

Υπουργείο Υγείας και Κοινωνικής Αλληλεγγύης



ΠΑΡΑΔΟΤΕΟ 1B: Επιτελική Σύνοψη (Executive Summary)

Στο πλαίσιο του έργου:

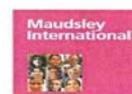
«Εκ των υστέρων (ex post) αξιολόγηση της εφαρμογής του
Εθνικού Σχεδίου Δράσης «ΨΥΧΑΡΓΩΣ» από το 2000 μέχρι και το
2009»

Εκπόνηση:



Institute of Psychiatry
at the Maudsley

South London and Maudsley NHS
Foundation Trust



Maudsley International
Box 27
Institute of Psychiatry
De Crespigny Park
London SE5 8AF
P: 00 20 7848 5421
F: 00 20 7848 5056
nick.bouras@kcl.ac.uk



Ελληνική Δημοκρατία



Ευρωπαϊκή Ένωση

Σεπτέμβριος 2010

Introduction

The development of community care-led systems of mental health care is patchy with great variation from country to country, and even within the same country. The extent to which services can be shifted from institutions to the community, and the shape that models of service provision can take, continues to be a key question for policy-makers. A report prepared for the WHO Regional Office for Europe's Health Evidence Network concluded that there are no persuasive arguments or data to support a hospital-only approach, nor is there any scientific evidence that community services alone can provide satisfactory comprehensive care (Thorncroft & Tansella, 2003). Instead, it argued that a "balanced care" approach is required where front-line services are based in the community, but that hospitals and other institutions can play an important role in providing services. Where required, hospital stays should be as brief as possible, with these services being provided in normal community settings rather than in remote isolated locations. There are many potential elements to a balanced care approach, and not all are applicable or appropriate in each country. Each needs to be considered for its local relevance and will be dependent on the flexibility, coordination and ready availability of resources. However, common key questions that should be addressed by policy-makers and service-planners are: what is clinically effective, what is cost-effective and what is feasible within different budgetary constraints?

These general trends and guidelines are of great value since they provide the basis for evaluating the development, organization and function of mental health systems.

Based on this systemic approach that has been, very briefly presented above, the current project evaluates the Greek mental health system within the framework of the reform that it has undergone over the last decade. The mental health reform programme, named 'Psychargos' was the main mechanism for the modernization of an outdated system of mental health services, which were based solely on institutional care.

More specifically the evaluation was structured around six basic themes:

1. The organizational structure of the mental health system
2. The type and function of mental health services
3. The policies and legislation that underlie mental health care provision
4. The monitoring and assessment mechanisms of mental health services
5. The mental health workforce
6. the system's approach towards service users

For each of these thematic categories, the evaluation team collected numerous data through: focus groups with service users and providers), interviews (with officials, mental health professionals of various specialties, organizations of users and users' families), site visits and thorough reviews of bibliography and formal documents.

The major findings of the data collection process were:

- The system is divided into three sub-systems (and various others that were not included in the evaluation, because their remote relation to the main psychiatric system), depending on the mental health service supplier. These sub-systems are: the psychiatric hospitals, the psychiatric units of general hospitals and the non-governmental organizations. Each of these basic suppliers is entitled to provide specific services.
- There is substantial variance in the type of services provided, which range from hospital-based to community-based services. Emphasis was given to the development of community mental health services and the deinstitutionalization.
- The policies and legislation underpinning the mental health system were developed largely to support the reform programme. The major issues they address are the deinstitutionalization process, the development of community mental health services based on the sectorization, the protection of patients' rights etc.
- The mental health system monitoring and evaluation are basic duties of the Mental Health Directorate of the Ministry of Health and Social Solidarity. However, in case the development of new services is European- funded, the Special Service of Health and Social Solidarity Unit is responsible to monitor and evaluate the projects' progress for the period that lasts the European funding.
- The number and type of professionals employed in community mental health services are determined by the law. Programmes related to staff's training in community mental health, have taken place for both newly-hired professionals and for those transferred from the traditional/institutional psychiatric services.
- Issues such as protection of patients' rights, social and vocational rehabilitation and reduction of stigma associated with mental illness have been addressed by the law, special committees (Special Committee for the protection of mental health patients' rights) and specialised programmes.

More specifically, the mental health system of Greece:

- Is based on the reform programme which was initiated in 1984 but took its current form and direction with the development of the Psychargos programme in 1999. The basic aims of the reform have been:
 - the deinstitutionalization of patients
 - the closure of psychiatric institutions
 - the development of community mental health services that would cover the whole country and that would aim at supporting deinstitutionalization, reducing admissions in psychiatric hospitals and promoting mental health
 - the social and vocational rehabilitation of chronic patients
 - the development of staff's skills
- Is organized into 58 sectors
- The major aim of closing down the psychiatric hospitals has been achieved to a great extent. Six mental health hospitals have been successfully ceased to operate, while the remainder 3 will cease operation by 2015. The hospitals that have closed down are:
 - Psychiatric Hospital of Petras Olymbou
 - Psychiatric Hospital of Chania
 - Psychiatric Hospital of Corfu
 - Psychiatric Hospital of Leros
 - Psychiatric Hospital of Tripoli
 - Child Psychiatric Hospital - Daou Pentelis
- The development of community mental health services has been partially successful. The following table depicts the current services provided in each of the 13 regions of Greece.

MH Services	Atti ca	East Macedo nia- Thrace	Central Macedo nia	Wester n Macedo nia	Epir us	Thess aly	Ioni an Isla nds	Weste rn Greec e	Ster ea Ella da	Peloponni sos	Nort h Aeg ean	Sou th Aeg ean	Cre te	Tot al
Psychiatric Hospitals*	2		1											3
Psychiatric and Child Psychiatric Units of General Hospitals**	11	3	9	1	2	3		3		1	2	1	4	40
Community Mental Health Centres	15	4	6		3	2	2	3	2	3			5	45
Mental Health Centers for Children and Adolescents***	13		7		1								1	22
Mobile Units		5	1	1	1	4	2	2	1	2	2	4	2	27
Day Centers	21	1	5		1	2	2		1	1	1	1	4	40
Psychosocial Rehabilitation Units	152	15	83	2	23	26	12	17	21	27	2	26	24	430
Guest Houses	31	1	10	1	8	5	2	6	3	9	1	2	9	88
Boarding Houses	51	6	14	1	4	9	7	2	9	7			6	116
Sheltered Apartments	70	8	59		11	12	3	9	9	11	1	24	9	226
Social –Vocational Rehabilitation Units	26	2	13		5	6	3	7				13	7	82
Alzheimer Centers	1		1			1								3
Drug-abuse centers														0
Alcohol-abuse centers														0
Social Enterprises	7		2		1	1	2	1	1		1	1	1	18
Autism centers for children	2													2
Home care (Κατ' οίκον Νοσηλεία)													1	1

*It includes the psychiatric hospitals that fully operate. In addition to these, the University Psychiatric Hospital “Aiginition” also operates but it does not entail a chronic patient unit

** 34 are psychiatric units for adults and 6 are for children and adolescents

***Of the 20 mental health centers for children and adolescents, the 13 operate as separate units of community mental health centers for adults

- Mental health promotion and activities to reduce the stigma associated to mental disorders are not carried out centrally, but by isolated providers. Some of the programmes have taken place at national level.

THE EVALUATION

Strengths

The current mental health system in Greece has several considerable strengths that the Evaluation Team (ET) was pleased to identify:

1. An overall substantial service transformation towards developing modern community based mental health services focus on deinstitutionalisation with extensive reduction of hospital-based long stay accommodation including the entire closure of some mental hospitals, while others e.g. Psychiatric Hospital in Attica, have modernised many of the services they provide.
2. There are a large number and variety of community services in many parts of the country including Community Mental Health Centres (CMHC), different types of residential provision, day centres and hospitals, mobile mental health units and vocational services. Some of the visited buildings were impressive, including, for example, EIPSY in Athens, CMHCs in Chania, Iraklion, Katerini, the vocational workshop in Katerini, and the Centre for addictions in Central Athens run by the Psychiatric Hospital Attikis.
3. The wide availability and conduct of physical activities in many of the residential units is to be commended as is the work being carried out in social reintegration of residents with families and friends.
4. Local communities are becoming gradually more accepting of people with mental illness.
5. There are positive changes in the attitudes of staff towards more person-centred care and examples of notable individual leadership.
6. There are a few examples of KoiSpe as active social firms or cooperatives which might resemble what is known in other countries as sheltered work.

7. There are examples of mental health promotion activities aiming to raise community and general public awareness by CMHCs, NGOs and other organisations. In addition there is an active anti-stigma campaign linked with similar international programmes, with indications of real progress in reducing stigmatisation.

8. Implementation of reforms has led to a very significant change in the pattern of mental health services provision. It is important that many people who have (or would have) been in institutions are now living in the community. Major changes have been achieved during Psychargos programme and some foundations have been laid for a strong mental health system and the direction of travel is correct. Overall it seems that the transformation of the mental health services in Greece has adopted the current philosophy on values and principles of modern service delivery to local populations.

Weaknesses

A number of weaknesses were identified which are described below divided in two categories General and Specific.

General

1. There was an overall impression of patchy, ill-coordinated and often inadequate provision on the ground, and that the processes used to implement the overall agreed policies were weak. In response to the lack of progress in Psychargos A, the second phase Psychargos B set out requirements in the form of prescriptive service models and key timeframe deadlines in different geographical areas. It seems likely that in some areas, Phase B plans were developed in the context of some existing reprovision plans that could be built upon (e.g. Thessaloniki/Katerini), whereas in others, they enforced timeframes that did not allow for thoughtful planning and implementation. A particular focus on psychiatric hospital reprovision in the first instance can serve a useful purpose if it is seen as a transition phase in the context of developing an overall system of service provision for the whole population - a system that is coherent, co-ordinated and reflects an appropriate balance of resources for particular activities based on agreed priorities. By contrast, the current pattern of service provision can be often characterised as inconsistent and uncoordinated.
2. There is a lack of a population-based approach to the mental health system, without clear evidence for assessing the needs of local populations for mental health care, and no clear understanding at the local level of what components are necessary for a comprehensive system of care.

3. The inequity in the development of services between different areas around the country gives the impression that some were more determined by opportunistic and entrepreneurial initiatives than according to real needs. As a consequence some areas are now relatively well provided and others have little or no provision. In effect therefore service users and carers are not able to rely upon having a full range of services locally available across the whole country. For example some residential homes for people with severe mental illness have been scattered around the country but without having the full range of other clinical mental health services locally available.
4. Another overarching theme relates to workforce and in particular the skill mix in services. It is not clear how it is linked (or not) to explicit expectations about activity levels and the impact on costs. Although there are variations in different parts of the system and in different geographical locations, there was a general impression of an over reliance on highly skilled professional staff and under utilisation of staff in supporting roles. This could be linked to the fact that the prevailing service model did not adequately focus on having an appropriate balance between health and social care support. If tasks and activities are not clearly defined, then it is inevitable that there will be anomalies in identifying a staff team with the right skills and experience to carry out the core roles. We found evidence that although some facilities and areas are clearly short of skilled professional staff, that other facilities, such as supported accommodation, in fact have a staff and skill rich that are provided in excess. This may be because these facilities were originally intended to act as a staff 'hub' also supporting other 'spoke' settings, where the latter were not later developed.
5. Another major contributing factor linked to workforce was the leadership and commitment demonstrated within some services and areas by individuals. However, this was not evident in some areas and it is interesting to consider whether there is a critical mass of "reformers" who are willing to play a key role in providing effective leadership to drive further developments. For the reforms to continue successfully, clear commitment by senior professional personnel is needed in addition to political decisions. Consideration must be given to creating and implementing, on an ongoing basis, a model of leadership and management for this process including how to integrate clinical and managerial imperatives.
6. The current system seems to encourage separate and parallel planning processes for different elements of provision. For example services have been developed for the "old long stay" population (who have been exposed to institutionalisation) which appear to be separate from those being developed for the group of people entering

the new “community MH centre based” system. It is suggested that it is important to consider how people originally provided for in more traditional “reprovision” services (for example group homes) may be supported to move on to more independent community services. Also, how the more traditional services may need to develop over time to accommodate the needs to younger people coming into the system. This process relies on the mental health service resources being seen as part of a network of provision providing a range of options that are likely to change over time.

7. Important services gaps were noticed for child and adolescent mental health services, services for older adults and specialist services for people with autistic spectrum disorders, those with intellectual disabilities, eating disorders and forensic psychiatric services.
8. There is very little interaction among the different components of the services with most of them having adapted their own operational criteria. For example some CMHCs seem to be functioning as outpatient clinics or centres for psychotherapy of certain type instead of being the focus point of community mental health services. The impression of the evaluation team, which mirrored that shared by the majority of the professionals and service users who advised us, is that the service system is fragmented, inconsistent and uncoordinated in need of correction actions. From a service user and carer point of view this means lack of information about locally available services, poor information flow between different services. There also no clear pathways for service users and family members to navigate the system. CMHCs are intended to be the first point of contact and fulfil the mental health primary care function but this is not consistently implemented. We did not see sufficient evidence of effective cross-sectoral working groups, both at national or at local level, which have the responsibility, authority and resources to implement and put the agreed policies into practice.
9. There are no quality assurance mechanisms and systems for clinical governance.
10. There is a paucity of health service research, information and monitoring and monitoring systems, which limits the extent to which the service system can progressively become more based upon evidence of what works to deliver patient benefit.

Specific

1. Sectors

The development of Sectors for mental health services which was the core concept of the implementation plan has been very patchy to the extent that this has not been functioning in most areas and has lost the confidence of professionals and service users. In spite of ministerial decrees Sectorisation has been put into practice only partially and most of the appointed Sector committees do not work effectively or have ceased. In fact it seems that, with very few exceptions the Sector committees never took off. As a result the System remains fully centralised without been devolved to Sectors. Sectors were supposed to plan, organise and deliver mental health services at a regional and local level to meet the mental health needs of the local population. In practice, the responsibilities of the Sector committees appeared to be mostly “advisory”, overseeing the operation of mental health services but without management responsibilities, allocation of funding and power to monitor quality and be able to impose sanctions. It seems that no administrative infrastructure was provided and there was not clarity about the formal accountability of the committees.

2. Admission Units

The admission units visited and reports received pointed out to a great pressure for beds and some of them have to put extra temporary beds in the corridors (Πάντζα). We received reports that due to the limited number of acute beds for psychiatric patients available in the general hospitals there is a difficulty in arranging admissions, and this is particularly so for voluntary patients. This in turn has led to an artificial increase in the number of involuntary admissions as this is often the only way for a resident to secure a bed in an in-patient unit of a general hospital. In one area compulsory admissions reached recently 65% of the total. The Ombudsman has expressed concern on this matter in a specially published report. The application of Sectorisation of services with due attention given to assessed population needs for acute services can address this problem. We did not see evidence that alternatives to acute hospital admission have been considered in terms of local service provision (such as home treatment/crisis resolution teams, acute day hospitals or crisis houses).

There is also a shortage of Psychiatric Intensive Care Units, known as PICU in UK and “acute cases in Greece, for patients in need of “intensive care”. We understand that there are very few such units operating and the designated beds are not adequate creating further pressure on the admission units either in the psychiatric departments of general hospitals or in the existing short term admission units in Mental Hospitals.

We understand that there are major difficulties in admitting people with a ‘dual diagnosis’ of drug/alcohol dependency and mental illness as several psychiatric units have developed exclusion criteria which provide barriers for this group. There are considerable delays in discharges resulting in blocked beds, while in other instances several admissions might have been prevented by the function of well coordinated system of community mental health services.

For some of the psychiatric units visited e.g. Chania there are serious reservations about the physical and environment suitability to function as a psychiatric unit in a general hospital. We also received reports that with the current structure system of the psychiatric units managed by general hospitals there are often delays in appointing staff because funding is diverted to other medical departments.

3. Community Settings

There seems to be considerable variation in the quality of care for the community residential settings which are mainly of 3 types Guest Houses, Boarding Houses and Sheltered Apartments. It does not seem that there is regular flow from the most supported to less supported settings. Most of the visited places were of good quality of care e.g. Athens, Chania, Thessaloniki, Katerini, Alexandroupolis, though some had an institutional flavour. We received, however, several reports including from service users, that the quality of care in some of them has seriously declined recently causing concern. Few discharges from community settings had taken place but even so, there were usually delays in replacing vacancies with new admission. We had reports of the existence of several vacancies in some residential units. Further, that new units had been set up, employed staff, but had not yet started operating (effectively standing empty). In other services we were told that there was a shortage of staff. The skill mix has already been mentioned as a general issue for consideration and the imbalance between health and social care.

There are over 60 NGOs providing mostly residential care, day care and mobile units. We noticed that several of the NGOs have small capacity providing 1-2 services either residential or day care. This would have been understood if there were specialist services provided by specialist organisation which is not the case with very few exceptions. With such small capacity there are issues for these organisations of economy of scale including staff training and retention as well as staff burn out.

The evaluation team received several reports of gross delays in staff payments that need to be addressed without delay.

There are some “mobile units” offering peripatetic service in islands and some non-urban areas. We talked to providers of some of these units who showed an admirable dedication e.g. Fokida, Evros, Lasithi, Naxos, Paros. However, they are experiencing serious problems with admissions and are often not integrated with other health and social services. One exception for example was in Kefalonia where the mobile unit was working closely with local and municipality authorities.

Day centres and day hospitals have been operating in several parts but their interaction and integration with other services is limited while the overall impression was that they have capacity to extend their function beyond their current case load.

4. Service Users Rights

The ET was concerned to receive reports that there is still violation of service users rights either been informal or compulsory detained under the Greek Mental Health Act, according to The Ombudsman and the “Special Committee for the Protection of the Rights of People with Psychiatric Disorders (*Ειδική Επιτροπή Ελέγχου Προστασίας των Δικαιωμάτων των Ατόμων με Ψυχικές Διαταραχές*)”. Reports are of great concern and should be addressed as an urgent priority.

5. Service Users Involvement

Service users’ involvement and carer advocacy remains underdeveloped despite some progress and the fact that there are some organisations in place. The user and family perspective described in the focus group was very disenchanted with the current situation (this was in contrast to very positive feedback we were given in the reprovision projects in Katerini for example). The focus group acknowledged that there had been an improvement in the overall conditions, the relationships between service users/carers and staff (described “our voice is heard”) and public perceptions had changed and improved. However, they also described a heavy reliance on families (who often become exhausted) and not understanding the “system” and where to get information and help. They described inhumane conditions in some hospitals (people chained to their bed), a suspicion that not all the money to support the developments had been spent on what is was intended for, many people finding it difficult to get into the system (especially if they needed residential care/support) and lack of respect (described social co-operatives using people as “servants”).

Policy & Service Implications

For the reform programme to continue and to achieve its objectives attention must be given to the structural changes required to make a sustainable modern, community based, mental health service. This is a critical moment and the programme needs to focus on integration of services and identify practical details of how the currently fragmented service elements will combine into effective networks, and to build upon and integrate the many positive local developments which have been established.

There are at present at least 4 separate mental health service systems delivered from Mental Hospitals, District General Hospitals, NGOs and the Private Sector. In addition there other systems delivered from the health system of the army forces, state controlled insurances, some local and education authorities and the Church. The private sector has a strong presence in Greece with individual practitioners, mostly psychiatrists and several private psychiatric hospitals. Reports suggest that their size and role is growing rapidly. The private sector has not been included in this evaluation and is recommended that further reports should include the role of the other systems of mental health care.

The existence of separate mental health systems is a key factor responsible for the current fragmentation and lack of coordination of mental health services. This is because there is not either integration between these separate systems of Mental Hospitals, Psychiatric Units of General Hospitals and NGOs, or between the different provision i.e. CMHCs, Admission Units and Community Settings within the same System. There are some notable exceptions of services visited e.g. CMHC in Ag. Anargiroi Attikis and CMHC in Katerini.

Recommendations

1. Integrated Mental Health Service System (ΕΝΙΑΙΟΣ ΦΟΡΕΑΣ ΨΥΧΙΚΗΣ ΥΓΕΙΑΣ). It is suggested that an Integrated Mental Health Service System is created to bring together organisationally and administratively Mental Hospitals, Psychiatric Unit in General Hospitals and NGOs.

Some of the options are:

- i. That the Integrated Mental Health Service System (ΕΝΙΑΙΟΣ ΦΟΡΕΑΣ ΨΥΧΙΚΗΣ ΥΓΕΙΑΣ) comes under the structure of the existing Mental Hospitals. The pros are that Mental Hospitals have long standing “know how” in running mental health services and also still have some large sites with physical and building facilities. The cons are that the Mental Hospital as a model and philosophy is outdated and there is a danger that the rest of the health and social care system is “let off the hook” with respect to meeting the needs of MH service users and those involved may actually be more familiar with old styles of practice and indeed may be resistant to change.
- ii. That the suggested integrated structure comes under the General Hospitals through the Psychiatric Departments. The pros would be that it mainstreams MH, keeps MH issues on the physical health agenda (and vice versa). The cons are that General Hospitals do not have the “know how” in running mental health services their interest in psychiatric services is variable and there is a danger of diverting resources to other health services. ” and eventually policies, procedures and priorities would be skewed to interests other than MH.
- iii. The suggested integrated structure comes under the new emerging regional and local administrative structures of Health Services in Greece but maintaining their independence in terms of funding, planning and priorities. The “know how” of the Mental Hospitals” can also be utilised. Some of their current facilities can be upgraded and regenerated and parts of their sites can be used by the general public e.g. for recreational activities such as parks or athletic grounds. The pros are the development of a strong integrated modern mental health system that would provide a fresh start making use of all existing systems including mental hospitals and community services. The cons are that this approach requires the development of a robust infrastructure and this may prove to be a too radical suggestion and indeed it may involve administrative set up costs that are difficult to justify in the current financial climate.
- iv. An alternative flexible option might be to focus on function rather than form and allow local variations based on the strength of the existing arrangements and crucially on the leadership/commitment of key

individuals. However, this approach is unlikely to address the issue of fragmentation and poor co-ordination in existing arrangements.

Similar problems have been experienced in other countries including the UK. The last 15 years the Mental Health Services developed independently from other Health Services and became what is known “Mental Health Trusts” having their own allocation of funding and their own organisational structures. Even the psychiatric departments in General Hospitals are the responsibility of the “Mental Health Trusts”.

2. Sectors if full operation is a priority. That is necessary to make a reality the idea of being responsible for co-ordinating services across a geographical area. This is also necessary in order for co-ordination of clinical services for the individual (care/case management and the articulation of care pathways). There is a need to take practical steps to integrate local networks of care, and this will depend to a large extent upon the balance of rewards, incentives and sanctions which act upon the component organisations when they decide whether to enter into such collaborative consortia.
3. Service specifications need to be reviewed to ensure that they reflect modern practice and are viable within the financial climate. They need to reflect care pathways that are explicit about transitions between different elements of the services. It would be helpful to reinforce the model of the focus being on community services with the back up of hospital services. It would also be helpful to challenge institutional or outdated provision. For example, duty system for acute admissions (instead of sectorisation); day hospitals (rather than vocational/community engagement projects); over reliance on “MH transport” (rather than locating services in the right place). CMHCs must become the focus of local mental health services and be fully integrated with the other elements of the system. They must be the champion of primary mental health, providing current evidence based interventions including assertive community treatments and home treatment approaches.
4. Existing major gaps in services such as in child and adolescent mental health must be addressed as a priority. Consideration also must be given to services for older adults that have become a priority in several other countries. Also specialist services for people with autistic spectrum disorders, intellectual disabilities, eating disorders and those with dual diagnosis of addiction and mental illness and forensic mental health services are needed.
5. Provision for the “new long stay” is also necessary as well psychiatric intensive care provision.
6. An audit of current vacancies in community residential settings should be carried out with the aim to fill them at the earliest opportunity. The skill mix of staff needs consideration with a view to the balance of health versus social care provision (making a distinction between roles and activities requiring professional mental health training versus those that support more general activities of daily living). The flow from more to less supported forms of accommodation must be examined based on clear service specifications, accountability and performance management. In

- some countries such as UK there are arrangements of partially paying for the cost of living in community settings from service users' welfare benefits. Such payments may occur in Greece from insurance agencies and a contribution from them to the cost might be considered.
7. Delay in staff salaries is a major problem and must be addressed as a priority. There were several reports of staff burn-out that cause concern. It would seem crucial to carry out a comprehensive workforce review linked to an updated set of service specifications which in turn are linked to explicit care pathways (describing journeys across different elements of the service system).
 8. An accountability framework is needed that sets out in explicit detail that is responsible for what at the different levels (from Ministry, through sectors and municipalities, down to individual services and projects). The current situation is a mixture of what might be regarded as excessive control by the Ministry for very operational issues (e.g. signing off proposals to recruit a replacement member of staff) whereas on the other hand there appear to be large gaps in the monitoring of the implementation of strategic goals (how sectors are overseeing development of a service system).
 9. It would be advisable to focus on working through "general" (or "mainstream") accountability structures for health and social care provision as much as possible but acknowledging that mental health services have characteristics which may require specific structures appropriate to the need to work across health and social care, and with many partners in different sectors.
 10. The link between resources and activity (performance management framework) needs to be explicit and monitored as a high priority. There is a need for more sophisticated models for assessing needs and priorities and making explicit decisions about the resources required to deliver a specified level of service activity. This needs to be monitored locally (and to an appropriate degree at sector/region/national level). Infrastructure costs appear to be very high e.g. very high quality buildings with comparatively modest levels of associated activity, dedicated transport etc. It would be helpful to encourage thinking about "unit costs" that include infrastructure as well as direct costs (based on a common formula to allow comparison between services).
 11. It would be helpful to suggest a process and associated tools that may support the next phase of review and reorganisation. For example an option might be a process of service and financial mapping (in line with revised service specifications and implementation guidelines), then a process to audit progress against core standards involving key stakeholders. The output of this process would mean there was a good level of local information (which could be used to produce a service directory), the opportunity to benchmark across sectors, regions and nationally, and to identify priorities for development and reorganisation plans. It would be possible to emphasise the importance of developing relationships and encouraging user and carer empowerment.

12. There must be clear processes for quality assurance and governance i.e. a framework for regulation and compliance for all services including the public sector, NGOs and the private sector. The introduction of “accreditation” for services should be seriously considered, and detailed discussions are required on how this could be established in a way that is sufficiently independent of provider organisations.
13. The suggestions for improvements from service users included focussing on the role of the community and the integration of health and social care, independent evaluation and research (including the role of users and their families), identifying pathways, emphasis on rehabilitation, vocational support and employment, separate services for adults and children, appropriate crisis responses, general hospitals supporting the developments, developing primary MH care.
14. Mental health promotion activity could reasonably focus on the way core services are delivered rather than being an “add on” i.e. if core services are provided well and with an appropriate focus on community engagement and outreach then it will impact on the views of local community members and challenge stigma in very practical way. It would probably be more cost effective to have a central approach to mental health promotion in a similar way to mental health systems in other countries.
15. Staff Training is of utmost importance and a co-ordinated programme will be necessary for clearly setting out training requirements. There is a need for practical problem solving orientation of training, refreshing courses with emphasis on evidence based practice. This will enable staff to apply treatment protocols and guidelines. Evaluation of the offered training is necessary.
16. KoiSpe have already produced some work but with limited exposure to the open market and few signs of commercial management practices. The view from service users was that they get squeezed out so they are in a minority on the Boards, may be used as cheap labour or even excluded from the enterprise. There is a need to consider becoming commercially viable by adapting to current management requirements. The experience of the ET is that these initiatives are seldom sustainable without continuing government support. There might be a desire to explore other forms of employment including new models of supported employment. In this approach, service users are encouraged to apply for jobs on the open market, given assistance with preparation of their curriculum vitae and provided with the support they need to perform the tasks of the job once they have secured a placement rather than undergoing lengthy periods of ‘pre-vocational’ training or sheltered employment. Research from North America, Australia and some European countries suggest that these approaches are feasible and acceptable to patients, result in greater employment rates with no apparent detriment to clinical function. Such programmes in Greece might be those offered by Organisation for Recruitment and Employment of Workforce (O.A.E.Δ.). Of course, no one approach will meet all needs and a variety of options should be available including opportunities for voluntary work.

17. The service users' rights must be protected by empowering existing structures such as the "Special Committee for the Protection of the Rights of People with Psychiatric Disorders (Ειδική Επιτροπή Ελέγχου Προστασίας των Δικαιωμάτων των Ατόμων με Ψυχικές Διαταραχές)".
18. There is a paucity of health service research and evaluation. More involvement of academic departments would be of value and can contribute to innovations, training and facilitate further service developments. Regular internal and independent evaluations are necessary.

Conclusion

In conclusion there are several positive and noteworthy achievements by the reforms of the Greek mental health system. However, emphasis should be given to policy-update possibly by developing a new operational plan (Psychargos C) that would define the future directions of the Greek mental health system. Such an operational plan could act as a catalyst to the existing fragmentation and lack of coordination of services. Simultaneously, it could contribute to the development of a new dimension that could promote further changes, effective organization and management of mental health services, thus resulting in the improvement of their quality.