Community Child Psychiatry: The Example of Mobile Mental Health Units in the NE and Western Cyclades

11

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Abstract

This chapter outlines innovative measures in the field of community child psychiatry in Greece and abroad, with emphasis on the special features of interventions in geographically remote areas. It presents the work done by mobile mental health units in the NE and Western Cyclades in the child psychiatry sector. Reference is made to the clinical work and the differences noted in terms of new cases, initial requests, referrals and diagnoses over the 10 years the units have been in operation. In addition it presents measures taken to record needs, promote mental health among children and adolescents, and in terms of the prevention and management of abuse. The data and the measures taken are directly tied into the new conditions which have emerged in Greece as a result of the socio-economic crisis.

11.1 Introduction

Good mental health is essential to the development processes of children and adolescents. It ensures optimum psychological and social functionality (WHO 2005a) and plays an important role in the development of identity and healthy interpersonal

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relationships, bolsters learning ability and the ability to manage developmental or other challenges on the path towards adulthood.

Using international literature (WHO 2005b) we can document the reasons why it is necessary to develop and implement effective interventions for children and adolescents:

A large percentage of the psychopathology which manifests in an individual's adult life starts in the early development stages, during which it is feasible to prevent future psychopathology.

The value of early intervention in mental disorders is particularly important and reduces the likelihood of chronic mental disability.

Effective interventions to promote the mental health of children and adolescents reduce the burden of psychiatric disorders in the individual and his/her family, thereby reducing the cost of long-term care for the health system.

Available research data supports the view that the prevalence of mental disorders in children and adolescents is high internationally, at around 10–20 % (Kieling et al. 2011). Studies point out that in geographically isolated areas, in particular, the occurrence rates for mental disorders are clearly higher (Ellis and Philip 2010), mainly where there are other risk factors as well, such as low socioeconomic levels, parental psychopathology and the effect of stressors.

It is also a fact that only 10–22 % of all those suffering from child and adolescent mental disorders can be identified by primary healthcare, which shows the inadequate levels of human resources and know-how in public mental health and the particularly significant treatment gap (WHO 2005a; Saxena et al. 2007). In addition, only the minority of high-risk children are monitored by mental health experts (Belfer 2008; NIMH 2001; Brugman et al. 2001). However, mood (affective) and behavioural problems of children appear to be stable over time, affect their quality of life and tend to develop into psychiatric disorders in adult life especially when there is no suitable intervention (Costello et al. 2003).

In a previous chapter, we reported on psychiatric reform in Greece and the essential change in the model from the provision of psychiatric care in asylums to community psychiatric care. However, as the national action plan PSYCHARGOS III (2011–2020) has recorded, "psychiatric reform has made deinstitutionalisation of chronic adult patients and the abolition of psychiatric hospitals a priority, with the result that few mental health structures have been created for children and adolescents" and concludes in relation to the modern Greek situation that "existing structures do not under any circumstances constitute an adequate network, while large geographical regions of the country have no child psychiatric services at all".

One can therefore understand that in order to abolish institutional care for children and adolescents, it would be necessary to operate an effective network of child and adolescent mental health services which would ensure that comprehensive child psychiatric care is provided at all levels of care, in the context laid down by international conventions and declarations on the protection of the rights of children (MHSS 2012).

As Kolaitis and Tsiantis (2013) have noted, "the lack of an adequate number of specialised community structures and services for child psychiatric care in Greece,

which are suitably staffed by well-trained child psychiatry experts in adequate numbers, is a major barrier to the protection of the rights of children". The rights of children and adolescents may be neglected or violated in various ways, from the prenatal stage (such as great poverty in the family, socioeconomic inequalities), at the time of birth (such as inadequate health services in remote areas), during infancy (such as inadequate mental healthcare for young mothers) and during childhood and adolescence. In this regard Anagnostopoulos and Soumaki (2012) have pointed out that the methods of violating rights may be clear-cut as in the case of abuse or less obvious in the context of family conflicts and divorces. These situations can have physical and psychological effects and frequently lead to poor educational adjustment, low performance and early dropout from school with clear, long-term repercussions in terms of economic cost. It can also lead to increased levels of unemployment and reduced social integration and participation (Kolaitis and Tsiantis 2013).

The development of services to care for the mental health of children requires specific organisational plans as a starting point, with the aim of recording needs and developing and disseminating services to cover geographically remote areas as well, and to ensure that they are accessible to all citizens. If this is not done, there is a risk of services being created in a piecemeal manner, offering ineffective, expensive or hard-to-access care (WHO 2005a).

This chapter will place particular emphasis on community-focused child psychiatry services and the special features of interventions in geographically remote areas by looking at how mobile mental health units operate.

11.2 Definitions

Child psychiatry refers to services provided to children and adolescents and their parents that relate to:

Child psychiatry services in the community/at the child's place of residence based on the principles of sectorisation
Recording the mental health needs of children and adolescents, to develop services tailored to the special needs of each community
Child psychiatric evaluation and development of a customised treatment plan in cooperation with other bodies in the community such as schools, health services and social services
Actions for mental health education and promotion for children in the community
Prevention of relapses in cases of severe child psychiatric disorders

These points reflect the principles in the UN Convention on the Rights of the Child and aim to promote emotional well-being and the right to multifaceted development on an emotional, social and cognitive level to promote his/her abilities to the greatest extent possible while taking into consideration "his/her interest" (WHO 2005b).

The framework within which mobile mental health units operate (which is the prime example of community-focused services) is a basic example of how child psychiatry services can be provided in the community. As a form of organising

psychiatric care and treatment, mobile mental health units' key features are that they provide comprehensive, quality mental health services while interfacing with primary healthcare and cooperating with existing health, educational and social services. Another feature is that they require minimal infrastructure of their own and maximise existing infrastructure which either belongs to other health services or local government authority services or agencies. Under Law 2716/1999 (Government Gazette 691/A), mobile mental health units provide services:

(a) In mental health sectors whose geographical area and layout, residential diversity and social, economic and cultural conditions coupled with the nature of mental disorders make it difficult for residents of those areas to access mental health services
(b) In neighbouring mental health sectors when there are no adequate mental health services there

Mobile mental health units are aimed at children and adolescents and adults suffering from mental disorders and/or psychosocial problems or who are in groups at high risk of manifesting mental disease. They are also aimed at the healthy population, through the mental health prevention, education and promotion programmes they run. Mobile mental health units operate in line with the principles and philosophy of social psychiatry (Mechanic 2001; Tansella and Thornicroft 2001).

11.3 Historical Background

Innovative steps towards psychiatric reform first began to be taken in Greece in the 1960s. During the 1970s and 1980s, community services were set up, cut off from traditional academic psychiatry, and the prime player in this field was Professor T. Sakellaropoulos. The Institute of Social Psychiatry was set up first in Pagrati followed by the Social Psychiatry Association, the first mobile unit in the Prefecture of Fokida (in 1981) and various structures in Evros (Livaditis 1995). At the same time, other social psychiatry services were set up such as:

The Paediatric Psychology Department at the Agia Sofia Children's Hospital in Athens
The Community Mental Health Centre in Thessaloniki
The University Clinic of the Ioannina Medical School
The University Mobile Unit for the Thessaloniki Region
The Vyronas – Kessariani Community Mental Health Centre

These structures provided satisfactory public care within their area (at that time the psychiatric sector as an area of remit was considered to be an innovation) to only 8 % of the country's population, due to the failure to complete sectorisation of services, the real lack of a central plan for deploying services in the regions, the absence of sufficient structures and the lack of coordination and cooperation (Sakellaropoulos 1995).

Today, the continued implementation of psychiatric reform is at risk both because of the economic crisis and its effects (Anagnostopoulos and Soumaki 2012, 2013b) and because of the attitude of public bodies to issues relating to how mental health services are deployed and organised (see the chapter on psychiatric reform in Greece and the chapter on the economic crisis and mental health: key issues).

The aim of modern child psychiatry is that all mental health problems are dealt with by keeping the children and adolescents in the community, providing them with the entire range of specialised psychosocial care and rehabilitation services they need (Anagnostopoulos and Lazaratou 2005).

Even though the system of mental health services for children and adolescents developed in a positive manner, it continued to be inadequate and limited in terms of development compared to the modern needs of children and adolescents and their families, while services are mainly focused in large urban centres, with the result that 30 prefectures in Greece do not have any child psychiatry services at all, and therefore a large proportion of the Greek population has no child psychiatry services at all (Asimopoulos 2007).

11.4 Current Situation

The current socioeconomic and cultural crisis (from 2009 onwards) highlighted a series of chronic dysfunctions which have hindered – but above all divided and fragmented – the psyche of individual subjects and of Greek society overall. These chronic defects in the structure and organisation of the very state and government have resulted in inadequate institutional functions and have also highlighted a plethora of contradictory forms of behaviour at social and individual level.

The combination of these factors, which are associated with the crisis, such as unemployment, insecurity, the abolition of institutions, continuous defeated expectations, lack of boundaries, serious conflicts and lack of a harmonious family life, has led to a major increase in new cases and therefore for demand for child psychiatry services and to a qualitative change in the psychopathology being encountered in day-to-day clinical practice.

Constant cuts in general spending on health and welfare have led to a shrinking in the already inadequate child psychiatry services offered by the Greek NHS and the abolition or reduction in real childcare policies for vulnerable groups of children and adolescents.

11.5 Literature Review

In one European study which covered 36 countries, it was found that the number of community child psychiatry units and the number of children and families treated were lower in general terms than the corresponding services for adults (Levav et al. 2004) even though the majority of mental disorders have the age of 14 as their starting point (Kessler et al. 2005). In addition, only 7 % of countries worldwide have

enacted a comprehensive plan for their child and adolescent mental health policy (Shatkin and Belfer 2004). As far as access to existing community child psychiatry services is concerned, a key barrier – in addition to the stigma over mental disorders – is geographical inequality in the spread of such services, with non-urban areas being at a clear disadvantage (WHO 2005b).

Based on this data, increasing emphasis is being placed on developing community-focused child psychiatry services in geographically remote areas, which is a need the Greek mobile mental health units were called upon to meet in large part. The philosophy behind the mobile mental health units derives from the principles of assertive cooperation between mental health experts in all available agencies operating in a community.

The relevant literature relating to the provision of child psychiatry services by mobile mental health units abroad is relatively limited. Mobile mental health units have been deployed in Switzerland targeted specifically at adolescents who are either in high-risk groups for the development of serious psychopathology or who refuse to continue treatment after hospitalisation or who find it difficult to access child psychiatry structures. Bonsack et al. (2008) described an intervention model based on Assertive Community Treatment. The model is based on setting up and implementing a customised, holistic intervention plan which involves the reporting child psychiatrist, mental health experts operating the relevant community and the school and the parents of each adolescent. An essential factor in each intervention is to develop a robust treatment alliance and cultivate a climate of trust with families and to gradually empower the socialisation of, and development of activities by, each adolescent. To achieve these goals, the treatment plan also includes specialist carers (nurses) who make daily home visits and provide real help in implementing the treatment plan. In addition, clinical meetings are held weekly, to help assess each intervention and redefine treatment targets. The results of interventions are considered to be satisfactory, when there is a clear improvement in the adolescent's level of functionality.

In the USA, the charity the Children's Health Fund provides funding for mobile medical units that focus on the child population in areas where such services do not exist. Fifty mobile units operate in 16 states in the USA to provide services to poor families and minorities (Brito et al. 2010). To effectively run the mobile units, they have adopted a holistic programme and integrative approach. Paediatricians, nurses and mental health experts cooperate to develop intervention protocols whose primary aim is to identify mental health problems and increase referrals to specialised treatment. The main principles of the holistic model they follow are (a) ensuring accessibility, (b) ensuring the continuity of the intervention, (c) liaising with other services, (d) getting families and schools involved in the treatment plan, (e) making it easy to travel to and carry out medical tests and children's hospitals and (f) tailoring the intervention based on the special cultural features of each area covered.

Similar mobile units have also been deployed in the USA so that they are ready at any time to travel to areas affected by natural disasters (Madrid et al. 2008). In the field of child and adolescent mental health in particular, a model is used which posits the coexistence of mental health experts and paediatricians to deal with problems

arising from a natural disaster from different angles. The initial focus takes into account the basic needs, while, as the programme continues, emphasis is placed on training professionals in the community and teachers to identify any mental health problems in children and adolescents in good time, as they emerge.

Although the existing literature is limited, it is clear that the key aspects of how mobile mental health units operate are that they must reflect the principles of primary, secondary and tertiary prevention, bearing in mind well-documented practices in the field of modern child psychiatry.

Interventions by community child psychiatry services such as those provided by mobile units must necessarily include programmes to deal with negative, stereotypical views in the community about the mental disorders of children and adolescents, in order to enable specialised help to be sought in good time (Naylor et al. 2009).

In addition, a key part of community interventions by mental health services for children and adolescents is to develop a stable partnership with schools and teachers (Bailey 1999; Eskin 1995). Schools are one of the most important community structures where mental health promotion programmes have a definitive impact (a) on combating stigma and (b) on improving the emotional and social functionality of students and (c) on identifying children with mental health problems (Rowling 2002; Zins et al. 2004; Payton et al. 2008). Early interventions to address emotional and behavioural problems and to train teachers to integrate techniques to promote student skills lead to long-term benefits in the field of child and adolescent mental health (Tennant et al. 2007; Wells et al. 2001).

Another feature of community-focused mental health services for children and adolescents, such as mobile units, according to the international literature is that the intervention team must have a multidisciplinary line-up which will enable it to target its work on the entire family. Some researchers have argued that in order for a child psychiatric diagnosis to be submitted, it is essential to know about and examine the interaction each child has with his family (Carr 2000; Cicchetti and Tucker 1994). A successful outcome from each treatment approach ought to include parental involvement, and when this is achieved, the results of treatment are clearly better (Dowell and Ogles 2010; Karver et al. 2006).

Another key area of intervention for child psychiatry services in the community is training primary healthcare doctors to identify children and adolescents with mental health problems early on (Hagan et al. 2008). This is vital since primary healthcare doctors tend to under-diagnose mental health problems in children and adolescents (Hickie et al. 2007) and consequently limit the number of referrals to mental health experts (Warfield and Gulley 2006).

Best practices: the example of mobile mental health units in the NE and Western Cyclades operated by the Regional Development and Mental Health Association.

A key priority of the mobile mental health units in the NE and Western Cyclades during their 10 years in operation has been to develop special prevention and promotion measures for the mental health of children and adolescents in the community within their territorial remit and to implement special treatment measures for children and adolescents and their families.

The child psychiatry department of the mobile units employs child psychiatrists, clinical psychologists specialised in children and social workers. The services are provided fortnightly, primarily at premises provided by health centres on the islands, at specially designed spaces in town halls and at the headquarters of the units. In addition, there is a special Family Clinic on Paros for children and adolescents with mental health problems. Systematic supervision of child psychiatry cases is also provided.

In short the operating targets for mobile units when providing services relating to children and adolescents can be summarised as follows (Pantelidou and Stylianidis 2010; Stylianidis and Pantelidou 2006; Stylianidis et al. 2007):

(a) To assess and record mental health needs for this age group
(b) To provide child psychiatry evaluation, diagnosis and treatment services for mental disorders and the psychosocial problems of children and adolescents
(c) To prevent, educate and promote mental health for children and adolescents by implementing special programmes and training groups of professionals working with children and adolescents and parents and to identify mental health problems in good time and refer them to a specialised service
(d) To liaise with primary healthcare, social and educational bodies in the community and to more effectively record needs and provide comprehensive interventions
(e) To develop specialised measures to prevent and deal with child abuse and victimisation

The section below provides a brief overview of the activities of mobile units in relation to those goals.

Clinical Treatments

During the 10 years the mobile mental health units have been in operation, they served a total of 1339 children and adolescents in the NE Cyclades and 567 in the Western Cyclades, whose average age was 9.2 years old ($SD = 4.1$, $min = 1$ $max = 2$). The key demographic characteristics of children and adolescents who attended the units are presented in Table 11.1.

Monitoring the change in new cases over time, as shown in Fig. 11.1, during the first years in operation, there is a gradual increase in new cases. There was then a drop in new cases which probably reflects changes from funding cuts (reduced numbers of staff). There was another drop in new cases attending the units in 2009 for the same reasons. This was followed by a gradual rise in requests, which is probably associated with the impacts of the socioeconomic crisis and also with the activities the mobile units had engaged in relating to prevention and awareness raising about the psychosocial health of adolescents and their families (due to the increased number of requests from the community for actions of this sort). It is also worth noting that the influx of new cases in the Western Cyclades had fewer fluctuations over time compared to the

Table 11.1 Demographic characteristics of children and adolescents who received services from the mobile mental health units in the NE and Western Cyclades in the first 10 years they were in operation ($N = 1906$)

Demographic variables	*f*	%
Gender		
Boy	1121	58.8
Girl	785	41.2
Country of origin		
Greece	1728	90.7
Abroad	178	9.3
Prior contact with a mental health expert		
Yes	391	24.5
No	1199	75.3

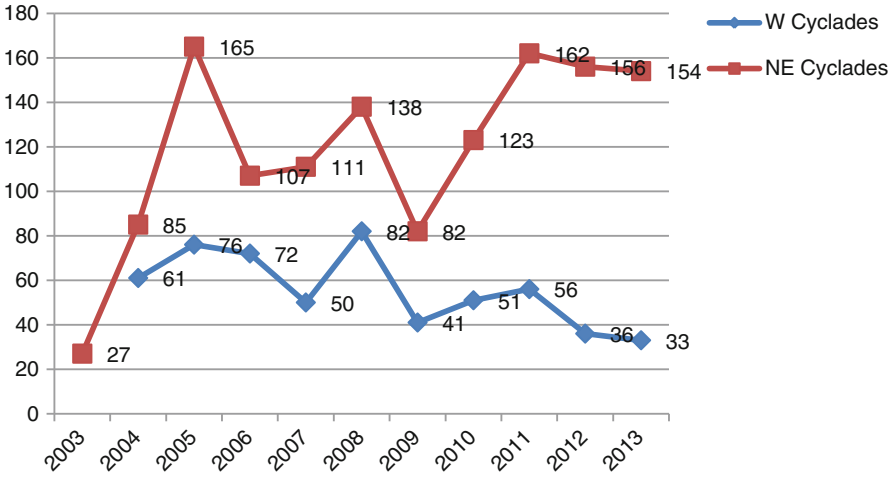

Fig. 11.1 Absolute frequencies of new cases of children/adolescents during the time the NE and Western Cyclades mobile units were in operation ($N = 1.339$ and 567, respectively)

NE Cyclades, even though increases and reductions in new cases probably follow the same trend. This can be attributed to the fact that this area has a clearly smaller population and consequently the corresponding fluctuations are smaller.

As far as diagnoses are concerned, it appears that frequencies follow a similar trend for both mobile units. More specifically, as one might have expected, the most frequent diagnoses related to psychological development disorders, behavioural and emotional disorders normally diagnosed in childhood and adolescence and psychosocial problems, followed by mood (affective) disorders (see Fig. 11.2).

Monitoring the distribution of diagnoses over the time period the mobile units were in operation (chi-square statistical verification (24) = 132.7, $p < 0.001$) (Fig. 11.3), one can see that in the last 4 years, the frequencies of psychopathologies of almost all types have increased. Exceptions are organic psychotic disorders, substance dependence and abuse and psychoses, possibly due to their low prevalence in the general child and adolescent population. As far as cases of developmental

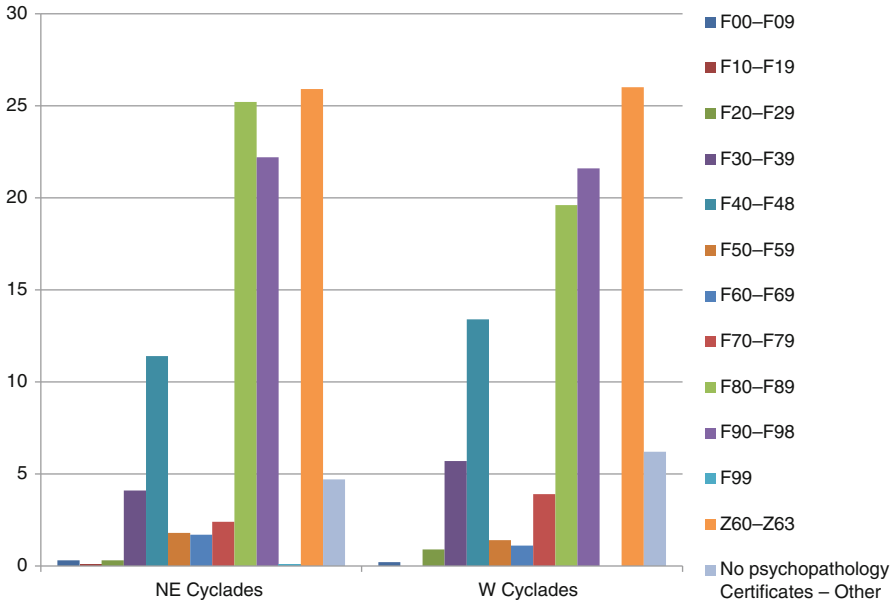

Fig. 11.2 Relative frequencies of diagnoses for children/adolescents who visited the NE and Western Cyclades mobile units during their first decade in operation ($N = 1.339$ and 567, respectively)

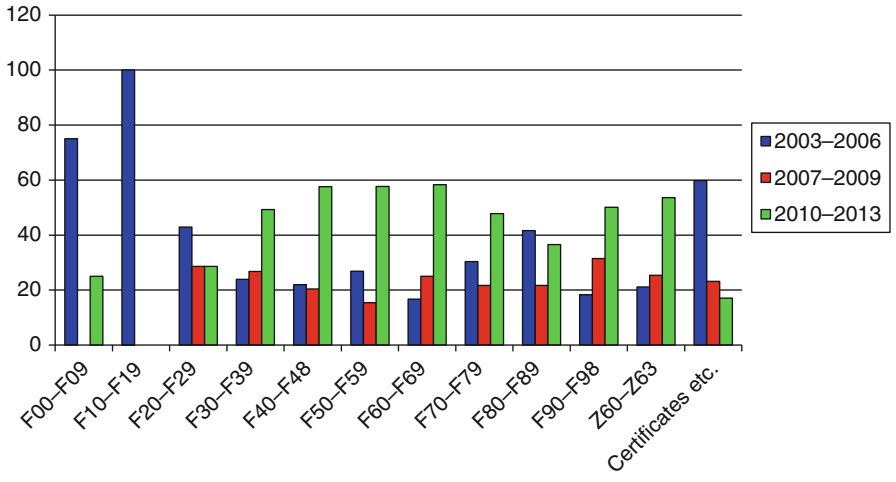

Fig. 11.3 Relative frequencies of diagnoses during the period the NE and Western Cyclades mobile units were in operation ($N = 1906$)

disorders are concerned, one can see a drop in frequency and then a rise over the last 4 years, which could be attributed to the raised awareness of parents and teachers about such matters.

As Table 11.2 shows, the most frequent source of referrals was self-referral, which in the case of children and adolescents in effect means requests originating from their parents. The second most frequent source of referral was the school, which is the prime place outside the family where psychosocial difficulties become perceptible, which emphasises the need for close cooperation between community mental health structures and schools. The phenomenon of primary healthcare somehow being bypassed by mental health structures also appears in the case of children and adolescents since the frequency of referrals by this source (third in the rankings) could be characterised as rather lower than expected, which is perhaps indicative of the problems in the running of primary healthcare (reduced staff levels, lack of paediatricians on most islands within the area of remit, etc.).

By comparing the sources of referrals separately for the two mobile units, one can see that self-referrals were more frequent in the NE Cyclades than in the Western Cyclades, where the percentage of referrals from "other" sources is clearly higher, which may show another form of social networking in place in the Western Cyclades, in what are mostly more closed communities with a smaller population. The lower frequency of referrals from primary healthcare and private doctors in the Western Cyclades reflects the dearth of health professionals in those areas. The higher frequency of referrals from community bodies in the NE Cyclades may reflect the larger number of services on those islands.

Reviewing the sources of referral over time, which revealed a statistically significant change, χ^2 (14) = 83.7, $p<0.001$ (see Fig. 11.4), shows that over time self-referrals increased and in fact that increase was higher over the last 4 years, i.e. since the socioeconomic crisis started. The crisis may have led a large portion of the population to seek out psychosocial help given the impacts it has had, and in the last 2 years in particular, the population has become more aware, thanks to mental health promotion programmes aimed at parents, adolescents and teachers. Those programmes also explain the increase in schools as a source of referrals. After 10 years of the mobile mental health units in operation, the number of self-referrals has increased significantly, which indicates an improvement in the level of basic trust between the multidisciplinary child psychiatry team and the population receiving services, the more pressing nature of requests due to the

Table 11.2 Relative frequencies of sources of referrals to mobile units in the NE and Western Cyclades in the first decade in operation ($N=1339$ and 567, respectively, 1906 in total)

Source of referrals	NE Cyclades (%)	Western Cyclades (%)	Total (%)
Self-referral	49.3	34.3	45.2
Primary healthcare	11.6	8.7	10.9
Private doctor	3.9	1.3	3.3
Community body	4.6	2.3	3.9
Public authorities	0.9	4.6	1.5
Church	0.2	0	0.1
Educational body	22.5	25	23.3
Other	6.9	23.7	11.8

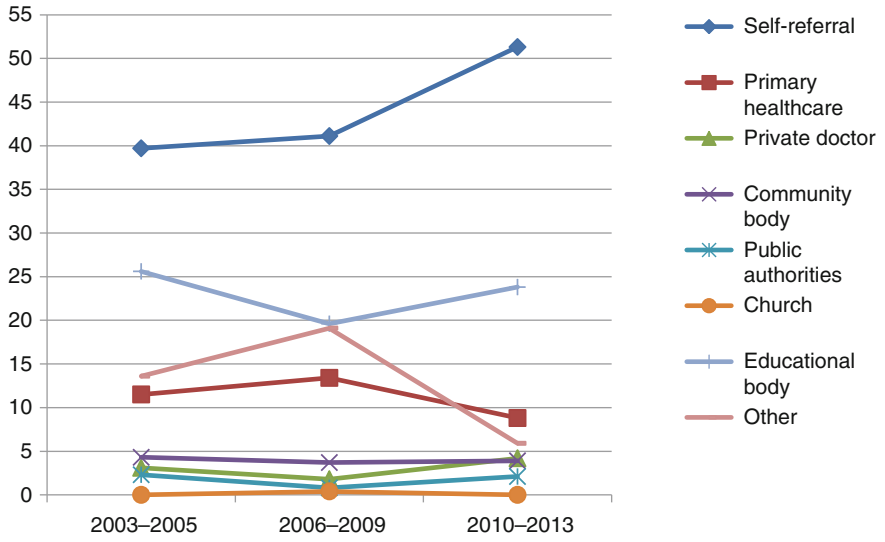

Fig. 11.4 Relative frequencies of sources of referral during the period the NE and Western Cyclades mobile units were in operation ($N = 1906$)

Table 11.3 Relative frequencies of initial requests made to mobile units in the NE and Western Cyclades in the first decade in operation ($N = 1339$ and 567, respectively, 1906 in total)

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

socioeconomic crisis and the way the units operate in the networks within local communities.

As is clear from Table 11.3, initial requests made by individuals who contacted the mobile units most frequently related to psychiatric, learning and behavioural problems. That was followed by family problems and social studies, which is clear from the fact that over the last years mobile units undertook to carry out social studies on certain islands in cooperation with the public authorities on Syros. Comparing the two mobile units, one can see that a higher frequency of requests related to

learning difficulties in the Western Cyclades, which is due to the fact that this mobile unit carried out interventions of this type in its first years in operation. However, over time those interventions were limited in number, thanks to a rise in other types of interventions, as is clear from a look at the types of requests over time. So it is clear that in the last 4 years, behavioural problems rose to a large degree as the type of requests made, as did psychiatric symptoms, since the initial requests differed in a statistically significant manner in the period under examination (chi-square statistical verification (22) = 148.62, $p < 0.001$). These phenomena can clearly be associated with the impact on the socioeconomic crisis on the family.

Special Measures

A Family Clinic opened on a pilot basis on Paros in 2012, funded for the first year by the Stavros Niarchos Foundation. It offered family therapy from therapists specialised in the systemic approach. Families were referred here by the Child Psychiatry Department of the mobile unit and by other community bodies working with children and families.

The need to develop a specialist family therapy programme on islands like Paros and Antiparos emerged, thanks to increased needs for interventions on multiple levels for individuals and families, the constantly increasing number of requests related to the economic crisis and the well-known effectiveness of family therapy in dealing with child and adolescent mental disorders (Campbell et al. 2003; Carr 2000; Tomaras and Pomini 2007). At the same time, family therapy seeks to improve the quality of life of the family and support all its members (not just the child/adolescent who has presented some symptoms).

During the first year, 60 sessions were held with families and the intervention was evaluated. The intervention's specific goals were (a) to reduce the psychopathology of children, (b) to reduce parental stress, (c) to improve family functioning and (d) to improve the family's quality of life.

To evaluate the intervention, the following scales were presented to six families which took part on the pilot operation of the family clinic (the scales were administered at the start and end of the intervention):

(a) Parental Stress Questionnaire (Berry and Jones 1995) to assess parental stress
(b) Family Assessment Device (FAD) (Epstein et al. 1983) to assess family functionality
(c) WHOQOL Bref (WHOQOL Group 1998; Ginieri-Coccossis et al. 2009) to assess the quality of family life
(d) Strengths and Difficulties Questionnaires (Goodman and Goodman 2009; Giannakopoulos et al. 2009)

A total of 9–11 sessions were held with each family. The initial results show that there was an improvement in the level of family functionality, and the symptoms of emotional disorders and behavioural problems that children and adolescents initially presented declined, and their clinical picture overall improved. Parental stress decreased by the end of the intervention, but it appears that there was not a major change in the quality of the family's lives. The evaluation process is under way at present since the Family Clinic is still in pilot mode.

The Role of Supervision

A child psychiatry team working in the community needs to follow specific principles and practices, such as providing services with the maximum therapeutic benefit in the shortest time period and the least possible cost and ensuring the continuity of care, availability and the type of treatment approach which the individual or family is entitled to have.

Another important issue is to ensure accessibility since the layout of the service must allow for easy access both for users of the service and therapists.

However, the most difficult subject is the principle of dialectical interaction, which relates to ongoing interaction between the mental health expert and each community, since he needs to understand cultural values and habits, applied health policies and the economic and ideological viewpoints they serve, in order to be able to assess real needs and prepare the corresponding programmes (Madianos 1994).

The child psychiatry team meets the child and the institutions and is required to synthesise all the relevant types of thinking (medical and therapeutic, psychological, pedagogical and institutional) which do not all operate according to the same rules, and do not all have the same influence, even though they intersect and are interwoven.

The importance of supervision, i.e. of continuous analysis of the team's actions, is vital so that everyone is aware of the difficulties arising from working in the community, in order to reveal the conscious and unconscious barriers and the synthesis going on. It is a process which seeks to promote the mutual exchange of information and views and the sharing and collective processing of day-to-day treatment practice and experience.

In this special setting, the supervisor will need to bear in mind the real conditions of the *setting* and balance them out, as well as the needs of the therapists being supervised, group and community dynamics which give rise to mass projections and multiple transferences.

Frequently, in difficult situations where the case is severe or the bodies involved face specific difficulties, it is easy for the institution to be considered as the only, undisputed objective value and for members to adopt "easy" solutions such as the suggestion of hospitalisation without adequate interaction with the child/adolescent's support network, or a shift in treatment responsibility to another specialised service in an urban centre, or for there to be divided opinions between therapists about the type of treatment or competition between institutions.

It is clear from this how essential supervision is as a complex process of learning and education, which can provide greater awareness of the counter-transference emotions of the therapists, as a meeting, as a body of experience and as a "space" for analysing and bringing together the child's and family's narrative in the social setting they belong to.

Assessment and Recording of Needs

It is important for the plan to deploy mental health services to be based (a) on epidemiological data about the prevalence of mental health problems that children and

adolescents face and (b) on the assumption that each problem must be explored by taking into account the cultural, geographical, social and family environment of the child (Grimes 2004).

The methodology employed over the 10-year period the mobile units have been in operation to assess and record needs includes the following:

Focus groups with teachers within schools. These groups discuss issues relating to child and adolescent behavioural problems as seen at school, cases of school violence and cases of possible neglect – abuse – and record teachers' requests to mobile units for support to manage such problems. After the groups are finished, needs and requests formulated by teachers are officially recorded.

Meetings with other professionals working with children in the community: paediatricians, speech therapists, occupational therapists and social workers (at health centres or social services) during which an empirical picture of needs in terms of mental health problems and the social problems faced by children and adolescents is obtained.

Systematic analysis of data relating to the reason why children and adolescents and parents have come to the units and the psychosocial profile of people receiving services from the mobile units.

Needs are recorded for this age group, especially via research activities which have been carried out over recent years in the context of how the mobile units operate. For example, on Paros a study was carried out to assess the prevalence of common mental disorders on 323 adolescents at the island's two high schools (among 16–18 year olds). The study was carried out in 2007 in cooperation with the Psychiatry Department of the University of Ioannina Medical School and is part of a wider epidemiological study on a sample of 5614 adolescents from schools in Epirus, Etolo-Akarnania and Attica (Skapinakis et al. 2011; Magklara et al. 2010, 2012). For Paros in particular, the key finding was that the prevalence of depression among adolescents who participated in the study was 12.7 % (the figure was almost twice as high in girls as in boys (OR = 7.12, CI = 3.42–14.82). The highest percentage was noted in students in the final year of high school and in students whose performance was average (OR = 4.31, 95 % CI = 0.97–19.13). A high positive correlation existed between reported victimisation in cases of school violence and the onset of depression (OR = 3.47, 95 % CI = 1.04–11.63). The use of cannabis also positively correlated with depression (OR = 4.23, 95 % CI = 1.29–13.89).

The general results of the nationwide study found that 32 % of adolescents have symptoms of psychological stress (42 % of girls and 20 of boys, $p < 0.01$) and there was a statistically significant correlation between mental health and the subjective assessment of the family's economic difficulties (Magklara et al. 2010). It was also found that the likelihood of the onset of suicidal ideation was higher for adolescents who reported that they were victims of

school violence especially when it happened weekly and that finding is independent of the existence of any psychiatric symptoms (OR = 7.78, 95 % CI = 3.05–19.90).

Mental Health Prevention and Promotion Actions in Cooperation with Community Bodies

As part of their operations, the mobile units place particular emphasis on developing mental health prevention and promotion measures in the community (Pantelidou and Stylianidis 2009). Just some of these are listed below:

In the period 2011–2013, a special 2-year programme was implemented to promote the mental health of children and adolescents funded by the Stavros Niarchos Foundation. During the programme groups were run for parents, teachers at all levels and adolescents on the Cyclades (within the remit of the mobile mental health units operated by the Regional Development and Mental Health Association). More than 900 people took part in the programme over the 2 years.

The aim of the monthly parent groups was to brief them about child and adolescent mental health problems, improve communication and parent-child relations, support them in their parental role, identify child and adolescent mental disorders in good time and refer them to specialised services.

Likewise, teacher groups were also held monthly, and they were able to learn about child and adolescent mental health issues so that they could recognise behavioural problems and emotional difficulties in good time. Particular emphasis was placed on communication between the school and family, on supporting them in organising actions to promote child and adolescent mental health at school and on prevention measures and measures to address school bullying. During the 2 years of the intervention, supervision groups for teachers were also in operation.

Support groups for adolescents were also run twice a month as well as a theatrical play workshop to promote mental health.

All special measures at schools included frequent meetings with teachers in order to ensure cooperation in supporting children with mental health problems and in dealing with cases of school bullying. In addition, special measures were taken to address the stigma of mental illness at school and workshops held to prevent school bullying for primary school pupils. Other special measures included organising workshops for teachers in cooperation with the Theseus Centre for the Prevention of Use of Addictive Substances in the Cyclades and the Prefecture of the Cyclades Health Prevention and Promotion Network based of Syros. The workshops held over the last 2 years were focused on prevention and dealing with problems of behaviour in the classroom and on prevention and managing cases of child abuse and victimisation.

In cooperation with health centres on the islands, training courses were held for paediatricians, GPs and rural doctors, to enable them to identify child psychiatric disorders in good time and refer them.

A total of ten workshops are held a year on the islands covered by the mobile units featuring theoretical presentations and experiential seminars to brief parents and teachers about child and adolescent mental health issues.

All these measures were implemented in cooperation with community bodies, especially schools, health providers and social services, with the support of local government and the Southern Aegean Region.

Preventing and Dealing with Child Abuse

Over recent years, because of the increase in requests for intervention in cases of child abuse and neglect, particular emphasis has been given to the development of measures to prevent and address those cases. In the 3-year period 2010–2013 in particular, experts at the mental health units dealt with 40 cases of child abuse. In cooperation with the Public Prosecutor and the competent community bodies in Syros and in Athens, social studies were carried out by social workers from the mobile units, and specialised intervention plans were drawn up to support the children and their families. Special educational seminars were organised to raise awareness among the police, so that they could suitably handle such cases, and special workshops have been held for teachers and doctors to brief them about how to identify such cases, how to suitably intervene and about the statutory framework. Cooperation with schools and community bodies was also important in developing the treatment plan. Working groups have also been set up with all local bodies on the islands (health services, social services, public authorities, educational bodies) in cooperation with the Ombudsman and Children's Ombudsman, to provide better liaisons with bodies so as to more effectively manage cases of child abuse and neglect.

11.6 Conclusions: Challenges and Prospects

In light of these points, it is essential to adapt how the community child psychiatry services provided by mobile mental health units are run in geographically remote areas to the new social and economic circumstances and the emerging needs in each community.

The challenge when faced with a lack of resources and the lack of consistency in institutional terms from the Greek state is to bolster the inventiveness of the multidisciplinary team in its dealings with local networks to implement innovative initiatives to deal with the complexity of requests for treatment and with societal demands.

In terms of secondary prevention, the importance of timely intervention in populations at high risk of developing mental disorders is well documented. Studies show that children with parents with severe mental disorders are vulnerable to the

development of emotional, behavioural, social and learning difficulties due to the simultaneous impact of genetic, environmental and psychosocial factors (Royal College of Psychiatrists 2010). Consequently, it is important to develop interventions targeted at parents with such problems and their children.

To that end, emphasis needs to be placed on interventions aimed at vulnerable population groups which are more affected by the economic crisis, who also have difficulty in accessing services: families with severe economic problems and unemployed parents, families of migrants, children who have been abused, children of parents with severe health problems and single-parent families (Tsiantis and Asimopoulos 2009; Reiss 2013). Specialised programmes relating to these population groups are expected to be launched soon on Andros as part of the operations of the NE Cyclades mobile mental health units, funded by the Moraitis Foundation. These programmes will include prevention actions and interventions at family and individual level (by setting up a Family Clinic).

Over recent years, research has also focused on identifying the qualitative criteria that ought to govern how community-oriented child psychiatry services operate (Bickman 2008; Warren et al. 2010). One key issue in increasing the quality of care provided is to ensure the commitment of children and families to treatment, since studies stress that a percentage of around 40–60 % terminate treatment at community services early (high dropout) (Gopalan et al. 2010). To that end it is vital to train mental health professionals on evidence-based treatment choices and to integrate research methods to evaluate the services provided (Glisson et al. 2010).

Finally, it is necessary to extend mental health promotion measures for children and adolescents, via special programmes aimed at the general population and vulnerable groups, which could be implemented in cooperation with educational bodies and community health providers (Hoagwood et al. 2001; Hooven et al. 2011) and in cooperation with bodies from abroad which have implemented and evaluated similar actions already.

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