemes.

- **Feeble perspectives of vocational rehabilitation. Today, a feeble possibility of employment is offered by social cooperative firms (Law: 2716/1999).** There are more than twenty social cooperative firms across Greece. They have limited financial activities and low budgets. They can assure the employment of some users of mental health services but they cannot offer a substantial remuneration.
- **Development of multiple rehabilitation programs focused on the training of social skills, artistic expression etc.** Many of these programs across the country offer a framework of rehabilitation activities. If we focus on the domain of recovery, the outcome is more than encouraging despite of the diversity of techniques used.

The example of the Rehabilitation Unit (C.M.H.C.) of Byron-Kessariani

At this point I would like to share my experience from running the psychosocial rehabilitation centre of Byron-Kessariani, which has been operating for more than 30 years. The major problem we have been facing is the shortage of staff. At the moment there are 3 occupational therapists (two of them part - time employed), 2 trainers in craft production, 2 psychiatrists (part - time employed) and 4 – 5 volunteer trainers

in artistic expression or drama, who are engaged into the three following complementary activities:

- A unit of sheltered employment: craft products.

[Users: 15-18 in 2014, plus 3 persons in the unit of sailing craft products.]

After the failure of a large cooperative project, this unit works in collaboration with two other units, in a project producing high quality craft.

- A day center for people suffering from psychosis.

[Users: 13-16 users in 2014. Duration of care: 8-10 months.]

Very often users join the centre after hospital discharge. We offer a great number of rehabilitation activities to these users.

- A social club called “Steki”.

[Users: 16 regular - everyday users, 10 more visit once a week and 10 others have a rare presence.]

In the past, the attending “Steki” users have participated in other rehabilitation programs. The club aims to develop and maintain and develop social skills. Users are in charge of the activities of the club and run it themselves. A part time occupational therapist and a part time psychologist coordinate the support groups, which take place once per week.

Summarizing

Sustaining existing psychosocial rehabilitation programs is even more crucial in a period of drastic budget reduction. The experience of these last years has shown how important these programs/actions are for promoting social support and networking, with the active involvement of families and users. Their contribution is of outmost importance and they show promising and cost – effective results, through activating venues of social capital.

References

- [1] Christodoulou G, Ploumpidis D, Christodoulou N, et al. Mental health profile of Greece. *Int Psychiatry* 2010; 7: 64-67
- [2] Loukidou E, Mastroyiannakis A, Power T, et al. Greek mental health reform: Views and perceptions of professionals and service users. *Psychiatriki* 2013; 24: 37-44.

- [3] Kentikelenis A, Karanikolos M, Papanicolas I, et al. Health effects of financial crisis: omens of a Greek tragedy. *Lancet* 2011; 378: 1457-1458
- [4] Economou M, Madianos M, Theleritis Ch, et al. Increased suicidality and economic crisis in Greece. *Lancet* 2011; 378: 1459
- [5] Kontaxakis V, Papaslanis T, Havaki-Kontaxaki B, et al. Suicide in Greece 2001-2011. *Psychiatriki* 2013; 24; 170-174
- [6] Economist. Mental health and Integration. Provision for supporting people with mental illness. A comparison of 30 European countries. http://mentalhealthintegration.com/media/whitepaper/eiu-janssen_mental_health.pdf

THE CONTRIBUTION OF NGOS IN THE EMPOWERMENT OF USERS AND FAMILY MEMBERS IN GREECE: ACTIONS AND PROBLEMS

Panagiotis Chondros

Abstract

Professional non profit organizations in Greece have been an important stakeholder of care provision and service reform since 1981. There are examples of good practice centred on promoting empowerment strategies and actions in accord to the guidelines of the World Health Organisation (WHO) and the European Commission (EC), in close collaboration with users and families and other stakeholders. Relevant actions include research, advocacy, training, and networking. However, there are specific barriers that should to be overcome so that empowerment actions can be promoted at community and social level.

Almost three decades ago a series of actions was initiated in Greece, by a small group of psychiatrists, which led to the formation of what is known as the reform of the Greek psychiatric services. This has now become the State's National Policy for Mental Health. The core point of this reform is the shift from institutional care to community based care. More than 3400 people with very long hospitalizations in asylums were transferred to community settings. Five psychiatric hospitals were closed down and more than 260 community-based services (residential facilities, day centres, mobile units, etc) were established ^{1,2}.

According to various evaluations over a period of time there has been substantial service transformation focused on deinstitutionalization. Changes in the attitudes of health professionals are evident and communities are now more accepting of mental illness. However, a series of problems and negative outcomes has been noted. The overall system remains fragmented, uncoordinated and unstable. Along with limited access to a full range of services, and inequity, users and carers also receive limited information about the types of services provided and guidelines for their use. They are also excluded from the decision making process concerning the development, delivery and evaluation of services. Furthermore, they are deprived of state support with respect to advocacy and empowerment, as there is no national policy on the

involvement of users and their families in mental health policies and empowerment planning^{3,4}.

The concept and theory of empowerment is paramount in the vision of the World Health Organization (W.H.O.) with regard to health promotion, as shown by the proceedings of the W.H.O. Europe and E.C. joint project on User Empowerment in Mental Health (2008-2011). In a mental health context, empowerment refers to the level of choice, influence and control that users of mental health services can exercise over events in their lives. The key to empowerment is the removal of formal or informal barriers and the transformation of power relations between individuals, communities, services and governments⁵. A quite older definition also offers a helpful perspective: "Empowerment is defined as an intentional, ongoing process centered in the local community, involving mutual respect, critical reflection, caring and group participation, through which people lacking an equal share of valued resources gain greater access and control over those resources."^{6,7}.

Historically the work of professional non-governmental organizations (NGOs) in Greece is linked with the reform of the psychiatric services. In 1981 the first NGO was developed, the Society for Social Psychiatry and Mental Health, providing mobile unite services in the area of Phokida. Also, in 1981 the Greek – French Symposium for Social Psychiatry was held, where important statements for the transformation of psychiatry in Greece were supported and published⁸. In 2015, as a part of the National Plan for Mental Health Psychargos, 66 non profit NGOs are currently operating as public bodies and provide community mental health care across Greece. Of all the community mental health services in Greece, approximately 28% are run by NGOs.

Actions:

- Research on issues concerning the users (satisfaction from services, protection of rights, involuntary admission, treatments alternative to medication, training, social inclusion)
- Advocacy
- Training: An example of good practice was the Regional Congress for Psychosocial Rehabilitation organized by the World Association of Psychosocial Rehabilitation and the Association for Regional Development and Mental Health (EPAPSY). Workshops on user's rights and empowerment were conducted and more than 600 people from 15 countries participated. Examples of good practice were later presented and published⁹.

- Networking: NGOs promote networking and collaboration on empowerment actions at an international (WHO, WAPR, OHCHR, EUFAMI, Mental Health Europe, etc.) and national level (Ombudsman, Co-federation of people with disabilities, Federation of Associations of Families for Mental Health).
- Actions for empowerment of specific population sub-groups (e.g. immigrants, women)
- Support for accessing employment and participation in the development of Social Cooperatives (23 Social Cooperatives – KOISPE in Greek- exist at the moment)
- Organizational support of users' and families' associations
- Cultural events against stigma and discrimination (mental health art festivals, sport events)
- Funded collaborative projects on advocacy, self help and empowerment

Problems:

The issues we have to deal with in order to improve these actions, so they can have a wider impact concern the following:

- The lack of systematic evaluation on the effectiveness and impact of the abovementioned actions and the dissemination of good practices
- Funding difficulties
- Respect of users and families autonomy. The terms of collaboration must be clear and the contribution of users should not only be on a voluntary basis
- Collaboration between NGOs
- Collaboration between NGOs' and other stakeholders (public sector, social agents)

As the economical and political crisis deepens, the voice of people with mental health problems becomes weaker ¹⁰ and the degree of tolerance for poor quality standards increases¹¹. We must be creative in our actions for promoting empowerment and democracy for mental health ¹².

References

- [1] Stylianidis S, Ghionakis N, Chondros P. La riforma psichiatrica greca rispetto all'esperienza della riforma italiana, *Psichiatrica di Comunita* 2010; IX(2): 93-102
- [2] Karastergiou A et al. The reform of the Greek mental health services. *Journal of Mental Health* 2005; 14: 197 – 203
- [3] Stylianidis S, Chondros P, Lavdas M. Critical approach of an Empowerment and recovery process: A case study from Greece. In: Soldatos C, Ruiz P, Dikeos D, Riba M (eds). *Pluralism in Psychiatry: I. Diverse Approaches and Converging Goals*. Bologna: Medimond; 2014.
- [4] Loukidou E et al. Greek mental health reforms: views and perceptions of professionals and service users. *Psychiatriki* 2013, 24:39-46
- [5] World Health Organization. *User empowerment in mental health – a statement by the WHO Regional Office for Europe*. Copenhagen: WHO Regional Office for Europe; 2010.
- [6] Rappaport J. Empowerment meets narrative: Listening to stories and creating settings. *American Journal of Community Psychology* 1995;23: 795-807
- [7] Baumann A, Ryan P & Griffiths C. Empowerment: Key Concepts and Evidence Base. In: Ryan P, Ramon S, Greacen T (eds). *Empowerment, Lifelong Learning and Recovery in Mental Health. Towards a New Paradigm*. Basingstoke: Palgrave McMillan; 2012.
- [8] Lebovici S, Sakelaropoulos P. *Greek French Symposium for Social Psychiatry*. Athens: Kastaniotis; 1984.
- [9] Stylianidis S, Ploumpidis D (Eds.). Proceedings of the Regional Congress for Psychosocial Rehabilitation “Psychosocial Rehabilitation in an Economic Crisis Context new practices for emerging needs”, EPAPSY & WAPR, Athens 30-31 March 2012. Available at http://www.me-psyxi.gr/images/proceedings_of_wapr%201.pdf.
- [10] Farmer P. *Pathologies of Power. Health, human rights and the new war on the poor*. Berkeley: University of California Press; 2003.
- [11] Puras D. Rights of persons with psychosocial disabilities: long way from declarations to non-discriminatory policies and practices. Speech at the OHCHR's Regional Office for Europe event “5th Forgotten Europeans”, 16 -17 October 2014, Brussels, retrieved on 20.5.2015 <http://www.europe.ohchr.org/SiteCollectionImages/Events/Disabilities%20symposium%20October%202014/Dainius%20Puras.pdf>

WORKING WITH FAMILIES WITH A MEMBER SUFFERING FROM PSYCHOSIS: THE PSYCHIATRIST'S PERSPECTIVE

Marina Economou

Abstract

Relatives of people with psychosis constitute an informal healthcare system, as they are the patients' long-term care providers in the community. Nonetheless, this role is often accompanied by substantial difficulties, which in turn impinge on relatives' well-being as well as on the patient's course of illness. In response to these problems, psychoeducational interventions have long been developed and converging evidence has corroborated their efficacy. In Greece, the effectiveness of family psychoeducation has been assessed in the context of a large training programme for mental health professionals. A randomized controlled trial has revealed that family psychoeducation has a positive effect on relatives' outcomes, including family burden and family cohesion. In spite of the clinical and scientific value of family psychoeducation worldwide, it is commonplace for mental health professionals to face barriers to their collaboration with relatives. Ways to overcome those barriers are suggested.

Families constitute an indispensable part of the support network for those developing psychosis. This is largely because the onset of the disorder typically occurs during late adolescence and early adulthood¹, when the majority of people still live at home with their relatives. Core psychotic symptoms, such as delusions, hallucinations and disorganized behavior, can be particularly stressful for the person with the illness as well as for his/her family². As a corollary of this, relatives of people with psychosis manifest elevated rates of anxiety, depression and distress as compared to the general population³, underscoring the need to support them in their caring role. This is in line with growing evidence corroborating the benefits of involving relatives in treating people suffering from psychosis⁴. The family commonly provides useful information about the patient and his/her illness and it can substantially contribute to an effective treatment plan by supervising medication, encouraging participation in rehabilitation programmes and generally providing an environment that facilitates

recovery and/or lowers disability. Nonetheless, family members often cannot fulfill their caring role effectively due to the daily challenges they face: they have limited resources, little information about the disorder and no training in managing patient symptoms⁵. They often feel isolated from common resources of social and emotional support and they report feeling disregarded by mental health professionals⁶. In this rationale, psychoeducational interventions have been developed in an attempt to address these problems and promote relatives' well being as well as the recovery of people with psychosis.

Family Psychoeducation

Psychoeducation is a psychotherapeutic method for enabling families to work collaboratively with mental health staff as a part of an overall treatment plan. Its origins are traced back in 1980s when Anderson and colleagues⁷ presented their findings for a new approach to family therapy in schizophrenia. They showed that when families were approached in a thoughtful manner and taught skills for tackling the emotional and interpersonal challenges of being the front-line caregivers of patients with schizophrenia, there was a decrease in patient relapse rates. Additionally, Ian Falloon and colleagues⁸ developed the Behavioural Family Therapy, an intervention targeting the whole family with the aim of promoting positive communication, problem solving skills and stress management. Mounting evidence supports the beneficial effects of psychoeducational interventions for both patients and relatives. In terms of patient outcomes, they reduce relapse and rehospitalization rates, promote medication adherence, decrease the duration of hospital stays, improve global and social functioning, enhance patients' quality of life and increase satisfaction with service providers.

Similarly, with respect to relatives' outcomes, they alleviate their degree of burden and level of distress^{9,10}. In spite of its strong empirical basis, family psychoeducational interventions have displayed low rates of dissemination in mental health services, while tailored training initiatives have shown modest uptake by staff and services¹¹⁻¹³.

Family Psychoeducation in Greece

In Greece, the concept of family psychoeducation is congruent with the country's social and cultural norms, as families maintain strong ties throughout one's life span and constitute a very strong institution¹⁴. Consistent with this, family psychoeducation can be especially conducive to the successful recovery of people with psychosis. In this context, an ongoing two-year training programme for mental health professionals on psychoeducation for families with a member suffering from

severe mental illness was established in 2004 by the University Mental Health Research Institute in collaboration with the First Department of Psychiatry of the University of Athens and the Families' Association for Mental Health (SOPSI).

The first year of training entailed theory learning and observation of relatives' groups. Specifically, professionals attended the basic course, where they were trained in the realm of family psychoeducation by means of guidelines, demonstrative videos, clinical scenarios and role-plays. Moreover, they observed psychoeducational and support groups of relatives –members of the Families' Association for Mental Health. During the second year, trainees implemented in pairs the Falloon Behavioural Family Management model⁸ on individual families' home, under supervision. It is noteworthy that the supervision occurred on a weekly basis to ensure the high quality of intervention, fidelity to the treatment protocol and uniformity in delivery among trainees. The content of the aforementioned 9-month intervention encompassed the following parts: (a) engagement of individual family members and the family as a whole, (b) assessment of individual family members and the family as a whole, (c) sharing of information, (d) communication skills training, (d) problem-solving training and (e) family meetings without the therapist.

An evaluation of the effectiveness¹⁵ of the particular intervention delivered in the context of this training programme was carried out in an endeavour to investigate whether individual family psychoeducation confers an additional benefit to relatives' support groups in the treatment of schizophrenia. For serving the purposes of this study, participants were recruited from relatives' support groups, through the Families' Association for Mental Health. To enter into the study, relatives had to care for a family member with a schizophrenia spectrum disorder, while the diagnosis was cross-validated by a clinical interview. A randomization process allocated 80 relatives to the control condition - consisting of relatives' support group intervention alone, and 80 to the experimental condition – consisting of both relatives' support group intervention as well as individual family psychoeducational behavioral management.

Outcome measures entailed patient hospitalizations, family burden, and family cohesion, while research data were collected at three time points: (i) at baseline, (ii) upon completion of the intervention and (iii) at one-year follow up. The intervention group displayed statistically significant improvements with respect to relatives' burden and family cohesion. On the contrary, the control group showed no substantial changes in any of the outcome indices. It is therefore clear that individual family psychoeducation – embedded in a training programme for mental health staff- can be an effective means for alleviating relatives' burden and promoting family cohesion and it can also be a promising venue for clinical and social recovery of people with psychosis in the long-term.

Working with Families: Barriers to Collaboration

Nonetheless, there are certain issues that necessitate thorough consideration in the initial and continuing education of mental health professionals in order to achieve a constructive collaboration between them and family caregivers. This is in line with evidence showing that gaps in communication and cooperation between professional and family caregivers are likely to interfere with the patient's adjustment and to render relatives' task even more difficult¹⁶.

The most common barriers to professionals'-family members' relationships are: conflicts over the nature of the relationship between relatives and staff, including confidentiality problems; professionals' misconception that parents are responsible for the illness; relatives' lack of gratitude to professionals and resource deficiencies in the mental health care system. A brief description of the aforementioned obstacles follows:

- ❖ The nature of the relationship between relatives and mental health professionals is a central issue. Should it be therapeutic, supportive, educational or collaborative? It is often heard among mental health staff that the patient is their primary responsibility. Nonetheless, this raises the question of whose responsibility is the well-being of relatives. Furthermore, confidentiality problems are frequently mooted when the patient does not want relatives to be kept informed resulting in a conflict between the patients's right to confidentiality and the relatives' right to appropriate information.
- ❖ Mental health professionals' misconception that parents are responsible for psychosis is often a result of the stigma surrounding severe mental illness and especially schizophrenia. This view is consistent with the outdated ideology that adult psychological difficulties stem from the mother – the so-called schizophrenogenic mother¹⁷ – a view which has been recently described as “a traumatic chapter in the history of psychiatry”¹⁸.
- ❖ Relatives may not express gratitude to the mental health staff for various reasons: the patient does not get cured, or they feel blamed, ignored and disparaged by professionals. As a result of this, while professional training points to caregiving irrespective of personal linking for the recipient of care, relatives' lack of appreciation and pertinent anger and complaints often hinder good working relationships between relatives and professionals.
- ❖ Regarding the deficiencies in the mental health care system, time pressure emerges as one of the most fundamental issues. It generally takes a long time for the mental health staff to see patients and relatives separately and then jointly, as it is often necessary in treatment plans emphasizing relatives' active involvement in decision-making processes. Furthermore, it requires a large amount of time for

mental health professionals to apply conflict resolution techniques within the family by employing interest-based rather than power-based negotiation.

Working with Families: overcoming the obstacles

Congruent with the aforementioned, any treatment plan involving psychiatric interventions with the family raises important questions with regard to the role of values, ways of striking a balance between the often competing interests of its members, conflict resolution and confidentiality. It is thus not surprising that many mental health professionals, and especially psychiatrists who are responsible for the treatment of people with severe mental illness, feel that they enter a moral arena. Building on previous guidelines and recommendations¹⁹, psychiatrists should take into consideration the following, when they deal with all these issues:

- I. The psychiatrist offers professional knowledge and skills as required but not at the expense of depriving the family of the opportunity to use their own strengths.
- II. The psychiatrist should withhold his or her own values and should avoid the imposition of what he or she considers being the “right” for the family.
- III. The patient’s interests always take priority, with the rest of the family regarded as ancillary. Although their potential contribution is sought, this is construed as an assistance to the patient.
- IV. While the interests of relatives are taken into consideration, the particular features of the therapeutic situation guide the clinician’s responses. The patient is not always the chief priority, as satisfactory functioning may occur at the expense of others. In this rationale, the clinician should monitor the welfare of each member within the family and adjust his or her interventions accordingly.
- V. The interests of all family members are relevant without exception, as their dynamics as a social group and the patients’ difficulties are intertwined.
- VI. Finally, it is important for psychiatrists to recognize that there will always be contradictions, ambiguities and at times conflicts between them and the patient or/and the relatives. However, good communication and understanding the needs of each person can minimize the damage which might otherwise ensue.

In conclusion, throughout the last decades, the psychiatry’s perspective on relatives of people with severe mental illness was gradually switched from considering them the culprit of schizophrenia to regarding them as essential allies in the treatment of the disorder. Family psychoeducational interventions have contributed substantially to this transformation. It is noteworthy that this transformation is largely attributed to the development and implementation of family psychoeducational interventions.

References

- [1] Lieberman JA, Fenton WS. Delayed detection of psychosis: Causes, consequences, and effect on public health. *Am J Psychiatry* 2000; 1727-1730
- [2] Addington J, Coldham EL, Jones B, et al. The first episode of psychosis: The experience of relatives. *Acta Psychiatr Scand* 2003; 108: 285-9
- [3] Kuipers E, Onwumere J, Bebbington P. Cognitive model of caregiving in psychosis. *Br J Psychiatry* 2010; 196: 259-265
- [4] Mueser KT, Sengupta A, Schooler NR, et al. Family treatment and medication dosage reduction in schizophrenia: Effects on patient social functioning, family attitudes, and burden. *J Consult Clin Psychol* 2001; 69: 3-12
- [5] Dixon L, Lyles A, Scott J, et al. Services to families of adults with schizophrenia: from treatment recommendations to dissemination. *Psychiatr Serv* 1999; 50: 233-8
- [6] Magliano L, Marasco C, Fiorillo A, et al. The impact of professional and social network support on the burden of families of patients with schizophrenia in Italy. *Acta Psychiatr Scand* 2002; 106: 291-8
- [7] Anderson CA, Gerard E, Hogarty GE, et al. Family treatment of adult schizophrenic patients. A psychoeducational approach. *Schizophr Bull* 1980; 6: 490-505
- [8] Falloon IRH, Boyd JL, McGill CW. Family care for schizophrenia: a problem solving approach to the treatment of mental illness. New York: Guildford Press, 1984
- [9] Pekkala E, Merinder L. Psychoeducation for schizophrenia. *Cochrane Database Syst Rev* 2002; 2: CD002831
- [10] Pitschel-Walz G, Leucht S, Bauml J, et al. The effect of family interventions on relapse and rehospitalization in schizophrenia: a meta-analysis. *Schizophr Bull* 2001; 27: 73-92
- [11] Fadden G. Implementation of family interventions in routine clinical practice following staff training programs: a major cause of concern. *J Ment Health* 1997; 6: 599-612
- [12] Getachew H, Dimic S, Priebe S. Is psychoeducation routinely provided in the UK? Survey of community mental health teams. *Psychiatr Bull* 2009; 33: 102-3
- [13] Magliano L, Fadden G, Madianos M, et al. Burden on the families of patients with schizophrenia: results of the BIOMEd I study. *Soc Psychiatry Psychiatr Epidemiol* 1998; 33: 405-412
- [14] Madianos M, Economou M. Schizophrenia and family rituals: measuring family rituals among schizophrenics and "normals". *Eur Psychiatry* 1994; 9: 45-51
- [15] Economou M. Individual family psychoeducation for schizophrenia: findings from a large training program for mental health staff. In: Soldatos C, Ruiz P, Dikeos D, Riba M, editors. *Pluralism in psychiatry: I Diverse approaches and converging goals*. Bologna: MEDIMOND, 2014
- [16] Lefley HR, Johnson DL. Families as allies in treatment of the mentally ill III: New directions for mental health professionals. Washington: American Psychiatric Association, 1990

- [17] Perris C. Parental rearing and schizophrenic disorders. In: Perris C, Arrindell WA, Eisemann M, editors. Parenting and psychopathology. Chichester. Wiley; 1994
- [18] Harrington A. The art of medicine- the fall of the schizophrenogenic mother. *Lancet* 2012; 379: 1292-3
- [19] Szmukler GI, Bloch S. Family involvement in the care of people with psychoses: an ethical argument. *Br J Psychiatry* 1997; 171: 401-5

EMPOWERING THE FAMILIES OF THE MENTALLY ILL IN AN ERA OF ECONOMIC CRISIS: RECORDS FROM THE FAMILIES' ASSOCIATION FOR MENTAL HEALTH (SOPSI) SUPPORT GROUPS.

Helen Louki

Abstract

Taking care of a family member with serious mental illness can place severe strain, not only on the primary carer but also on friends and other members of the family. Carers play a vital role in the mental health care system; yet their needs are usually overlooked. Support groups may offer them an avenue through which they can unburden themselves, as they are surrounded by people who face similar situations; while they also provide them with some sense of control over an otherwise chaotic life experience. In this contribution, Families' Association for Mental Health (SOPSI) support groups for relatives with people with mental illness are briefly described and participants' views with regard to the impact of the Greek financial crisis on their caring role, will be elaborated on.

Severe mental illness has far reaching effects not only for the person who is ill but also for the entire family¹. The diagnosis of a severe mental illness can be a frightening and ominous experience for family members; an experience that often leaves the family in a state of shock and disbelief. Additionally, taking care of a relative who suffer from severe mental illness can place considerable strain not only on the primary carer but also on friends and other family members. Families may be emotionally, socially and physically burdened by the persisting symptoms, the relapses of the disease and the impairments caused by the illness. They are likely to experience helplessness, anger and despair in the face of the illness, blame themselves or other family members for the illness' onset and eventually isolate themselves in an attempt to deal with the stigma, shame and exclusion that accompany mental disorders³.

On the other hand, family is an important social agency that fulfills the social, educational, psychological and various other needs of its members⁴. For mental ill patients, family members are considered their main support system⁵, since they are

the ones providing them with emotional support, instrumental and financial assistance, housing and advocacy⁶. In most of the cases, families of the mentally ill operate as the primary caretakers without receiving any guidance, support or relief; while their needs are often underestimated or entirely overlooked⁷.

The needs of carers fall into two categories: The need for assistance with regard to burdens and the need for assistance in coping with the associated subjective emotions – learning into come to terms with feelings of guilt, anger, fear, depression, shame and grief⁸. Carers not only need information and advice about how to cope with their ill relative, but they also need emotional support. Support groups, whose fundamental characteristic is emotional support, can adequately meet those needs, by creating a 'safe' environment where family members can compare predicaments, decrease negative emotions, form friendships, re-establish social networks, decrease isolation, establish hope and focus on positive role models within the group⁸. Support groups offer carers an "avenue" through which they can 'unburden' themselves, by being among people with similar life experiences, and regain a sense of control over an otherwise chaotic experience².

The imperative need for this objective and subjective support of relatives is met by the Families' Association for Mental Illness (S.O.P.S.I.); a non-profit organization, founded in 1993 by the families and relatives of people with mental illnesses. S.O.P.S.I. was formed to help family members share this devastating life experience with others who had faced similar situations, support each other and advocate for the rights of their loved ones. SOPSI aims to provide solidarity and support to its members, protect and support both patients with mental illnesses and their families, by providing them with up-to-date information on mental illness and its contemporary treatment, increasing society's awareness, sensitizing the public, decreasing stigma and discrimination while also developing and promoting a positive image for people who suffer from serious mental illnesses. In line with this, SOPSI offers its members annual psychoeducational sessions and support groups on a weekly basis (every Monday and Wednesday) which are coordinated by mental health professionals trained in cognitive behavioral therapy for families of mental patients. Support groups have a 90 minute duration and an open access participation, in the sense that participants may attend whenever they can or feel they need to. Participants are mainly parents of mental patients – with mothers outnumbering fathers – and their number varies from 20 – 30 individuals. SOPSI's support groups offer participants benefits on both objective and subjective levels regarding information about the illness, training in coping skills and effective communication, as well as emotional support. In a "protected" environment and within a group of people with similar problems, parents can have ample opportunities for disclosure, empathic connection, friendship and consequently, a way out of social isolation. Additionally, when knowledge about the illness is increased, the illness is demystified. Information about available services is also provided to the carers, along with some techniques to help them enhance their

problem solving skills. These “techniques” take the form of practical advice and suggestions for coping with difficult behavior, providing them with new ways of thinking, feeling and dealing with life experiences. Finally, there is a shift in illness attributions held by the members; from blaming themselves, to accepting that their relative’s problems are due to a biological disorder.

The topic under discussion in each session is usually inspired by everyday difficulties and current affairs. In most cases, the topics that carers bring up for discussion mainly concern emergency issues that call for immediate attention or everyday life problems. In brief, topics may be roughly grouped to the following categories: 1) **mental illness** (diagnosis, symptoms, causes, identifying the signs of relapse, treatment, dealing with aggressive behavior, accepting the illness etc), 2) **feelings / emotional burden** (shame, guilt, stigma, family relations, over involvement, expressed emotion etc), 3) **everyday life with the patient** (communication, setting limits, dealing with difficult behavior, smoking etc), 4) **involuntary admission** (practical issues, emotional burden, stigma etc), 5) **legal custody** (practical issues, involvement of other family members etc) 6) **cooperation with mental health professionals** (patient’s reluctance to visit a therapist, communication difficulties with mental health professionals, inadequate support and information from therapists etc) 7) **patient’s socialization / chances for employment** (forming friendships, interpersonal relations, rehabilitation, employment opportunities etc) 8) **substance abuse** (difficulties in dealing with both, which of the two caused the other etc) 9) **siblings’ involvement** (parents guilt for neglecting their other children, questions about involving them in managing the illness etc) 10) **carers’ right for a personal life** (entertainment, social life, feelings of guilt about enjoying life when the patient does not etc) 11) **future of patients** (what will happen after parents are gone, involvement of siblings etc) and 12) **economic crisis** (consequences on mental health services, mental health workers, carers, family members and patients). The Economic crisis, in particular, has recently been a common theme for discussion in support groups, as its devastating effects seem to have additionally burdened carers of mental patients.

Preparing for this presentation, support group participants were asked to elaborate on the Greek financial crisis and talk about the areas of their lives as well as of their relatives’ that they believe to have been affected the most by the currently difficult economic situation. From what they reported on the issue, it seems that this extra burden does not only involve financial strains, but emotional difficulties as well. In particular, carers in their contact with services and mental health professionals talk about shortages in available services and personnel, tired and overloaded professionals, limited rehabilitation services and restrictions in the number and duration of sessions with therapists. In addition, they report that the overall cost of caring for mental patients has increased dramatically. Also, when it comes to medication they report increases in the cost of medication as well as difficulties in

finding the ones prescribed to them. The use of generic medication raises a number of questions for relatives, as it makes them feel uncertain about whether the choice of their prescription is based on the patient's best interest or it is due to financial factors.

However, apart from the aforementioned, the emotional burden is equally heavy, with carers reporting major changes in their overall quality of life. In an effort to cover for the patient's expenses, they may put aside their personal needs, including clothing and entertainment, whereas some even increase their work hours in order to make ends meet. In line with this, family balance has also been distorted since many carers have either suffered great salary cuts, or have lost their jobs. Families are further burdened by other family members who may be also experiencing unemployment or financial difficulties and may be turning to them for assistance. Overall, from what the carers themselves report, it can be concluded that many of them only manage to preserve their relatives' condition without being able to offer any additional help that could possibly improve their health or their quality of life, and without being able to offer to their relatives or to themselves any opportunities for leisure or entertainment.

In conclusion, support for carers of mental patients in the era of the economic crisis is more vital than ever. Parents, siblings and extended family members are in great need to find support and empowerment in order to effectively cope with their relative's illness and to find a way through daily difficulties and problems. In such times of need, support groups play a double role; supporting and training carers in managing the illness and instilling hope to people devastated by an unpredictable and turbulent daily life.

References

- [1] Friedrich RM, Lively S, Rubenstein LM. Siblings' coping strategies and mental health services: A national study of siblings of persons with schizophrenia. *Psychiatr Serv.* 2008; 59 (3): 261-267
- [2] Gruber EN, Kajevic M, Agius M, et al. Group psychotherapy for parents of patients with schizophrenia. *International Journal of Social Psychiatry.* 2006; 52(6): 487-500
- [3] McDonnell MG, Short RA, Berry CM, et al. Burden in schizophrenia caregivers: Impact of family psychoeducation and awareness of family suicidality. *Family Process.* 2003; 42(1): 91-103
- [4] Anuradha K. Empowering families with mentally ill members: A strengths perspective. *International Journal for the Advancement of Counseling.* 2004; 26(4): 383-391

- [5] Ohaeri JU. The burden of caregiving in families with a mental illness: a review of 2002. *Current Opinion in Psychiatry* 2002; 16: 457-465
- [6] Dixon L, Adams C, Lucksted A. Update on family psychoeducation for schizophrenia. *Schizophrenia Bulletin*. 2000; 26 (1): 5-20
- [7] Leung GM, Rastogi SC, Woods J. Relative support group of long-stay psychiatric patients. *Psychiatric Bulletin*. 1989; 13: 417-419
- [8] Shankar J, Muthuswamy SS. Support needs of family caregivers of people who experience mental illness and the role of mental health services. *Families in Society*. 2007; 8 (2): 302-310

BUILDING BRIDGES OF COMMUNICATION AMONG THE MENTAL HEALTH SERVICES AND THE FAMILIES: THE EXAMPLE OF APPLYING A GOOD QUALITY PRACTICE THROUGH FAMILY PSYCHOEDUCATION.

Alexandra Palli

Abstract

Taking into consideration the principles of Psychosocial Rehabilitation as defined by the World Association of Psychosocial Rehabilitation (W.A.P.R.) in its founding declaration as well as major international guidelines concerning the treatment of schizophrenia, we implemented family psychoeducational approach as a “good quality practice” regarding the communication between mental health services and families of people suffering from severe mental illness, especially of the schizophrenia spectrum. In my contribution I will describe the case of a patient and her family, where single-family psychoeducation at home was implemented.

Although schizophrenia is considered to be the most usual diagnosis found in psychiatric hospitals², the majority of people suffering from the disorder live in the community. Patients are mainly cared for by their families, with pertinent figures reaching 60-62% in western countries^{3,4}, 70-84% in Mediterranean countries⁵ and 90-98% in Asian countries, like China⁶ or India⁷.

It is well documented that the quality of the relationship and the communication between the members of the family and the patient plays an important role in triggering relapses, leading to a duplication of their frequency and to prolonged hospitalizations^{8,9,10}.

Besides that, a meta-analysis on the topic has substantiated that due to their caring role and its implications, family members display multifaceted needs pertaining to social interactions, support resources, coping and stress management, advancement of knowledge about the disorder, destigmatization and enhancement of quality of life¹¹.

Psychoeducational interventions have been shown to be beneficial for both patients and their family members. Twenty-five intervention studies were meta-analytically examined regarding the impact of including relatives in schizophrenia treatment. The

studies investigated family intervention programs aiming at educating relatives and helping them cope better with the patient's illness. The main finding of the study was that the relapse rate can be reduced by 20% if relatives of patients with schizophrenia are included in the treatment plan. In fact, if family interventions continued for more than 3 months, the effect was particularly marked¹². Concerning relative outcomes, results show that psychoeducation has a beneficial effect for family cohesion, global family burden, objective family burden, and relatives' depressive symptomatology¹³.

A considerable number of researchers and scientific groups recommend family psychoeducation as a good quality practice that needs to be readily accessible to all patients suffering from schizophrenia^{14,15}. As an illustration of this point, an international scientific team in an attempt to set quality assurance criteria for the operation of mental health services for people with chronic mental illness, has identified nine areas that contribute substantially to patient recovery, including family psychoeducational interventions¹⁶. The national research project on evidence-based intervention in schizophrenia, known as Science-to-Service Gap¹⁷, has also found that psychoeducation, among other interventions, leads to increased continuity of care and slightly improved social functioning. Furthermore, to date, the most extensive - and in fact landmark- government-funded study conducted in the United States, including 34 community care clinics in 21 states, concluded that schizophrenia patients who received a program intended to keep dosages of antipsychotic medication as low as possible and emphasized on individual talk therapy and family psychoeducational support demonstrated substantial improvement with respect to functional and clinical outcomes over the first two years of treatment, as compared to patients who received the treatment as usual care, centered on pharmacotherapy. Effects were found to be more pronounced for patients with shorter duration of untreated psychosis¹⁸.

Nonetheless, psychoeducational interventions are poorly disseminated and not regularly offered as a standard treatment to chronic patients nor to young people with mental illness, although they have been found to reduce the use of mental health services and related psychiatric departments¹⁹.

This is in line with the view of Julian Leff, who has arguably stated that anyone able to create a drug powerful enough to reduce relapse rates in schizophrenia by 30% in two years, would most certainly become the wealthiest man in the world. But if the same man developed a family therapy treatment to manage the same results, he would be no richer than he was in the first place²⁰.

The current reality in our country is quite similar to international evidence, the psychoeducational interventions applied to both the patients themselves and to their relatives are scarce. In the case presented here three services collaborated and made the intervention possible for more families.

The psychoeducational model applied was the comprehensive Behavioral Family Management Approach developed and optimized by Falloon²¹, which has since been implemented in a wide range of services worldwide²².

The Family on the Spotlight; the case of patient X

The main focus of my contribution will be centered on the case of X and her family, in order to present an application of the Behavioral Family Management Approach as developed by Falloon (1996) for individual families in a real clinical setting.

To begin with, the core characterological aspects and distinctive features of this particular case are to be reviewed and firmly discussed below.

X is a 28-years-old woman, studying at the Greek University. She is not employed and she lives with her family.

The diagnosis for this young lady is schizophrenia of the paranoid type. Patient X is actually suffering from the presence of dominant, recurring delusional ideation with its content pertaining to elements of hypochondria and persecution. Negative symptomatology is also present.

Patient X is the youngest member of her family. She is described as a good offspring, but really closed up to herself; she is also portrayed by her intimates as a good, diligent student (at school) with a number of extracurricular activities in her daily routine, such as playing the piano or sports activities. After her entry into the Greek University, she attends the first semester there and then decides to quit her studies in Greece and move to an EU country in order to study a more preferable subject.

The onset of the disorder is pinpointed by the time X goes abroad for continuing her studies. At this exact frame of time, the symptoms of the disorder have started to become apparent. To be more precise, X started being indifferent towards taking care of herself; she had low interest in her physical or emotional well-being and she was somehow withdrawn. The closed-ones noticed the changes in her behavior. As they were worried about this shift on their daughter's functioning, they kept in touch with her during the time she was away- the parents have been keeping a regular, frequent communication through the telephone and they were also taking care of the financial support their daughter needed for the completion of her studies.

Two years later, the problem of X became more apparent to her parents while they realized at that point of time that things were getting progressively more serious than they thought. The parents decided to travel to meet their offspring at the city she was living in and studying, in order to bring her back to Greece, so as to seek professional help about X and the difficulties she was going through.

Indeed, X came back to her homeland escorted by her parents and for the next few months her condition was worsening. The situation in the family house was characterized by apprehension, great tension for X and continuous quarrels among the family members. X used to go out for long-lasting walks in the city of Athens, where she was wandering around the streets for several hours daily all by herself.

Under these adverse circumstances, X was involuntarily admitted to a psychiatric unit and was indeed hospitalized twice. By the moment she was discharged from the inpatient psychiatric treatment unit, she quitted her drug therapy and refused to

follow the physicians' recommendations for getting better. That quickly resulted in a vast deterioration of her already serious condition.

In particular, patient X for a long period of time she was alone, homeless and wandering in the city streets. At a specific point, X decided to seek for professional help and this is how she was admitted for the third time in an inpatient psychiatric clinic.

During her third hospitalization, patient X and her relatives become aware through internet-based search of the psychoeducational intervention and so they decided to start receiving family therapy in order for X to be assisted in getting better and remain that way.

In order for us to hold a better grasp of the family discussed in this paper some distinctive features of the family of X will be presented.

Behavioral Assessment

The family consists of five (5) members, living together in the same building. The behavioral assessment which included an initial assessment of each family member and an assessment of communication and problem-solving deficits of the whole family showed that they are interconnected with strong family bonds. An important asset of X's family is the good relationship between the mother and the father. They are both presented as overly protective parents towards the patient, showing high levels of expressed emotion²³. Moreover, what X's parents do have is a strong motive to help their daughter get better, receive the help she needs for her disorder and assist her in building and integrating positive changes in her life.

Concerning the particular needs of X family and the Therapeutic Goals, they were carefully reviewed and analyzed by the experts, while they were subsequently addressed in the family treatment. The primary aim of the psychoeducational therapy is to combine the optimal pharmacological treatment with empirically validated and well-established psychosocial interventions.

Breaking down this primary aim into separate goals and objectives will provide the family and the therapists with a better understanding of the problem. Additionally, this process will assist the members receiving family therapy to work towards the primary goal step-by-step. In this rationale, we can pinpoint three different subgroups of goals. The first and very important benefit of the therapy would be to increase patient adherence to the pharmacotherapy, through systematic contact and collaboration with the psychiatrist in charge and, of course, the receipt of a proper medication treatment. The second goal concerned all members; and it entailed enhancing the intrafamilial communication amongst them. Last but not least, the third objective of the family intervention planning had to do with encouraging all family members to meet their own personal goals and therefore reinforce each one of them to do so separately from the other family members.

Mental Health Services involved

To address the needs of this family, three services were involved and collaborated systematically to this end:

- The Pan-Hellenic Association of Families for Mental Health (where parents got informed about psychoeducation and attended a relatives' support group).
- Community Psychiatric Health Center of Papagos-Cholargos (a sectorised mental health service of the UMHRI where patient X receives routine psychiatric care).
- The University Mental Health Research Institute (UMHRI) & the 1st Psychiatric Department of the University of Athens – these two institutions organize a 2-year training program in behavioral family therapy and in psychoeducational interventions. The delivery of relatives' group psychoeducation and of the individual family psychoeducation at home was made possible through this program. Two trainees, in this case a psychologist and a nurse, implemented the intervention for one year under weekly supervision by me.

The Content of the Intervention

The content of the intervention/ family therapy included various components, all of which are to be reviewed and explained below.

The first step towards a successful and rewarding therapy is to train the members of the family in appropriate communication skills. In our case, the family of X was engaged into developing carefully selected communication skills. The communication skills were presented to them and they had to find a reason for cultivating these particular skills in terms of its usefulness in their everyday life. The therapists served as communication role-models and also provided the family members with printed handouts- those handouts were answering questions about the disorder, the state of the patient etc. Role-playing techniques were also a crucial part of the process, as a matter of fact. Consistent with this, the family was given tailor-made exercises to complete as homework- in their own time- until the next session/meeting. The therapists strongly encouraged all members of the family to try to apply what they learnt during the session to their daily life and to write down their progress in doing so. The key goal of all the methods described above, was the co-ordination of the therapists with the family and the enforcement of the behavioral-family therapy protocol.

The therapists also trained family members in problem-solving & goal achievement techniques, an approach developed in the frame of cognitive therapy by D'Zurilla & Goldfried²⁴ and adapted in the psychoeducational frame by Falloon²¹. This technique consists of six steps, including:

1. Formulation of the problem.
2. Brainstorming about possible solutions.
3. Evaluation of solutions.
4. Agreement as regards the best solution.

5. Planning of the implementation of the solution.
6. Evaluation.

The third step of the intervention included education about the illness. This step was introduced last because of the initial lack of insight on the part of the patient concerning her illness.

All sessions pertaining to these three steps integrated components of supportive psychotherapy and stress management techniques.

Single Family Sessions

The meetings with the family took place in the family house, where all members participated in the course of therapy. Therapeutic sessions lasted for about 1 and a half hour. X's family received 26 behavioral-family therapy sessions by a couple of therapists. Seven out of the 26 sessions were centered on training the family in communication skills, 14 sessions were about training the members in practicing problem-solving/achieving goals technique, 4 sessions focused on educating them on the disorder and 1 session was the closing session. At the same time, 26 family meetings took place, in which the family members had to practice skills or to complete several exercises, as instructed. In these meetings no therapist was present.

Evaluation of the Intervention

The patient was involved in most of the therapeutic sessions. The intervention helped her in increasing her knowledge and insight about the disorder. During and after the behavioral family therapy she received regularly her drug treatment and she generally felt more relieved by the symptoms. The patient now stays in a house of her own and she is capable of taking care of herself and of the space she is living in. She works sporadically and continues her studies in the Greek University. Patient X has learnt to communicate in better and more efficient ways with her family, while she now engages in discussions/ conversations with them instead of arguing and fighting. After all, she expresses her future desires and sets future goals.

As for the rest members of the family, they achieved a better and more frequent communication within them. They started sharing responsibilities and they re-negotiated the role that each member holds in the house. At the end of the intervention the parents appeared less over-protective towards the patient, while all the members accepted X's problem and formed realistic expectations of her. They accepted the wish of X to move alone in another district of the city and have regular contact with her, while respecting her need to be at a certain distance from them. Arguably, the family functioned in a much better way when it came to managing family issues.

At the closing session the family members recognized the changes they have made and X. expressed her wish to go on having single therapy sessions with the therapists.

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References

- [1] WAPR. Psychosocial Rehabilitation Consensus statement. Division of Mental health and Prevention of Substance Abuse. World Health Organization. Geneva; 1996 June.
- [2] Wienberg G. Schizophrenie zum Thema machen-Psychoedukative Gruppenarbeit mit schizophren und schizooaffektiv erkrankten Menschen - PEGASUS- Grundlagen und Praxis. Bonn. Psychiatrie Verlag; 1997.
- [3] Gibbons JS, Horn SN, Powell JM, et al. Schizophrenia patients and their families. A survey in a psychiatric service based on a district general hospital. *The British Journal of Psychiatry*.1984. 144, 70-77.
- [4] Lefley HP. Family psychoeducation for serious mental illness. New York. Oxford University Press, Inc.; 2009.
- [5] Warner R. Recovery of Schizophrenia. Psychiatry and Political Economy, London. Routledge & Kegan Paul; 1986.
- [6] Xiong W, Phillips M, Xiong Hu, et al. Family based intervention for schizophrenic patients in China: a randomised controlled trial. *The British Journal of Psychiatry*, 1994, 165, 239-247.
- [7] Shankar R, Rao K. From Burden to Empowerment: The Journey of Family caregivers in India, in Sartorius N, Leff J, Lopez-Ibor JJ, Maj M & Okasha A (eds). Families and Mental Disorders – From Burden to Empowerment, (pp. 259-290). World Psychiatric Association, England, John Wiley & Sons Ltd.; 2005.
- [8] Kuipers E, Bebbington PE. Research on burden and Coping strategies in Families of people with Mental Disorders: Problems and Perspectives. In Sartorius N, Leff J, Lopez-Ibor JJ, Maj M, Okasha A (eds). Families and Mental Disorders. From Burden to Empowerment, (pp. 217-234). World Psychiatric Association. West Sussex, England. J. Wiley & Sons Ltd.; 2005.
- [9] Butzlaff RL, Hooley JM. Expressed emotion and psychiatric relapse: a meta-analysis. *Archives of General Psychiatry*.1998, 55, 547-552.
- [10] Marom S, Munitz H, Jones PB, et al. Expressed emotion: Relevance to Rehospitalization in Schizophrenia Over 7 Years. *Schizophrenia Bulletin*. 2005, 31 (3), 751-758
- [11] Habibi R, Sirati Nayer M, Khaghani Zadeh M. Educational Needs of Families of Patients with Schizophrenia: A Literature Review. *International Journal of Medical Reviews*, [S.l.], v. 2, n. 2, jun. 2015. ISSN 2345-525X.
- [12] Pitschel-Walz G, Leucht S, Bäuml J, et al. The Effect of Family Interventions on Relapse and Rehospitalization in Schizophrenia: A Meta-Analysis. *Focus*. 2004

- January, 2(1), pp. 78–94. Palli A, Kontoangelos K, Richardson , et al. Effects of Group Psychoeducational Intervention for Family Members of People with Schizophrenia Spectrum Disorders: Results on Family Cohesion, Caregiver Burden, and Caregiver Depressive Symptom. Special Issue: Psychoeducation for Severe Mental Illness. *International Journal of Mental Health*. 2015, Volume 44, Issue 4, 277-289. DOI:10.1080/00207411.2015.1076291
- [13] NICE. Schizophrenia: Full National Clinical Guideline on core Interventions in Primary and Secondary Care. Gaskell Press; 2003.
- [14] Lehman AF, Kreyenbuhl J, Buchanan R, et al. The schizophrenia patient outcomes research team (PORT): updated treatment recommendations. *Schizophrenia Bulletin*. 2004. 30(2), 193-217.
- [15] Taylor T, Killaspy H, Wright C, et al. A systematic review of the international published literature relating to quality of institutional care for people with longer term mental health problems. *BMC Psychiatry*, 2009, 9, 55, <http://www.biomedcentral.com/1471-244X/9/55>.
- [16] Van Duin D, Franx G, Van Wijngaarden B, et al. Bridging the science-to-service gap in schizophrenia care in the Netherlands: the Schizophrenia Quality Improvement Collaborative. *International Journal for Quality in Mental Health Care*. 2013 Dec; 25(6):626-32. doi: 10.1093/intqhc/mzt072. Epub 2013 Oct 31.
- [17] Kane JM, Robinson DG, Schooler NR, et al. Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year outcomes from the NIMH RAISE Early Treatment Program. *The American Journal of Psychiatry*, published online October 20, 2015. Online ISSN: 1535-7228. <dx.doi.org/10.1176/appi.ajp.2015.15050632>
- [18] Dyck DG, Hendryx MS, Short RA, et al. Service use among patients with schizophrenia in psychoeducational multiple-family group treatment. *Psychiatric Services*. 2002, 53, 749-754
- [19] Bertrando P. The evolution of family interventions for schizophrenia. A tribute to Gianfranco Cecchin. *Journal of Family Therapy*, 2006, 28(1), 4-22
- [20] Falloon I, Mueser K, Gingerich S, et al. *Behavioural Family Therapy: A Workbook*. U.K. Buckingham Mental Health Service; 1996
- [21] Falloon IRH, Economou M, Palli A, et al. The Clinical Strategies Implementation Scale to Measure Implementation of Treatment in Mental Health Services, *Psychiatric Services*. 2005, 56, 1584-1590
- [22] Leeb B, Hahlweg K, Goldstein MJ, et al. Cross-national reliability, concurrent validity, and stability of a brief method for assessing expressed emotion. *Psychiatry Research*. 1991 Oct; 39(1):25-31
- [23] D'Zurilla TJ, Goldfried MR. Problem solving and behavior modification. *Journal of Abnormal Psychology* 78:107-26, 1971.

The editors compiled this monograph drawing directly on the material contributed as presentations and key note speeches at the 2nd European Regional Training Programme, organized by the Hellenic Branch of the World Association for Psychiatric Rehabilitation (WAPR), titled: **“Psychosis: Patient and Family – International and Greek Examples of Psychiatric Rehabilitation”**, that was held in Athens Greece, on May 9th 2015. We would like to thank the speakers, the contributors and organizations listed below for their participation in this scientific event and their valuable contributions.

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Psychosis: Patient and Family

International and Greek Examples of Psychiatric Rehabilitation

The Hellenic Branch of WAPR established in 2014 the European Regional Training Programme: Advanced Institute for Psychosocial Rehabilitation for Families and Carers: From Theory to Practice in an endeavour to stimulate interest in psychosocial rehabilitation in times of uncertainty. The present Booklet consists of a compilation of the topics presented and discussed in the 2nd European Regional Training Programme, with emphasis on “**Psychosis: Patient and Family – International and Greek Examples of Psychiatric Rehabilitation**”, that was held in Athens Greece, on May 9th 2015. Beginning from what’s new on psychiatric rehabilitation on a global scale, the editors (authors) move on to setting the scene for Greece through the perspective of the mental health care system and finally, shift the focus to the perspective of caregivers by briefly presenting effective family therapy interventions.