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Views of Mental Health Professionals on the Necessity and Effectiveness of Mobile Psychiatric Care Units for Patients in Greece

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Abstract

The aim of this research was to study the views of mental health professionals on the necessity and effectiveness of mobile psychiatric care units for patients in the community. The survey method was used for the implementation of this research, the aim of which was to produce quantitative and statistical results. The research process lasted one (1) month (March – April 2010) and took place in 5 Prefectures in our country (Achaia, Thessaloniki, Lasithi (Crete), Rhodes and Serres). According to the views of mental health professionals, the results of the research showed that: i) the professional role of mental heath professionals in the Mobile Mental Health Units is very important because it is clearer, thus leading to the cohesion of the therapeutic group, ii) the inability of the existing mental health services to monitor the mentally ill patients in the community regularly was the major reason for the immediate development of Mobile Mental Health Units, iii) the most significant aim of the operation of Mobile Mental Health Units is to meet the needs of mentally ill pa-

tients residing in remote areas, and iv) the mental health professionals suggest that Mobile Mental Health Units should be made available in all prefectures of our country.

Introduction

In our country, psychiatric reform officially began during the ’80s following our accession to the European Community and also on the occasion and at the height of international sensitization with regard to the hospitalization conditions at the Psychiatric Hospital of Leros (Liakos, 2003). According to Stylianidis and Stylianoudi (2008), the Leros De-institutionalization Programme resulted from the panic created by articles concerning the living conditions of patients at the Psychiatric Hospital of Leros that were published in the international press. The Leros Programme was a product of the psychiatric reform in Greece mentioned in EEC Regulation 815/84, introducing remarkable support and funding for the modernization of the archaic institutional system of Greece.

However, there were delays in its implementation according to the timetable, to some extent due to administrative difficulties and to some extent due to the nature of fundamental changes required for the transition from the traditional psychiatric care of patients within the environment of a psychiatric hospital to the structures to be provided within the framework of a community-targeted integrated model (Tzoraki-Chatzaki et al., 2005). The second phase of the Leros Programme, which was implemented during the period 1993-1995, provided for the expansion of an intervention for humanization of the living conditions throughout the State Mental Hospital of Leros (http:/www.koispe.gr).

The Psychargos Programme continued the policy of a structured reformative programme with specific interventions aiming at the social and economic integration of people with mental illnesses. It continued the establishment of new structures to provide integrated community-based mental health services throughout Greece, thus offering local services to the whole population and all age ranges (Tzoraki – Chatzaki et al., 2005). This programme is the operational arm of the policy of the Greek state with regard to psychiatric reform, deinstitutionalization and modernization of the system for provision of mental health services, establishing modern services which are community-oriented and included in the Mental Health Sectors (http://www.yyka.eu).

The programme includes the establishment of the following new structures: Integrated psychiatric services in General Hospitals, Integrated Child Psychiatric services in General Hospitals, Mental Hygiene Centres for adults, Medical-pedagogical Centres for children and adults, Immediate Crisis Intervention Units for people addicted to drug use, Units in General Hospitals, Units of physical purgation and psychological support for alcoholics, Integrated Units for people with autism spectrum disorders which include a Day Care Centre, a Hostel, a Crisis Intervention Centre, a Centre for Research and Education, Mobile Mental Health Units for particularly inaccessible areas, Day Care Centres for adults and children or adolescents, High or Medium Support Hostels and short-term or long-term accommodation Hostels, linked with the Integrated Psychiatric Services, Professional Reintegration Units and Social Cooperatives with Limited Liability (Madianos, 2000).

Mobile Mental Health Units constitute the cornerstone for the provision of mental health services, especially in small and remote prefectures. They undertake prevention, informing the population about mental health issues, prompt intervention, often in cases of crisis, and therapeutic treatment as well as contact with the patient’s family. It is the mobile unit that ensures steadiness and continuance of care. It primarily addresses psychotic and severely disturbed patients, without excluding milder mental disorders. The main aim is to treat psychiatric problems within the community without necessitating the patient’s being cut off from his social environment. At the same time, treating the patient as a biopsychosocial whole, it endeavours to manage social issues, vocational rehabilitation issues or even proceed to the necessary actions for the patient to receive the required medical care, whenever this is deemed necessary (Vlachaki, 2009).

Moreover, Giantselidou-Fragouli (2003) report that the task of the mobile mental health unit is the sensitization of the social group towards mental health, and the prevention and treatment of mental disorders within the community. In this way, the mobile mental health unit contributes to the development of a less guarded attitude towards the patients, thus facilitating their integration into the social web of the city.

A significant objective of extra-hospital structures is the secondary prevention of chronic psychotic disorders, namely a reduction in the intensity and duration of psychotic symptoms and a reduction in the number of relapses. A precondition for this is the availability of therapists and continuing patient care. A great part of these kinds of activities has been undertaken by the Mobile Mental Health Units A mobile crisis team offers many advantages to the community, some of which are as follows:

- Accessibility of services: Increased accessibility leads to improved provision of services.
- Accuracy of assessments: observing a patient at their home and at the time of crisis allows for fuller assessment with less trauma for the patient.
- Efficiency and effectiveness: The early treatment of patients can offset the need for emergency hospitalization.
- Collaboration with other services: Due to its mobility and visible presence, a mobile crisis team can serve as linkage with all public and private community-based mental health services (Livaditis, 2003).

The revision of the Psychargos Programme (Psychargos programme revision plan of 4-2-2012) by the Greek State, within the framework of the policy of cuts in the Health sector, due to the Loan Facility Agreement of Greece with the IMF, lead not only to the shrinkage but also the privatization of the currently existing Community Mental Health Services. Privatization of mental health services is also in the form of Non-Governmental Organizations, which have now undertaken the development and operation of Mobile psychiatric care units (Matsa, 2012).

The crucial phase in which mental health reform in our country now finds itself, the clear danger of painful retrogression and replication of asylum practices both on an intrahospital and community level, the destructuralization of the welfare state and the weakening of the Public Health sector via 40% cuts in funding, the upward trend in the number of psychiatric patients, mainly cases of depression and suicide incidents ((37%), 2009-2012) in Greece (Anon, 2012a), the growing number of unemployed and uninsured (approximately 30%) who refer to Non-Governmental Organizations because they do not pay for the mental health services provided (Kentikelenis et al, 2011) necessitate more than ever the existence and operation of mobile mental health units.

Research Design – Methodology

Aim of the study and research hypotheses

The aim of this study was to investigate the views of mental health professionals on the necessity and effectiveness of mobile psychiatric care units for mentally ill patients in the community.

The research hypotheses upon which this study was based were as follows:

i. The Mobile Mental Health Unit is considered to aim at prevention, information of the population on mental health issues, prompt intervention in cases of crisis, therapeutic treatment as well as contact with the patient's family (Lazaridou, 2009).

ii. The Mobile Mental Health Unit, in small and remote prefectures, is the cornerstone in terms of provision of mental health services (Lazaridou, 2009).

i. The Mobile Mental Health Unit deals with psychiatric problems in the community without necessitating the patient's being cut off from his social environment (Lazaridou, 2009).

ii. The Mobile Mental Health Unit provides every possible help for the rehabilitation of the patient in the community post hospitalization and reduction of the possibility of relapse and readmission (Madianos, 1994).

The research questions arising from the afore-mentioned research hypotheses concerned the following:

i. The significance of the role of the mental health professionals who work in the Mobile Mental Health Units;
ii. Those factors that contribute to the development of Mobile Mental Health Units;
iii. The aims of the intervention made by the Mobile Mental Health Units in the community and the effectiveness of Mobile Mental Health Units;
iv. The suggestions of mental health professionals with regard to the operation of Mobile Mental Health Units.

Sample

The sample of this study consisted of one hundred and ten (110) mental health professionals, who worked in mental health services. The selection of the sample was made on the basis of stage sampling. In particular, 23 people (20.9%) were selected from psychiatric departments in General Hospitals, 13 people (11.8%) from psychiatric hospitals, 10 people (9.1%) from hostels, 23 people (20.9%) from boarding homes, 6 people (5.5%) from Mobile Mental Health Units and 35 people (31.8%) from Mental Health Centres in the prefectures of Achaia, Thessaloniki, Lasithi, Rhodes and Serres. With regard to the sample characteristics, 81 (73.6%) were women and 29 (26.4%) were men. Their ages ranged from eighteen (18) to sixty-five (65) years old. The specializations of the mental health professionals were as follows: 10 (9.1%) psychiatrists, 20 (18.2%) psychologists, 19 (17.3%) social workers, 40 (36.4%) nurses, 3 (2.7%) occupational therapists, 4 (2.7%) speech therapists, 6 (5.5%) child psychiatrists, 7 (6.4%) health visitors and 1 (0.9%) physiotherapist. 41 of the employees (37.3%) had from 2 to 7 years' work experience, 36 (32.7%) had from 8 to 15 years' work experience, 21 (19.1%) from 16 to 25 years, 9 (8.2%) from 0 to 1 years while 3 (2.7%) of them had work experience of 26 years and over.

Research method

The survey method was used for the implementation of this study. According to the survey method, this study was divided into three (3) phases: the preliminary phase, the main phase (carrying out of research) and the statistical analysis of results phase. Specifically, the specification of the general aim of the research, the formulating of research questions and research hypotheses, the selection of the research method and identification of the population and the subjects to constitute the sample were implemented during the first research phase.

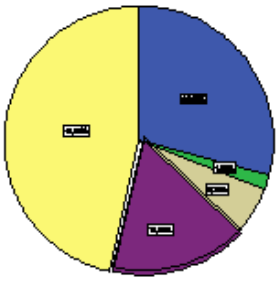
During the second phase, telephone communication with the organizations and mental health services was implemented in order to inform the officers in charge of the aims of this research, and asking them if they would agree to participate in the research process as sample subjects. Finally, there followed the formulating of the questions in the questionnaire as a research tool, the distribution of questionnaires to the sample subjects and the collection, within a week, of completed questionnaires. During the third phase of this study, the codification and statistical analysis of research results on the basis of the Statistical Package for Social Sciences were implemented, and conclusions were drawn.

Statistical Research Results

The role of Mobile Mental Health Units is determined in the above table. 46.4% maintain that the Mobile Mental Health Unit is a service for the prevention, diagnosis and treatment of psychological and psychiatric problems in the community, a service for rehabilitation of mentally ill patients, an intermediate service that precludes the committal of mentally ill patients, and one that provides therapeutic treatment to mentally ill patients of the community to avoid their hospitalization in psychiatric clinics. 29.1% of respondents believe that the Mobile Mental Health Unit is a service for the prevention, diagnosis and treatment of psychological and psychiatric problems in the community. 16.4% believe that it is a service that provides therapeutic treatment to mentally ill patients of the community to avoid their hospitalization in psychiatric clinics. 6.4% believe that the Mobile Mental Health Unit is an intermediate service that precludes the committal of mentally ill patients and 1.8% believe that the Mobile Mental Health Unit is a service for rehabilitation of mentally ill patients (Table 1).

TABLE 1

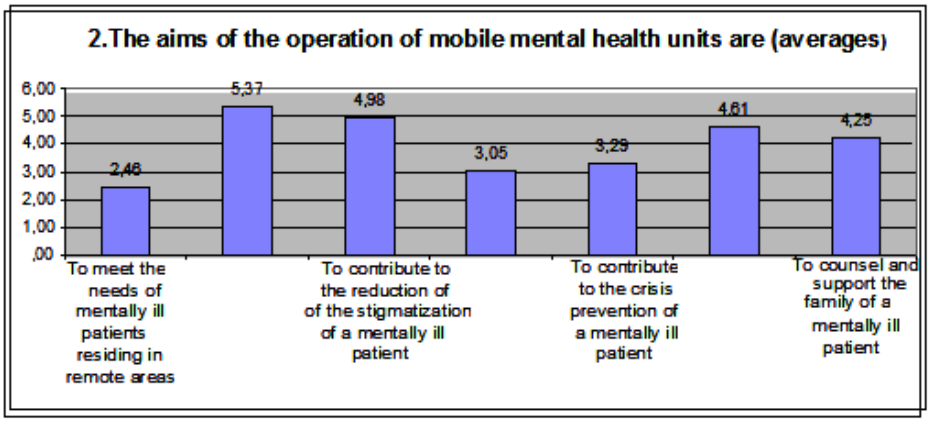
Which of the following determines the role of a mobile mental health unit in the community? Put an X in the relevant box



1. A Mobile Mental Health Unit is a service for the prevention, diagnosis and treatment of psychological and psychiatric problems in the community (29.1%)
2. A Mobile Mental Health Unit is a service for rehabilitation of mentally ill patients (1.8%)
3. A Mobile Mental Health Unit is an intermediate service that precludes the committal of mentally ill patients (6.4%)
4. A Mobile Mental Health Unit is a service that provides therapeutic treatment to mentally ill patients of the community to avoid their hospitalization in psychiatric clinics (16.4%)
5. All the above (46.4%)

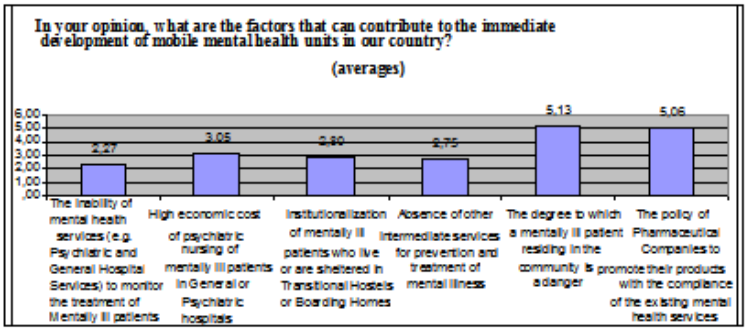
According to the scale used, it should be noted that the lowest average indicates the main priority of participants in the research. The most significant aim of the operation of Mobile Mental Health Units is to meet the needs of mentally ill patients residing in remote areas, with an average of 2.46 and standard deviation of 1.811, followed by the provision of individualized psychosocial support and home psychiatric nursing, with an average of 3.05 and standard deviation of 1.721, the contribution to the crisis prevention of a mentally ill patient, with an average of 3.29 and standard deviation of 1.599, the counseling and support for the family of a mentally ill patient, with an average of 4.25 and standard deviation of 1.485, the informing and sensitization of the community about mental health issues, with an average of 4.61 and standard deviation of 1.843, the contribution to the reduction of the stigmatization of a mentally ill patient, with an average of 4.98 and standard deviation of 1.692 and, finally, the decentralization of psychiatric hospitals and clinics, with an average of 5.37 and standard deviation of 1.981.

Table 2



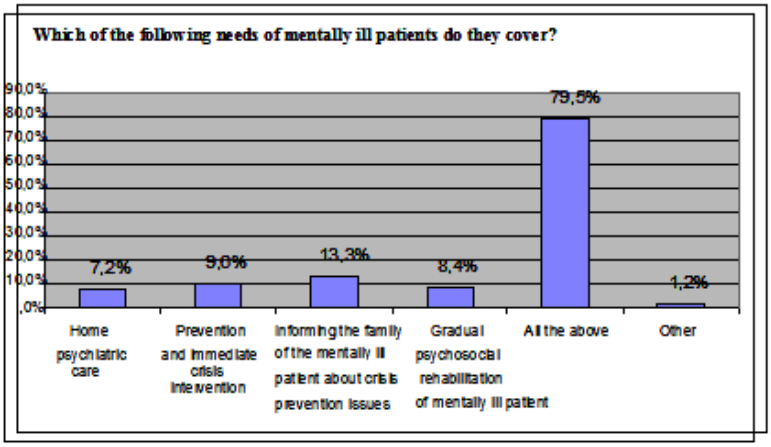
According to the lowest average indicates the main priority of participants in the research), the most significant factor that can contribute to the immediate establishment of mobile mental health units in our country is the inability of the mental health services (i.e. Psychiatric and General Hospital Services) to monitor the treatment of mentally ill patients in the community regularly, with an average of 2.27 and standard deviation of 1.226, followed by the absence of other intermediate services for prevention and treatment of mental illness, with an average of 2.75 and standard deviation of 1.267, the institutionalization of mentally ill patients who live or are sheltered in transitional Hostels or Boarding Homes, with an average of 2.80 and standard deviation of 1.276, the high economic cost of psychiatric nursing of a mentally ill patient in General or Psychiatric Hospitals, with an average of 3.05 and standard deviation of 1.553, the policy of Pharmaceutical Companies to promote their products with the compliance of the existing mental health services, and with their ultimate goal being profit over the psychosocial rehabilitation of mentally ill patients, with an average of 5.06 and standard deviation of 1.265, and finally the degree to which the mentally ill patient residing in the community is a danger, with an average of 5.13 and standard deviation of 1.085

Table 3



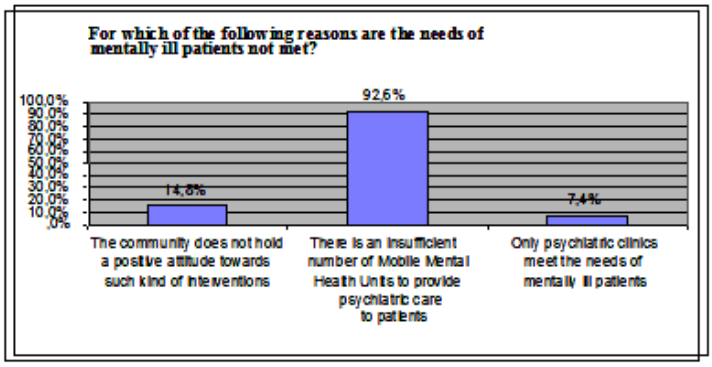
79.5% of mental health professionals believe that they meet the needs of mentally ill patients, such as providing home psychiatric care, prevention and immediate crisis intervention, informing the family of the mentally ill patient about issues regarding crisis prevention, and gradual psychosocial rehabilitation of the mentally ill patient. 13.3% believe that they meet the need to inform the family of the mentally ill patient about crisis prevention issues, 9.6% that they meet the need for prevention and immediate crisis intervention, 7.2% that they meet the need for provision of home psychiatric care, while 1.2% answered that the Mobile Mental Health Unit can meet other needs.

TABLE 4



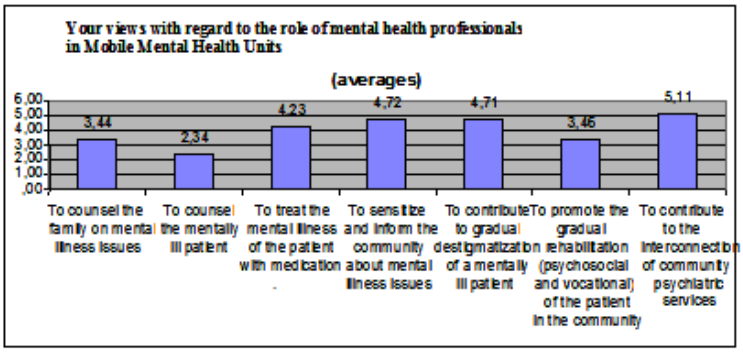
To the question why the needs of mentally ill patients are not met, 92.6% of those who answered negatively believe that there is an insufficient number of Mobile Mental Health Units to provide psychiatric care to patients, 14.8% believe that the community does not hold a positive attitude towards such kind of interventions, and 7.4% believe that only psychiatric clinics meet the needs of mentally ill patients.

TABLE 5



The Mobile Mental Health Units employ mental health professionals with various specializations which characterize the role each plays in them. If we observe the table and charts, it should be noted that, according to the scale used, the lowest average indicates the main priority of participants in the research. Therefore, the most significant role of a mental health professional in the Mobile Mental Health Units is counseling of the mentally ill patient, with an average of 2.34 and standard deviation of 1.435, followed by counselling of the family on mental illness issues, with an average of 3.44 and standard deviation of 1.468, promotion of gradual rehabilitation (psychosocial and vocational) of the patient in the community, with an average of 3.46 and standard deviation of 1.851, treatment of illness of the mentally ill patient with medication, with an average of 4.23 and standard deviation of 2.444, contribution to gradual destigmatization of a mentally ill patient, with an average of 4.71 and standard deviation of 1.627, informing and sensitizing the community about mental illness issues, with an average of 4.72 and standard deviation of 1.527 and, finally, contribution to the interconnection of community psychiatric services, with an average of 5.11 and standard deviation of 1.983.

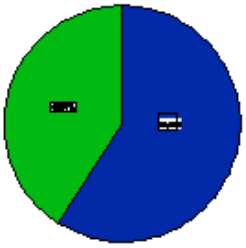
TABLE 6



59.1% of respondents answered positively to the question whether or not they believed that the professional role of mental health professionals is more efficiently carried out in Mobile Mental Health Units than in other mental health structures and services. On the contrary, 40.9% of them answered negatively.

TABLE 7

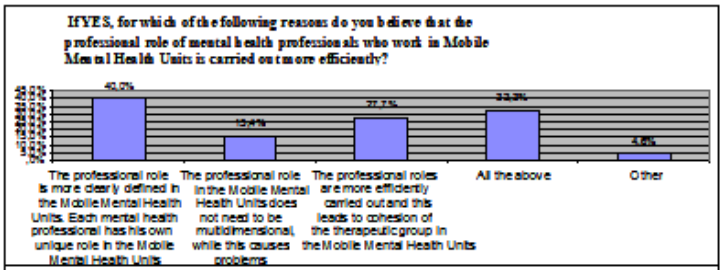
In your view, is the professional role of mental health professionals who work in Mobile Mental Health Units more efficiently carried out than in other mental health structures and services?



Yes (59.1%)
No (40.9%)

To the question: if yes, for which reason or reasons do you believe that the professional role of mental health professionals who work in Mobile Mental Health Units is carried out more efficiently, 40% believe that the professional role of mental health professionals who work in Mobile Mental Health Units is more efficiently carried out because it is more clearly defined in the Mobile Mental Health Units. Each mental health professional has his own unique role in the Mobile Mental Health Units. 27.7% believe that professional roles are more efficiently carried out, and this leads to cohesion of the therapeutic group in the Mobile Mental Health Units. 15.4% believe that the professional role in the Mobile Mental Health Units does not need to be multidimensional, while this causes problems in other mental health structures and services. 32.3% believe that all the above reasons contribute, while 4.6% selected the option titled other.

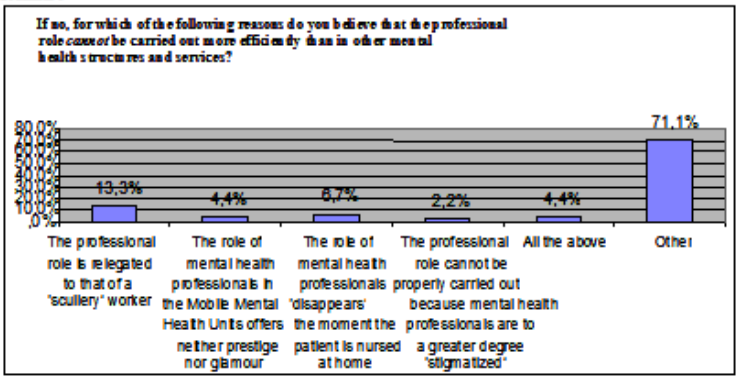
TABLE 8



According to the question: For which of the following reason or reasons do you believe that the professional

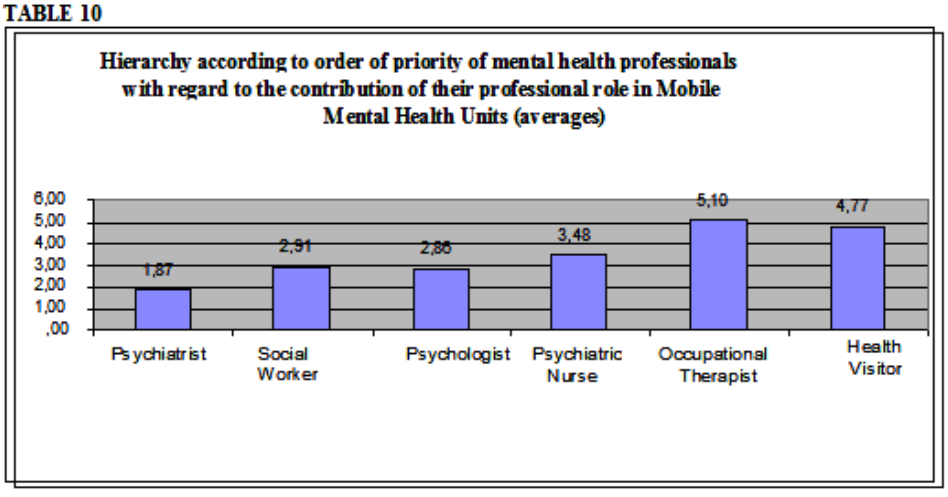
role cannot be carried out more efficiently than in other mental health structures and services, 71.1% selected the option titled other. 13.3% answered that the professional role is relegated to that of 'scullery worker', 6.7% answered that the role of mental health professionals 'disappears' the moment the patient is nursed at home, 4.4% answered that the role of mental health professionals in the Mobile Mental Health Units offers neither prestige nor glamour, the same percentage considered all the above reasons to be possible and 2.2% believed that the professional role cannot be properly carried out because mental health professionals are to a greater degree 'stigmatized' when they work in the Mobile Mental Health Units.

TABLE 9



According to the lowest average of the main priority of participants in the research, the most significant role in a Mobile Mental Health Unit is that of the Psychiatrist, with an average of 1.87 and standard deviation of 1.369, followed by the Psychologist, with an average of 2.86 and standard deviation of 1.296, the Social Worker with an average of 2.91 and standard deviation of 1.162, the Psychiatric Nurse, with an average of 3.48 and standard deviation of 1.283, the Health Visitor, with an average of 4.77 and standard deviation of 1.607, and finally the Occupational Therapist, with an average of 5.10 and standard deviation of 0.938.

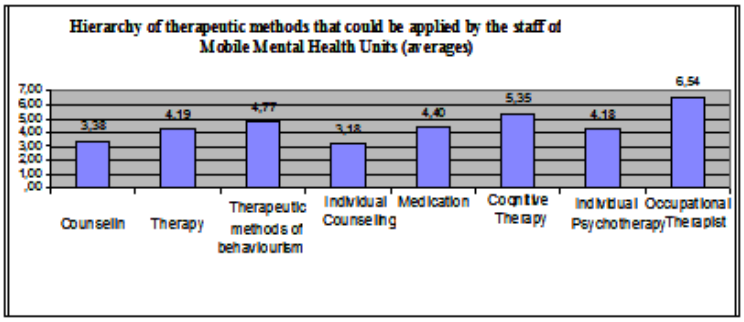
TABLE 10



The most significant method used by mental health professionals for the implementation of programmes of the Mobile Mental Health Unit is individual counseling, with an average of 3.18 and standard deviation of 1.868, followed by family counseling with an average of 3.38 and standard deviation of 2.171, individual psychotherapy, with an average of 4.18 and standard deviation of 2.288, family therapy with an average of 4.19 and standard deviation of 2.052, medication with an average of 4.40 and standard deviation of 2.700, therapeutic methods of behaviourism, with an average of 4.77 and standard deviation of 1.640, cognitive therapy with an aver-

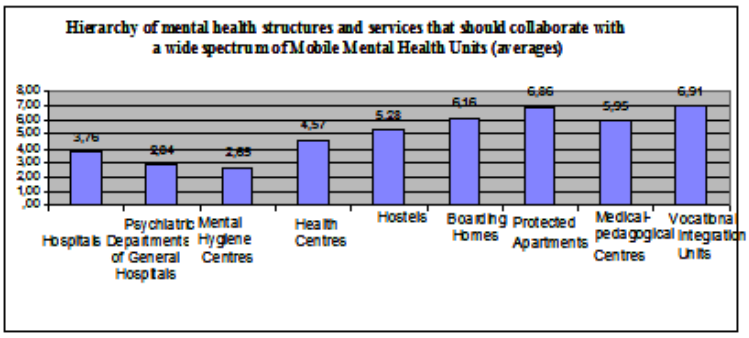
age of 5.35 and standard deviation of 1.899 and occupational therapy with an average of 6.54 and standard deviation of 1.712.

TABLE 11



According to the scale used, it should be noted that the lowest average indicates the main priority of participants in the research. Thus, mental health professionals state that mobile mental health units should collaborate with a wide spectrum of mental health structures and services, indicating the mental health centres as being the most significant, with an average of 2.65 and standard deviation of 1.505, followed by psychiatric departments of general hospitals, with an average of 2.84 and standard deviation of 1.993, psychiatric hospitals, with an average of 3.76 and standard deviation of 2.692, health centres, with an average of 4.57 and standard deviation of 2.532, hostels with an average of 5.28 and standard deviation of 1.793, medical-pedagogical centres, with an average of 5.95 and standard deviation of 2.135, boarding homes, with an average of 6.16 and standard deviation of 1.989, protected apartments, with an average of 6.86 and standard deviation of 1.865, and, finally, vocational integration units, with an average of 6.91 and standard deviation of 1.975.

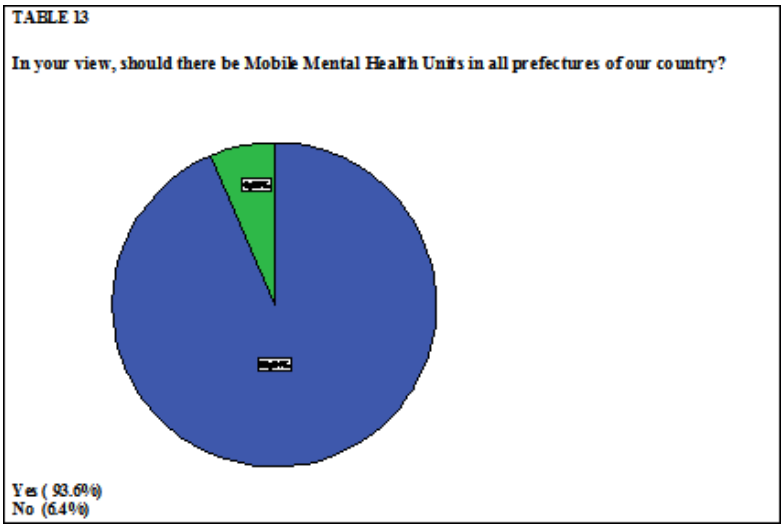
TABLE 12



93.6% of mental health professionals believe that Mobile Mental Health Units should be made available in all prefectures of our country. 6.4% believe that this is not necessary.

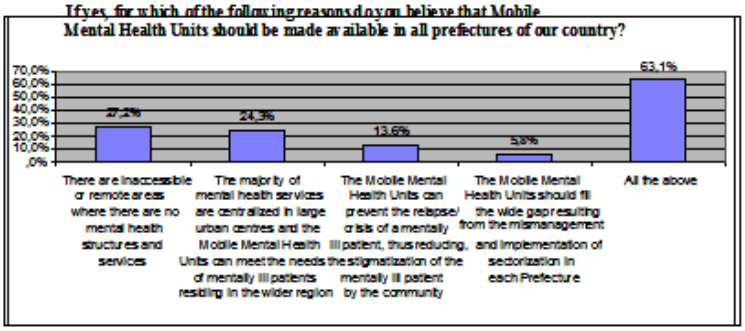
TABLE 13

In your view, should there be Mobile Mental Health Units in all prefectures of our country?



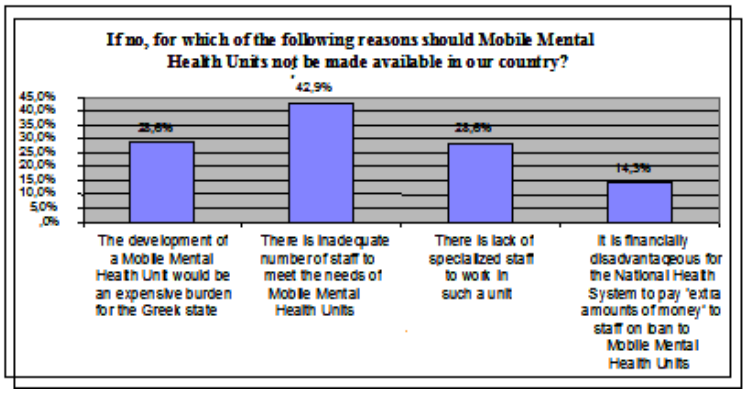
27.2% of the respondents believe that Mobile Mental Health Units should be made available in all prefectures of our country because there are inaccessible or remote areas where there are no mental health structures and services, 24.3% because the majority of mental health services are centralized in large urban centres and the Mobile Mental Health Unit can meet the needs of the mentally ill patients residing in the wider region, 13.6% because the Mobile Mental Health Units can prevent the relapse/crisis of a mentally ill patient, thus reducing the stigmatization of the mentally ill patient by the community, 5.8% because Mobile Mental Health Units should fill the wide gap resulting from the mismanagement and implementation of sectorization in each Prefecture, with the greatest percentage (63.1%) selecting all the above reasons

TABLE 14



To the question why Mobile Mental Health Units should not be available in all prefectures, 42.9% believe that there is an inadequate number of staff to meet the needs of Mobile Mental Health Units, 28.6% believe that the development of a Mobile Mental Health Unit would be an expensive burden for the Greek state, 28.6% believe that there is lack of specialized staff to work in such a unit and 14.3% believe that it is financially disadvantageous for the National Health System to pay 'extra amounts of money' to staff borrowed for Mobile Mental Health Units.

TABLE 15



Discussion

In accordance with these research results, mental health professionals in the Mobile Mental Health Units may function more efficiently because their professional role is clearly defined and significant, and this can contribute to the cohesion of the therapeutic unit. In the Mobile Mental Health Unit, the main role appears to be undertaken by the Psychiatrist.

According to Vaslamatzis (2005), the multidisciplinary therapeutic group is called upon to form interdisciplinary approaches through a holistic consideration of the patient's needs, to plan its interventions in terms of therapy and rehabilitation, to set objectives and to organize action, after having evaluating its progress, to undergo reconstruction and renewal, and to adapt to new theoretical or scientific developments. The therapists engaged in rehabilitation are drawn from a wide spectrum of scientific and professional backgrounds. The psychiatrist, the psychologist, the social worker, the occupational therapist, the nurse and the art therapist constitute the rehabilitation team, within which each one has a specific role due to their different education level, way of thinking and approach to psychosocial issues and their role towards the patient and his environment. At the same time, however, the different roles come together in a unified rehabilitation plan for each patient. The contribution of different mental health professionals is required for social reintegration of a patient after a long term stay in a psychiatric hospital (Vaslamatzis, 2005).

The rehabilitation team must work closely together, meet at regular intervals and discuss issues of role conflict and ambiguity. Moreover, they should discuss the opposition of mental health professionals to their being transferred, which often leads to disruptive behaviour in their relationships with patients and their families. The psychiatrist engaged in rehabilitation, in addition to clinical experience in chronic disabilities resulting from mental illness, should also have administrative skills and knowledge relevant to groups and organizational psychology. It could be said that the psychiatrist should also be able to monitor, understand and supervise the work of the occupational therapist (if he is engaged in vocational rehabilitation), the psychologist and speech therapist, the social worker, the art therapist and the nurse. However, it is important that he is sensitized to different approaches and coordinates the rehabilitation in such a way that the provision of rehabilitation care is fully integrated and aims to meet the real needs of each individual patient (Vaslamatzis, 2005).

The basic principles that should govern the course of action of the team are: i. Coordination with other services, ii. Mutual and equal cooperation, iii. optimism, iv. Individualized approach to the problem of each person-client, v. Taking the significance of family and community into consideration as support systems, vi. Always planning alternative suggestions and solutions, vii. Setting minimum realistic targets, viii. Discretion, ix. Constant encouragement of every effort made by the client, and of his positive features, x. Provision of information and support to the family and sensitization of the community and other services, xi. Investigation of employment opportunities in the free market and adjustment of vocational rehabilitation programmes to these

conditions (Madianos, 2000).

According to Sakellaropoulos (2003), the new mode of operation of the rehabilitation approach requires further cognitive training and a different attitude and thinking by the mental health experts. It presupposes a constant procedure for processing of views and principles (theory) as well as clinical practice (practice). This type of training is mostly acquired through practice, within the framework of experience gained while working in mental health structures. The basic training of both old and new staff (psychiatrists, child psychiatrists, psychologist social workers, psychiatric nurses, speech and language therapists, educational psychologists, occupational therapists, health visitors, administrators, etc) must be oriented towards the new practices and the different mode of operation of the new services.

The training of psychiatrists, psychologists and generally all the psychiatric team is a need arising from the spirit of reform, and at the same time an integral part of its implementation. The education-training of mental health experts is obtained through short or longer postgraduate programmes leading to a specialization. These programmes can be implemented either after the completion of basic studies or within the framework of speciality of each mental health professional. The practical training, namely the theoretical-clinical activities carried out by the trainee within the service (in service training), plays a significant role in education. Finally, the attendance of conferences, symposia, educational seminars, etc. is also part of postgraduate studies (Martin- Jacob, 2003).

Moreover, the staff must be trained in special skills, such as: i. Empathy, ii. Management of special problems related to chronic mental illness, iii. Drawing up of individualized care plan, iv. Cooperation within the framework of an interdisciplinary therapeutic team (White and Bennett, 1981, Lamb, 1982). Both their becoming a team (psychiatric team – therapeutic team) and continuous training of employees are of fundamental significance because such a team includes occupations and specialities with different initial education and roles (Ploumpidis, 2005).

Mental health professionals believe that the existence of Mobile Mental Health Units in all prefectures is necessary because these units can fill the gaps resulting from sectorization. According to Lazaridou (2009), the Mobile Mental Health Unit constitutes the cornerstone for the provision of mental health services, especially in small and remote prefectures, within the framework of Community Psychiatry.

According to this research, the therapeutic team must inform and sensitize the community. It should aim at changing the attitude of the population towards mental illness, recording the problems and needs of the community and acceptance of the therapeutic team by the population in order to become an active part of it. Community education and a simultaneous change in the attitude of the population also contribute to prompt intervention. In this way, there is prompt response to the request for psychiatric help and the cases are referred or followed up before their symptomatology is exacerbated or peaks (Antoniadis, 2003).

According to the bibliography, the Mobile Mental Health Unit provides services for prevention and nursing or special mental health care at home: i. to mental health regions where their geographical extent and topology, their residential dispersion and their social, economic and cultural conditions in combination with the nature of mental disorders obstruct access to mental health services for the inhabitants of these areas and ii. to adjacent mental health regions where there are no mental health services.

The task of a mobile mental health unit is to provide services for prevention, nursing and special care at home, psychosocial rehabilitation and community education to inaccessible areas, specifically: i. prompt diagnosis and intervention to prevent the onset of the illness or its relapse, ii. home intervention for dealing with and management of crisis, iii. home nursing and medication monitoring, monitoring the development of the illness at regular intervals and continuing the psychiatric care of the patient, iv. provision of help and support enabling

the patient to deal with their practical needs and problems, emphasizing skills learning and preparing the patient for the ultimate goal, which is independent living, v. counseling and support intervention for the patient's family, with the aim of improving their communication and reducing the stress of both family and patient, vi. training of volunteers and vii. fighting social stigma through community education programmes (www.mohaw.gr).

The activities of the Mobile Mental Health Unit are, in brief: i. prevention, sensitization of the community through discussions, lectures, seminars for professionals, e.g. doctors, with the aim of changing the attitude of the community towards mental illness, ii. dealing with crisis situations, home psychiatric care of the patient, continuance of care (follow-up), psychiatric interviews and iii. training of mental health professionals (www.-mohaw.gr).

It is a fact that the task of the Mobile Mental Health Unit is complicated, carried out under unfavorable conditions and necessitates the collaboration of many people for both the provision of services and the cohesion and functioning of the team itself (Lazaridou, 2009). A precondition for this is the availability of therapists and continuance of patient care (Livaditis, 2003).

Through the use of mobile units, psychiatric services are available, on the one hand, in the Community Health Centres-Hospitals and, on the other hand, at home for patients residing in various provincial regions (Blue,1999).

The therapeutic aims set by mental health professionals of the Mobile Unit are: i. The therapeutic completion of the transitional phase of the patient's life from the psychopathological condition to normal life within the community, ii. The provision of all possible assistance for the rehabilitation of the patient in the community post hospitalization, and reduction of the possibility of relapse and readmission. Some mental health professionals believe that there is also another aim: to avoid committal in a psychiatric hospital through the services of a day hospital. This latter aim is often realized under certain preconditions (Madianos 1994).

Conclusions

According to this research, the most significant role of a mental health professional in the Mobile Mental Health Units is counseling of the mentally ill patient, counselling of the family on mental illness issues and promotion of gradual rehabilitation (psychosocial and vocational) of the patient in the community. The role of a mental health professional in a Mobile Mental Health Unit is extremely significant. The professional role off a mental health professional who works in a Mobile Mental Health Unit is more clearly defined than in other mental health structures and services where this role is required to be multidimensional. Each mental health professional has a clearly defined role in the Mobile Mental Health Units and therefore there is cohesion of the therapeutic group. The most significant role in a Mobile Mental Health Unit is that of the psychiatrist, followed by that of the psychologist, the social worker, the psychiatric nurse, the health visitor and, finally, the occupational therapist.

The most significant factor directly contributing to the establishment of Mobile Mental Health Units is the inability of the mental health services to monitor the treatment of mentally ill patients in the community on a regular basis, followed by the absence of other intermediate services for provision and treatment of mental illness, while another important factor is the institutionalization of mentally ill patients who live or are sheltered in transitional Hostels or Boarding Homes. Mobile Mental Health Units should be made available in every prefecture of our country, because there are inaccessible or remote areas where there are no mental health structures and services, the majority of mental health services being centralized in the large urban centres, and therefore a Mobile Mental Health Unit can meet the needs of mentally ill patients residing in the wider region. Mobile Mental Health Units can prevent the relapse/crisis of a mentally ill patient. Mobile Mental Health

Units are called to fill the wide gap resulting from the mismanagement and implementation of sectorization in each Prefecture.

The most significant aim of the operation of Mobile Mental Health Units is meeting the needs of mentally ill patients residing in remote areas, provision of individualized psychosocial support and home psychiatric nursing, contribution to the crisis prevention of a mentally ill patient, counseling and support for the family of a mentally ill patient, informing and sensitizing the community about mental health issues, contributing to the reduction of the stigmatization of a mentally ill patient and, finally, the decentralization of psychiatric hospitals and clinics.

The Mobile Mental Health Units meet the following needs of mentally ill patients: home psychiatric care, prevention and immediate crisis intervention, informing the family of the mentally ill patient about issues regarding crisis prevention, and gradual psychosocial rehabilitation of the mentally ill patient.
The therapeutic techniques used by the Mobile Mental Health Units to approach and deal with mental illness are effective. The most significant methods used for the implementation of programmes by the Mobile Mental Health Unit are individual counseling, family counseling, individual psychotherapy, family therapy, medication, therapeutic methods of behaviourism, cognitive therapy and occupational therapy.

Mental health professionals suggest that Mobile Mental Health Units should be available in all prefectures of the country. They should be staffed with a greater number of mental health professionals to cover all the remote areas in each prefecture. Specialization should be offered to all mental health professionals.
Motivation should be given to mental health professionals to encourage them to work in Mobile Mental Health Units. Financial motivation should be created in relation to the workload. There should be state funding, as there is a lack of resources, which entails low wages and staff cuts.

The Mobile Mental Health Units should collaborate with a wide spectrum of mental health structures and services, with the mental health centres first in order of priority, followed by psychiatric departments of general hospitals, psychiatric hospitals, health centres, hostels, medical-pedagogical centres, boarding homes, protected apartments and, finally, vocational integration units. Appropriate infrastructures should be developed in order to have a flexible and functional system facilitating interconnection of psychiatric services.

References

1. Antoniadis, C. (2003). The role of the psychiatric nurse in the community. In the book: Deinstitutionalization and its relation to primary care, Ed.: Damigos D., Athens: Papazisis, p. 270.

2. Blue, A. (1999). The making of Greek psychiatry, Exantas publications, Triapsis Logos, Athens, pp. 125-132, 141-144.

3. Giantselidou, A., Fragouli, A. (2003). Protected apartments: A step closer to community. In the book: Deinstitutionalization and its relation to primary care, Ed.: Damigos D., Athens: Papazisis, pp. 401-403.

4. Kentikelenis, A.,Karanikolos, M., Papanicolas, I., Sanjay,B., Mc Kee, M., Stuckler, D. (2011). “Health effects on Financial Crisis: Omens of a Greek Tragedy” , The Lancet, 378(9801), 1457-1458.

5. Lamb, H.R. (1982). Treating the long–term mentally ill. San Francisco, Jossey – Bass, 1982.

6. Lazaridou, M. (2009). Psychoanalytic practice in a Mobile Mental Health Unit within the framework of social psychiatry. In the book: The contribution of psychoanalysis to Greek psychiatric reform, Ed.: Zeikou E., Kontostergios N., Koralli E., Chatzistavrakis G., Athens: Papazisis, pp. 111-116.

7. Liakos A. (2003). Social and Community Psychiatry. In the book: Deinstitutionalization and its relation to primary care, Ed.: Damigos D., Athens: Papazisis, pp. 55-69.

8. Livaditis, M. (2003). The psychiatric services in the Prefecture of Euboea. In the book: Deinstitutionalization and its relation to primary care, Ed.: Damigos D., Athens: Papazisis, pp. 154-163.

9. Madianos, M. (1994). The Psychiatric reform and its development: From theory to practice, Athens: 'Hellenic Letters", pp. 178-188, 199, 221-228, 248.

10. Madianos, M., & Michael, G. (2000). Community Psychiatry and Community Mental Hygiene, Kastaniotis Publications, Athens.

11. Martin, M., Jacob, B. (2003). Mental Health Policy in Belgium (1975-2002), The first reform of hospital care. In the book: Deinstitutionalization and its relation to primary care, Ed.: Damigos D., Athens: Papazisis, pp. 106-115.

12. Matsa, K. (2012). Notice of Panhellenic Rallying for Psychiatric Reform

13. Ploumpidis, D.N. (2005). The Mental Health Centre. In the book: Preventive Psychiatry and Mental Hygiene, Ed.: Kontaxakis, V.P., Havaki-Kontaxaki, M.I. and Christodoulou, G.M., Athens: Beta, pp. 55-63.

14. Sakellaropoulos, P. (2003). Introduction to the applications of modern psychiatry. In the book: Deinstitutionalization and its relation to primary care, Ed.: Damigos D., Athens: Papazisis, pp. 44-54.

15. Sakellaropoulos, P. (2003). Brief presentation of psychiatric care in the patient's home. In the book: Deinstitutionalization and its relation to primary care, Ed.: Damigos D., Athens: Papazisis, pp. 201-204.

16. Stylianidis, S., Stylianoudi, L. (2008). On Greek psychiatric reform and the Leros programme, In the book: Community and Psychiatric Reform. The experience of Euboea 1998-2008, Ed: Stylianidis S., Stylianoudi L., Topos books, pp. 352-355.

17. Tzoraki-Chatzaki, A., Tzanaki-Melissari, M. and Kastanaki, A. (2005). Transition to Psychargos Programme. In the book: 2nd Pan-Hellenic Two-day Meeting, Contemporary social care needs, Structures and Programmes in local society, Heraklion, Crete: Hellenic Society of Social Workers 2005.

18. Vaslamatzis, G. (2005). The role of mental health professionals in psychosocial rehabilitation. In the book: Preventive Psychiatry and Mental Hygiene, Athens: Beta, pp. 573-576.

19. Vlachaki E. (2009). From insanity to mental hygiene. The Mental Hygiene Centre experiment. In the book: The contribution of psychoanalysis to mental health reform in Greece, Ed.: Zeikou E., Kontostergiou N., Koralli E., Chatzistavrakis G., Athens: Papazisis, pp. 39-42.

20. White, H.S., & Bennett, M.B. (1981). Training psychiatric residents in chronic care. Hospital and Community Psychiatry, 32, 339 – 343.