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Editorial
Άρθρο Σύνταξης

Economic crisis, mental health and psychiatric care: What happened to the "Psychiatric Reform" in Greece?

Psychiatriki 2013, 24:13–14

Since 1984, when the EEC Program 815/84 was introduced, the term "psychiatric reform" was made synonymous to the imperative change of the asylic psychiatry towards a decentralized and community based psychiatric care. This program presented various stages of non absorption of funds, stagnation and finally a developmental phase until the completion of the program in 1995. A total of 250 new services and programs have been developed. In 1999, the most progressive Mental Health Law 2716 was passed. In 2000, the "Psychargos" program continued the psychiatric "reform" project, with 700 million euros funding for a ten years period. Its goal was the completion of the reform, the deinstitutionalisation of the remaining long stay patients, in the eight mental hospitals and their closure, the development of psychosocial rehabilitation and housing services as well as the further development of community based mental health services. Four mental hospitals have been closed down until now. Forty three Community Mental Health Centers are in operation (instead of the needed 94). However, there are no evaluative data on their effectiveness and efficiency. Regarding the rest of the types of services, 57 Day Care Centers with 855–900 places (1500 places are needed), 25 Mobile Units, 37 Outpatient Psychiatric Clinics, 28 Psychiatric Departments in General Hospitals, with 650 beds, have been developed in the country. The latter number is insufficient. There is a need of 2900 short stay beds to cover 40,000 admissions per year in order the remaining public mental hospitals to be closed down. Additionally, 343 hostels, sheltered apartments have been developed with 3100 beds as well as 2000 places in various rehabilitation services for the support of the deinstitutionalised patients. To overcome the bureaucratic and rigid public accounting system the intervention of the NGO's was introduced. In 2012, 65 NGO's were involved with 220 units (30% of the total mental health units) covering 50% of the deinstitutionalisation beds and a total budget of 45 million euros in 2010. The Ministry of Health had no provision for their evaluation or their requirement to provide fiscal annual reports publicly. It should be noted that the first NGO's were established by dedicated mental health experts in the eighties, for the fulfilment of the 815/84 program. In the coming years decades of NGO's were developed under rather unclear criteria by several non mental health professionals for the completion of the Psychargos projects. With respect to the private sector in 2007 there were 4207 inpatient beds.

The evaluation of the whole process of these significant changes in Greek psychiatry during the last 28 years did not prove that these changes constitute a true reform for the bellowing reasons: (1) These changes were made not by a public demand or the majority of mental health professionals. They were a result from "above", mainly the European Commission under the pressure of the Leros Asylum scandal. (2) There was not a scientific design starting from the catchmentation of the country which was introduced 20 years later in 2004, providing 58 sectors (instead of the needed 94) on the basis of epidemiological data. (3) No specific mental health ideology was prevailed among the personnel in contrast to the Italian psychiatric reform. (4) There has been no real system of care, to be coordinated toward the maintenance of continuity of care. The existing CMHC's are not operating on 24 hours basis. They are not connected to the Emergency Medical System. This problem is causing the loss of emergency cases and the hospitalization of the patients outside their catchment area. The Sectorized Mental Health Committees are not connected with the Public Health Regional Committees. (5) The role of community (local authorities, resources, families and relatives of patients, active citizens for human rights) is absent from the legislative and delivery of care levels. (6) There is a lack of coordination between public health and welfare system and mental health care. The newly established National Organization of Delivery of Health Services (N. 3918/11) might help the improvement of this coordination.

In this rather pessimistic climate, while these changes are still in progress, the current great economic crisis "invaded" the country with a loss of 25% of NGP, 26% unemployment rate (more than 50% among the young adults), 40% draw backs in salaries and pensions. The magnitude of NGP is synonymous to the global prosperity of society and the achievements of social state. As a result of this crisis, human dignity, human rights, the beliefs in democracy, institutions, the respect of the "other", the feeling of social cohesiveness and security are undermined. The first "victims" are the young, the poor and the disabled. The economic crisis has caused and continued to produce adverse psychological indicators such as a 35% increase in the consumption of antidepressants as well as an increase by 62% of new HIV cases. It was also found a dramatic increase by 185% of persons who had attempted suicide (0.6% in 2008 and 1.5% in 2011). In 2008, the prevalence of major depression was found 3,3% in a nationwide general population survey, while the corresponding prevalence rate was 8,2% in 2011. The above findings are drawn from systematic epidemiological studies on the impact of crisis on mental health of the population conducted by the University Mental Health Research Institute. The most disturbing finding is that of the significant correlations between public debt, unemployment rates and the age specific suicide rates between 2001 and 2011. The current crisis influencing every area of delivery of care, especially mental health, with first "victim" the deinstitutionalisation project involving the NGO's resulting budget cuts by 50% of all expenses including suspension of salaries for six and more months. Several mental health services are understaffed and they are forced to stop some specialized programs. This picture is completed with the increasing trends of homeless persons in urban centers, in their majority being chronically mentally ill. With the current crisis the limits of social state are diminished with thousand of uninsured persons due to their unemployment, the abolition of collective jobs agreements and lack of protection from job losses. The intrusion and strengthening of neoliberalism as an antidote to crisis, given the fact of the collapse of the Keynesian social policy, brings out the risk of a destruction of psychosocial protection with the introduction of managerial ideology of cost benefit in the prevention, treatment and rehabilitation of mental illness and the human suffering. The "Managed Care" approach is a true example of this kind of policy.

It is becoming clear that the future of this even incomplete psychiatric reform is at serious risk. The defense of the social state and the mental health apart from the austerity measures and policies is imperative. It is perhaps a solution, the acknowledgment and the empowerment of the multiple roles and resources of the community, in the defense of mental health of its members, to overcome this crucial phenomenon.

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Άρθρο Σύνταξης
Editorial

Οικονομική κρίση, ψυχική υγεία και ψυχιατρική περίθαλψη: Τι απέγινε η «Μεταρρύθμιση» στην Ελλάδα;

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Από το 1984, με την έναρξη του Προγράμματος 815/84 της τότε ΕΟΚ, ο όρος «Ψυχιατρική Μεταρρύθμιση» έγινε συνώνυμος της επιθυμητής αλλά και επιτακτικής αλλαγής της τότε παραδοσιακής, ασυλιακού σε μεγάλο βαθμό τύπου περίθαλψης προς μία αποκεντρωμένη παροχή φροντίδας ψυχικής υγείας με βάση την κοινότητα. Το πρόγραμμα πέρασε από διάφορες φάσεις στασιμότητας και μη απορροφητικότητας κονδυλίων, μέχρις ότου αναπτυχθεί και ολοκληρωθεί τελικά τον Ιούνιο του 1995. Δημιουργήθηκαν περίπου 250 νέες υπηρεσίες αποκαλούμενες «νέες δομές». Το 1999 ψηφίστηκε ο πιο προοδευτικός Νόμος για την ψυχική υγεία (2716/17.5.99), αποτέλεσμα του οποίου υπήρξαν σημαντικές αλλαγές στην ψυχική υγεία. Το «Ψυχαργώς» αποτέλεσε τη συνέχιση του εγχειρήματος της «μεταρρύθμισης». Πρόκειται για ένα φιλόδοξο πρόγραμμα που ξεκίνησε το 2000, είχε κόστος 700 εκατομμύρια ευρώ και βασικούς στόχους: (α) τον αποϊδρυματισμό των απομεινάντων χρόνιων ψυχικά ασθενών στα οκτώ δημόσια ψυχιατρεία που λειτουργούσαν ως τότε και με κατάληξη το κλείσιμο των τελευταίων, (β) την περαιτέρω ανάπτυξη κοινοτικών υπηρεσιών σε όλη τη χώρα ως υποστηρικτικών της προηγούμενης διαδικασίας αποϊδρυματισμού και (γ) την ψυχοκοινωνική αποκατάσταση των ασθενών. Μέχρι σήμερα έχουν κλείσει τα ψυχιατρεία Πέτρας Ολύμπου, Χανίων, Κέρκυρας, Νταού Πεντέλης, ενώ εκείνο της Τρίπολης υπολειτουργεί. Λειτουργούν επίσης 43 Κέντρα Ψυχικής Υγείας (ΚΨΥ) αντί των 94 που είναι αναγκαία για τη χώρα ώστε να καλυφθούν οι ανάγκες του πληθυσμού. Για τη λειτουργία, την αποτελεσματικότητα και την και αποδοτικότητά τους δεν υπάρχουν σχετικά στοιχεία. Από τις λοιπές υπηρεσίες αναπτύχθηκαν 57 Κέντρα Ημέρας με 855–900 θέσεις έναντι των 1500 θέσεων που απαιτούνται, 25 Κινητές Μονάδες, 37 Εξωτερικά Ψυχιατρικά Ιατρεία, 28 Ψυχιατρικά Τμήματα σε Γενικά Νοσοκομεία με 650 κρεβάτια, ενώ χρειάζονται 2900 κρεβάτια ταχύρρυθμης νοσηλείας που να καλύπτουν 40.000 νοσηλείες τον χρόνο. Τέλος, για το Πρόγραμμα Αποϊδρυματισμού δημιουργήθηκαν 343 ξενώνες και άλλες στεγαστικές δομές με 3100 κρεβάτια, καθώς επίσης και 2000 θέσεις σε μονάδες ψυχοκοινωνικής αποκατάστασης και ΚΟΙΣΠΕ. Για να υπερκεραστεί το άκαμπτο και γραφειοκρατικό δημόσιο λογιστικό υιοθετήθηκε η παρέμβαση των Μη Κυβερνητικών Οργανώσεων, ΜΚΟ (Non Governmental Organizations, NGOs), οι οποίες το 2012 ανήρχοντο σε 65 που ανέπτυξαν 220 μονάδες (το 30% του συνόλου των μονάδων ψυχικής υγείας) που διαθέτουν το 50% των κρεβατιών του Προγράμματος Αποϊδρυματισμού. Οι ΜΚΟ απορρόφησαν 45 εκατομμύρια ευρώ το 2010. Από πλευράς ΥΥΚΑ δεν υπήρξε πρόβλεψη αξιολόγησης του έργου τους, ούτε και υποχρέωσή τους να δημοσιεύσουν τα οικονομικά τους πεπραγμένα. Πρέπει να σημειωθεί ότι οι πρώτες ΜΚΟ ιδρύθηκαν από καταξιωμένους επαγγελματίες της ψυχικής υγείας στις δεκαετίες του 1980 και 1990 για την ολοκλήρωση των προγραμμάτων του Κανονισμού 815/84. Αργότερα και συχνά με αδιαφανή κριτήρια, αναπτύχθηκαν δεκάδες ΜΚΟ από μη ειδικούς που ανέλαβαν έργα του «Ψυχαργώς». Όσον αφορά στον ιδιωτικό τομέα, το 2007 αυτός κάλυπτε 4207 ψυχιατρικά κρεβάτια.

Από την αποτίμηση της όλης διαδικασίας των αλλαγών στην ψυχιατρική περίθαλψη κατά τα τελευταία 28 χρόνια, δεν μπορούμε να θεωρήσουμε τις αλλαγές αυτές ως πραγματική μεταρρύθμιση για τους ακόλουθους λόγους: Το αίτημα για τις αλλαγές αυτές δεν διατυπώθηκε από την πλειοψηφία του ψυχιατρικού κόσμου, ούτε από την κοινωνία, αλλά επήλθε «από τα πάνω». Δεν υπήρξε ένας αρχικός επιστημονικός σχεδιασμός, ξεκινώντας με την τομεοποίηση (αφού αυτή σχεδιάστηκε το 2004 και αφορούσε σε 58 τομείς αντί των αναγκαίων 94) και με βάση επιδημιολογικά προσδιορισμένες ανάγκες. Δεν φαίνεται να υπήρξε κυρίαρχη ψυχιατρική ιδεολογία, σε αντίθεση με την αντίστοιχη ιταλική ψυχιατρική μεταρρύθμιση. Δεν δημιουργήθηκε ένα σύστημα συντονισμένων υπηρεσιών με στόχο τη διατήρηση της θεραπευτικής φροντίδας. Τα υπάρχοντα ΚΨΥ δεν εφημερεύουν και δεν διασυνδέονται με το σύστημα εφημεριών, με αποτέλεσμα να «χάνονται» τα επείγοντα περιστατικά, οι δε νοσηλείες να γίνονται εκτός τομέα. Επίσης, οι ΤΕΨΥ δεν συνδέονται με τις ΔΥΠΕ. Ο ρόλος της κοινότητας (τοπική αυτοδιοίκηση, λοιπές τοπικές αρχές, οικογένειες και συγγενείς ψυχικά αρρώστων, οργανωμένες ομά-

δες πολιτών για τα δικαιώματα των ψυχικά ασθενών) απουσιάζουν εντελώς τόσο σε νομοθετικό όσο και σε επίπεδο παροχής υπηρεσιών. Απουσία συντονισμού των υπηρεσιών υγείας, ψυχικής υγείας και πρόνοιας. Η συγκρότηση του ΕΟΠΥΥ (Ν. 3918/11) ίσως βοηθήσει στη βελτίωση του συντονισμού.

Μέσα σε αυτό το κλίμα και με τις διαδικασίες των αλλαγών να βρίσκονται ακόμη σε εξέλιξη, ενέσκηψε η μεγάλη οικονομική και κοινωνική κρίση στη χώρα με απώλεια του 25% του ΑΕΠ, συρρίκνωση αποδοχών και συντάξεων (40%) και ανεργία (26%), η οποία επιδείνωσε την όλη κατάσταση. Το μέγεθος του ΑΕΠ, ως γνωστόν, είναι συνώνυμο με τη συνολική ευημερία της κοινωνίας, των ατόμων και των οικογενειών τους, καθώς και των κοινωνικών κατακτήσεων μέσω του κοινωνικού κράτους. Ως αποτέλεσμα της κρίσης, η ανθρώπινη αξιοπρέπεια και τα δικαιώματα, η πίστη στη δημοκρατία, τους θεσμούς και τις αξίες, ο σεβασμός στον «άλλον» το αίσθημα της κοινωνικής συνοχής και ασφάλειας έχουν υπονομευθεί. Οι ομάδες που πρώτες και κυρίως θίγονται είναι οι νέοι, οι φτωχοί και ανήμποροι, καθώς και τα άτομα με ειδικές ανάγκες. Η οικονομική κρίση έχει προκαλέσει ήδη και συνεχίζει να δημιουργεί αδιαμφισβήτητους δυσμενείς ψυχοκοινωνικούς δείκτες, όπως ότι μεταξύ 2006 και 2011 παρατηρείται μια αύξηση κατά 35% της κατανάλωσης των αντικαταθλιπτικών, μια αύξηση κατά 62% των νέων κρουσμάτων HIV, ενώ βρέθηκε μια ιδιαίτερα μεγάλη αύξηση κατά 185% των ατόμων που έκαναν απόπειρες αυτοκτονίας (0,6% το 2008 και 1,5% το 2011). Επίσης, η μείζων κατάθλιψη το 2008 βρέθηκε να είναι 3,3% σε πανελλήνιο δείγμα γενικού πληθυσμού, ενώ το 2011 η επικράτηση ανήλθε στο 8,2%. Τα ευρήματα αυτά προέρχονται από συστηματικές επιδημιολογικές μελέτες της επίδρασης της κρίσης στην ψυχική υγεία, που οργανώθηκαν και υλοποιήθηκαν από το ΕΠΙΨΥ. Ένα ιδιαίτερα ανησυχητικό εύρημα είναι η στατιστικά σημαντική συσχέτιση δημόσιου χρέους, ποσοστών ανεργίας και ποσοστών αυτοκτονιών ανά ηλικία (age specific rates) μεταξύ 2001 και 2011. Η κρίση έπληξε κάθε τομέα παροχής υπηρεσιών υγείας και ιδιαίτερα ψυχικής υγείας με πρώτο «θύμα» το πρόγραμμα αποϊδρυματισμού που υλοποιείται μέσα από τις ΜΚΟ, αφού υπήρξε περικοπή κατά 50% της χρηματοδότησης έτσι ώστε να επέλθει στάση πληρωμών λειτουργικών δαπανών και μισθοδοσίας για έξι και πλέον μήνες. Επίσης, πολλές υπηρεσίες ψυχικής υγείας υποχρεώθηκαν να σταματήσουν ορισμένα ειδικά προγράμματά τους, ενώ την ίδια στιγμή εμφανίζονται να είναι υποστελεχωμένες. Η εικόνα συμπληρώνεται με την αυξητική τάση των αστέγων στα μεγάλα αστικά κέντρα, πολλοί από τους οποίους βρέθηκε να είναι ψυχικά άρρωστοι. Με την κρίση, επίσης, ελαχιστοποιείται το κοινωνικό κράτος με χιλιάδες ανασφάλιστα άτομα λόγω ανεργίας και κατάργησης των συλλογικών συμβάσεων, χωρίς προστασία από ενδεχόμενες απολύσεις. Η εισβολή και εδραίωση του νεοφιλελευθερισμού ως αντίδοτου της κρίσης, αφού η κεϋνσιανή κοινωνική πολιτική έχει καταρρεύσει, ενέχει τον κίνδυνο υπονόμευσης της ψυχοκοινωνικής προστασίας, με την εισαγωγή της διαχειριστικής λογικής «κόστους-κέρδους» στην αντιμετώπιση της πρόληψης, της θεραπείας και αποκατάστασης της ψυχικής αρρώστιας και του ανθρώπινου πόνου. Το «κλειστό ενοποιημένο νοσήλιο» είναι ένα απτό παράδειγμα τέτοιας πολιτικής.

Γίνεται λοιπόν σαφές ότι το μέλλον ακόμη και αυτής της ατελούς μεταρρύθμισης βρίσκεται σε κίνδυνο. Είναι επιτακτική η προάσπιση του κοινωνικού κράτους και της ψυχικής υγείας και η αποσύνδεσή τους από τις πολιτικές λιτότητας που έχουν υιοθετηθεί. Ίσως η αναγνώριση, η αναβάθμιση και η υποστήριξη των πολλαπλών ρόλων και πόρων της κοινότητας στην προάσπιση της ψυχικής υγείας των μελών της μπορεί να συμβάλει στην αντιμετώπιση του κρίσιμου αυτού φαινομένου.

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Review article
Ανασκόπηση

Ideology, psychiatric practice and professionalism

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Psychiatry, associated as it is with social and cultural factors, has undergone profound changes over the last 50 years. Values, attitudes, beliefs and ideology all influence psychiatry. Deinstitutionalisation, the normalization principle, advocacy, empowerment and the recovery model are ideologies that have been closely associated with policy, service developments and clinical practice in psychiatry. A "new professionalism" is emerging as a consequence of a number of changes in mental health care that needs to be guided by the highest standards of care which are best epitomized in psychiatry as a social contract with society. Looking to the future it is important that the profession recognises the impact ideology can make, if it is not to remain constantly on the defensive. In order to engage proactively and effectively with ideology as well as clinical science and evidence based service development, psychiatry as a profession will do best to approach significant future policy, practice and service changes by adopting an ethical approach, as a form a social contract. Psychiatrists must pay increasing attention to understanding values as expressed by ideologies, working in a collaborative way with other mental health professionals, involve service users and manage systems as well as be competent in clinical assessment and treatment. Whether in time of plenty or in times of deprivation, ideology produces effects on practice and in the context of constantly changing knowledge and the current financial stress this is likely to be more the case (and not less) in the foreseeable future. Psychiatrists must take into consideration the new social problems seen in some high income countries with the increased availability of highly potent "street drugs", perceived threats from various immigrant and minority communities and breakdown of "social capital" such as the decline of the nuclear family.

Key words: Ideologies, deinstitutionalization, normalisation, empowerment, recovery, professionalism

Introduction

The clinical practice of psychiatry cannot be seen in isolation from trends in society and culture.[1] Society funds (mental) health services and in return expects certain patterns and standards of care. Medicine and psychiatry's contract with society is influenced by attitudes, beliefs, values and ideology, as well as science. Western societies have moved from post Second World War austerity and cold war paranoia, through the social movements of the 60s and 70s, to the neoliberal economics and globalisation of recent decades. These changes in society have had an impact on the way mental health policies and services have developed and therefore on the circumstances and the way in which psychiatrists practice.

In this paper we discuss ideologies that have been closely associated with policy, service developments and clinical practice in psychiatry and mental health care over the past few decades and review their implications for professionalism in psychiatry.

Ideology

The Oxford English Dictionary defines ideology as a "manner of thinking characteristic of a 'class' or individual". A social psychological view of ideology would be as a "set of values determined by material or rational considerations".

Psychiatrists, like other groups, have ideologies. In the early post World War II decades distinct psychiatric ideologies could be divided into "custodial" and "humanistic". Alternatively they could be divided into somatotherapeutic, psychotherapeutic and sociotherapeutic, emphasising respectively biological, individual psychological and environmental factors in the aetiology, formulation and treatment of psychiatric disorder.[2,3] Increasingly, however, the deleterious effects of the long stay institutions and asylums, where psychiatrists were practicing, were strongly criticised.[4–7] Such criticisms and the dominant position that psychiatrists held in the asylums fuelled ideologically motivated views of psychiatry and mental health services, some of which persist even today.

The criticisms of asylums and psychiatry gained momentum during the 1960s when United States and Western European societies were rocked by the civil rights movement, Viet-Nam era anti-war demonstrations and the cultural and sexual revolutions. In the UK, Enoch Powell, the Minister of Health in his infamous "Water Tower Speech", as part of the address to the National Association of Mental Health Conference, March 9, 1961, advocated the reduction of the number of hospital beds and a move towards a local authority community infrastructure for people with mental health problems. In this context, the enactment of the "Maternal and Child Health" and "Mental Retardation Planning" Amendments and the "Mental Retardation Facilities and Community Mental Health Centres Act" in the US in 1963, arguably marked the beginning of changes in mental health services with strong ideological impetus.[8]

The ideologies under review in this article are: the deinstitutionalisation movement, the normalization principle, patient and carer advocacy and empowerment and the recovery model. The impact they have had on psychiatric professionalism has been profound and, arguably, has touched most parts of the world by now.

Ideology and aspiration

Deinstitutionalisation

The deinstitutionalisation movement's main aim was to replace long-stay psychiatric hospitals with less isolated community mental health services. The emerging use of effective new psychotropic medication in the 1950s, legislative initiatives, such as for example John Kennedy's New Frontier programme, changes in public opinion about those with mental health problems and governments desire to reduce cost gave impetus to this movement and its aims. Deinstitutionalisation first focused on reducing the size of the population in long stay institutions by releasing individuals to community facilities such as supported housing. The concurrent development of Community Mental Health Centres aimed to reduce numbers of new admissions, length of inpatient stay and number of readmissions into hospital. The movement gained momentum and spread gradually worldwide when it adopted philosophies from the civil rights movement in the US. Overall, professionals, civil rights leaders and humanitarians saw the

shift from institutional confinement to local care as the appropriate approach; however, concerns and fears were expressed as well, mostly by psychiatrists but also some patients, carers and other members of the community. Historians suggest a combination of social policy, anti psychiatry and consumer activism contributed to the implementation of deinstitutionalisation.[9] In France the reform of psychiatric institutions became a political issue and for some groups of radical mental health professionals it was seen as defending a politically alienated individual.[10] There was also an association of the timing of psychiatric reforms with the wider planning movement in France in the 60s and 70s that led to the emergence of the "secteur" in psychiatry (ibid). The "secteur" was primarily a planning device, even though psychiatrists thought that it brought about new ways of thinking about their work. In the following years the "secteur" was considered as the French way of deinstitutionalisation. The radical psychiatric reforms in Italy introduced by Basaglia, founder of the Italian Psychiatric Democratic Movement in the 70s, also had a strong political flavour.

Normalisation

The normalisation principle emerged from practical work in services for people with intellectual and developmental disabilities in Scandinavian countries.[11,12] The parents' movement there demanded standards in relation to facilities and treatment programmes. The aim was to make available to all people with disabilities living conditions and lifestyles which were as close as possible to the mainstream. In the United States[13,14] Wolfenberger expanded the normalisation principle into a comprehensive ideology with detailed guidelines for providing and evaluating human services. Wolfenberger[15] introduced a new term for normalisation, namely Social Role Valorisation. This new concept championed the establishment of socially valued roles for people with intellectual and developmental disabilities. The reasoning was that if a person engages in valued social roles, s/he is likely to enjoy those social goods generally wished for and available in society. There was little sound theory or scientific evidence to support the vision, either in terms of mental development or institutional change.[16] With some exceptions, psychiatrists remained reserved and sceptical. Reservations notwithstanding, the normalisation principle captured the imagination and commitment of many professionals, service planners, service providers and others. Normalisation workshops were led by charismatic individuals whose vision about how to revolutionise human services became contagious. Some psychologists numbered among the leading advocates. There is no doubt that over the past few decades every policy initiative for people with intellectual and developmental disabilities has explicitly stated its commitment to deinstitutionalisation and the principle of normalisation.

Advocacy and empowerment

Many mental health service users describe personal experiences of not being listened to within the mental health system. A lack of an ongoing, constructive dialogue between service users and professionals has been a major source of dissatisfaction.

John O'Brien,[17] a widely known advocate for people with intellectual and developmental disabilities, defined advocacy as "...*the creation by the advocate of a relationship with a person who is at risk of social exclusion and chooses one or several of many ways to understand, respond to and represent that person's interests as if they were the advocate's own*...". Also known in the UK as service users' participation, advocacy has the main aim of supporting service users to speak out and persuade providers of services to listen to them.

Advocacy and empowerment broke on the scene with the establishment in the United States of what is currently known as Arc (*http://www.thearc.org/page. aspx?pid=2338*). Previously called the National Association for Retarded Children and Citizens, it was led by parents of children with intellectual and developmental disabilities who had been active even before the first ideas of deinstitutionalisation and normalisation emerged. Arc, with many branches around the world, has been promoting and protecting the human rights of people with intellectual and developmental disabilities and actively supports their full inclusion and participation in the community throughout their lifetimes.

The Advocacy movement for people with intellectual and developmental disabilities has been

campaigning for self-determination and self-advocacy on the principle that all people with intellectual and developmental disabilities should be defined by their own strengths, abilities and inherent value, not by their disability. The overall vision is that with appropriate resources and supports they can make decisions about their lives. It is important that people with intellectual and developmental disabilities, their parents, siblings, family members and other concerned members of the public have meaningful opportunities to inform and guide the direction of organizations that are involved in their welfare, including determining policy and positions on important issues.

Recovery

The origins of the recovery model can be traced in early Alcoholics Anonymous programmes. The recovery model itself first emerged in the early 1990's and is one of the most recent ideologies in psychiatry. It is a product of deinstitutionalisation and driven by the understanding that people with mental illness have multiple residential, vocational, educational, and social needs and require more than just treatment for symptoms.

Recovery is often referred to as a process, outlook, vision, and conceptual framework or guiding principle.[18] One definition has been "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life, even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness".[19]

Rethink[20] in an overview statement suggest that "*recovery can be defined as a personal process of tackling the adverse impacts of experiencing mental health problems, despite their continuing or long-term presence. It involves personal development and change, including acceptance that there are problems to face. Also a sense of involvement and control over one's life, the cultivation of hope and using the support from others, including direct collaboration in joint problem-solving between people using services, workers and professionals. Recovery starts with the individual and works from the inside out. For this reason it is personalised and challenges traditional service approaches*."

Although the concept of recovery had previously been recognised for physical illness and disability,[21] it had received little attention with respect to people with mental illness.[22] The concept of recovery from physical illness and disability does not mean that the suffering has disappeared or all the symptoms removed or that functioning has been completely restored.[23] For example, a person with paraplegia can recover even though the spinal cord has not. Similarly people with mental illness can recover even though the illness is not "cured." For many people, the concept of recovery is about maintaining control of their lives despite experiencing mental health problems. Putting recovery into action means focusing care on building resilience, not just treating symptoms.

Mental illness and social attitudes to mental illness often impose limits on people experiencing ill health.[24] Professionals, friends and families can be overprotective or pessimistic about the potential of people with mental health problems. Recovery is about looking beyond those limits to help people achieve their own goals and aspirations. The model aims to help people with mental health problems to look beyond mere survival and existence. It encourages them to move forward, set new goals and do things and develop relationships that give their lives meaning. Recovery emphasises that, while people may not have full control over their symptoms, they can have control over their lives. It is about seeing beyond a person's mental health problems, recognising and fostering their abilities, interests and dreams.

A recovery approach has been adopted as the guiding principle for mental health or substance dependency policies of several countries and continues gaining increasing acceptance. In many cases practical steps are being taken to organize mental health services on a recovery model.[25]

Ideology in practice

Deinstitutionalisation in practice

The closure of mental asylums and deinstitutionalisation was perhaps the largest social experiment of the 20th century and has had variable degrees of

success.[26] Although it has been positive for the majority of patients, it has also had severe shortcomings.

Psychiatrists raised early concerns about deinstitutionalization and community care in the US, without being heard.[27] Bacharach[28] concluded early that deinstitutionalization in that country failed to address the needs of the diverse population of patients. In Britain, Kathleen Jones,[29] a professor of social policy, criticized the destructive effect on psychiatry of ideologies that led to a precipitate reduction in inpatient beds.

Despite such concerns and experiences, deinstitutionalisation has progressed relentlessly internationally, more so in some countries than others. Successive legislation and service planning in the UK, for example, reinforced deinstitutionalisation and promoted community care, so that today there are almost no long stay mental institutions in the country. Regrettably, despite such change, the comprehensive community care defined[30] as "services that provide a full range of effective mental health care to a defined population, dedicated to treating and helping people with mental disorders, in proportion to their suffering or distress, in collaboration with other local agencies" remains an aim and not a current reality.

Patients have too often been discharged without sufficient preparation or support and a high proportion became homeless or ended in prison instead of asylum. The "out of sight, out of mind" policy of Victorian era seems to have been replaced by an "out of hospital, do not mind" policy, in which the overriding prerogative seems to be to hasten discharge not recovery. Expectations that community care would lead to further social integration have not been fulfilled and many patients remain secluded in sheltered environments and have extremely limited social contacts and no prospect of work.

Even though the UK has a well developed primary care sector, a relatively sophisticated range of hospitals and community based specialist mental health services and widely praised policies,[31] most people with mental disorders do not receive appropriate health care and their many needs remain significantly unmet.[32] Priebe et al[33] have expressed concern that a process of "re-institutionalization" may have started, with increasing numbers of new forensic psychiatric beds and relentlessly rising numbers of mentally ill people in the prison population. Struggling clinicians have to carry out care to the best of their abilities in what are unsatisfactory policy and service environments (ibid).

A period of unprecedented investment of funds in mental health services by the Labour government (1997–2010) notwithstanding, many senior practicing clinicians continue to express alarm about the quality of services people receive.[34,35] Tyrer[36] points out that the remaining inpatient psychiatric units have lost their therapeutic spirit and members of staff look demoralized and discontented.

The process of deinstitutionalisation for people with intellectual and developmental disabilities has fared well compared to that for mental disorders. It evolved more gradually and selectively and was driven by the normalisation principle. It resulted in less recidivism and was accompanied by low rates of readmissions. Perhaps the fact that it is more difficult to deny the presence of actual disability in this group, compared to the mentally ill, has made the crucial difference in this respect, in that more care has been taken with this group.

Normalisation in practice

Overall the ideology of normalisation has been a unifying and positive force among those who have worked to end the social exclusion and devaluation experienced by people with intellectual and developmental disabilities. Lakin and Bruininks[37] suggest that the normalisation principle was widely accepted as a concept because of its elegant simplicity in providing both a utilitarian and an egalitarian guide to measuring the coherence of services for people with intellectual and developmental disabilities.

The prescriptive nature of the normalisation principle and social role valorisation had an undoubted appeal to two contrasting but important professional groups. Firstly, a significant number of administrators who had previously had little experience of providing services, but who were seeking some kind of conceptual template against which to judge the quality, efficacy and effectiveness of their services.

Secondly, to the many inexperienced, untrained and unsupported front-line staff who were searching for a comprehensive set of practice guidelines which could be applied easily and quickly.[38] However, the crucial point that advocates of the normalization principle missed, was that it was an ideology to help guide but not dictate thought and action. To achieve best results it needs a sensitive and pragmatic approach, not an inflexible and dogmatic one.

Advocacy and empowerment in practice

The provision of advocacy and empowerment for people with mental health problems has increased significantly over the past 20 years. Advocacy has been well received in general, including psychiatrists and is no longer perceived as a marginal activity. In some countries, including the UK, service users' participation is recognised in policy, legislation and research. In several countries there are now independent experienced providers of advocacy services designed to support those who are vulnerable. They help make informed decisions and secure the rights and services to which they are entitled.

Recovery in practice

Failures in the implementation of policies of deinstitutionalisation confronted the psychiatric profession, as well as others, with new challenges and radically changed thinking about how the mental health system should be organised and delivered. This new way of thinking about services and about the people laid the foundation for the gradual emergence and acceptance of advocacy of the recovery vision in the 1990s. Consequently recovery, as well as advocacy and empowerment, has been increasingly adopted in policy and training. However there has been debate about its intentions, nature and outcomes.

The ideology of recovery has been interpreted by some critics as implying that everyone can fully recover through sheer willpower and, therefore, as giving false hope and implicitly blaming those who may be unable to recover in symptomatic or functional terms. It has been argued that true recovery requires improvement in symptoms of mental illness and, unless additional resources are made available, either symptomatic treatment or recovery or both will remain deficient.

There have also been tensions between the recovery model and "evidence-based practice" models. Tyrer[39] casts doubt on the way the recovery model has been used in psychiatry, by stating that it has been overused driven by policy with questionable evidence-base. Others have perceived cultural biases in the "North American" model and practice of recovery, as well as the lifestyles that might be considered acceptable or valuable.[40]

In response, the critics have themselves been accused of failing to recognize that the model is intended to support a person in their personal journey rather than achieve a given outcome. Recovery relates to social and political support as well as individual empowerment. Many have argued that the critics undermine consumer rights and yet others emphasise that service user led research should be viewed side by side with professional led research.

Aspiration, practice and psychiatric professionalism

In March 1961 Enoch Powell, minister responsible for health in the UK at the time stated:

"I *have intimated to hospital authorities who will be producing the constituent elements of the national hospital plan that in fifteen years' time, there may be needed not more than half as many places in hospitals for mental illness as there are today... Now look and see what are the implications of these bold words. They imply nothing less than the elimination of by far the greater part of this country's mental hospitals as they stand today. This is a colossal undertaking, not so much in the physical provision which it involves as in the sheer inertia of mind and matter that requires to be overcome... Do not for the moment underestimate their power of resistance to our assault...*".

Was this, rather than legislation in the US, the signal for ideology driven reform of psychiatric services? Enoch Powell was certainly a deeply ideologically driven politician with libertarian commitments. He was also highly likely to have been knowledgeable about intellectual and policy developments in the US![48,49]

As we have seen, the ideologies of deinstitutionalisation and normalisation that swept across countries were received with caution, even hostility, by many

psychiatrists. They argued that these ideologies were based on theory rather than evidence. They perceived a potential gap between what theory promised and what could be achieved in reality, as it seemed evident that their implementation in practice required significant additional resources. These doubting psychiatrists were accused of defending the status quo in order to maintain their professional dominance. In contrast, other mental health professionals, mostly psychologists but also nurses were more welcoming and some of them became leading advocates. Service users and policy makers also embraced these ideologies for different reasons.

We have also seen that there has been increased acceptance of the newer ideologies of advocacy and recovery by psychiatrists. Perhaps the increased acceptance of newer ideologies reflects less their greater merit in theory or evidence, compared to the older ones, and more the changed circumstances in which psychiatrists have practiced in recent years. These new circumstances include the closure of asylums, the increasing role of primary care in mental health, the growth of allied professions (psychology, nursing and social work) and the engagement of patients in service delivery as "experts by experience". Citizens and patients in many countries are now better informed about their conditions and their treatments, while their human rights have been increasingly recognised in legislation. In many countries there has also been an increased dominance of neoliberal politics and the emergence of the entitlement society.

Two significant trends over the last twenty years in USA and UK have changed the delivery of mental health care. They are the rise of for-profit managed care and evidence-based practice.[8] Managed care systems have dramatically reduced length of stay for psychiatric inpatients, while health maintenance organisations (HMO) in the USA have been contracting non-psychiatrists to offer different treatment modalities even to employees at their work place. The introduction of "care management" in UK has established community-based mental health care and reducing mental health expertise base in hospitals. Mental health care is not only provided in hospitals but in a variety of community settings such as residential houses, prisons, courts, schools, sports centres etc. In part this reflects the expansion of translational research in psychiatry which was bound to influence the provision of mental health care and the boundaries between researchers and clinicians. In addition, networks of global collaboration between mental health professionals, researchers and organisations, profit and non-profit, may be expected to influence the standardisation of diagnoses and therapeutic interventions.

During the same time, health care has evolved into huge enterprise, what some may be tempted to call an "industrial complex". As such, the medical profession has become a component of an industry in which issues of public policy, market forces, and consumer demands are key influences, along with developments in the clinical sciences.[41] Increasingly non-professional workers are delivering health-care in psychiatry and beyond. Is all this a contemporary trend towards de-professionalization of psychiatry? Is the story of post war psychiatry one of a process whereby clinicians have gone from being independent professionals to becoming case mangers, from "practitioners of an art to providers of technological services"?[42]

Professionalism in medicine is defined[43] as "the norms that guide the relationships in which physicians engage in the care of patients". A "new professionalism" is emerging as a consequence of this industrialisation of healthcare and advances in information technology, improved literacy about health care in the community and changing social expectations.[40] This implies in psychiatry a contract between the medical profession and society.[44]

Looking to the future, it is important that the profession recognises the impact ideology can make, if it is not to remain constantly on the defensive. In order to engage proactively and effectively with ideology as well as clinical science and evidence based service development, psychiatry as a profession will do best to approach significant future policy, practice and service changes, by adopting an ethical approach as a form a social contract.

Bhugra et al[45] identified specialised training and skills, expert assistance, trustworthiness, efficacy and devotion to serve the best interests of society as core

components of professional ethics. Ikkos[46] emphasises that psychiatrists must maintain an unflinching focus on the human rights, welfare and social inclusion of people with mental illness and learning disability, as they are amongst the most vulnerable in society. Ikkos et al[44,47] add that the profession must at the same time attend increasingly to choice and personalization in mental health services. They conclude that the essentials of psychiatric professionalism are the 7 Es: attention to *evidence*, *emotions* and *ethics*, *engagement* in service development and quality assurance, integration of these in clinical *expertise*, *education and research* for future care and commitment to the *empowerment* of patients.

Discussion

A brief paper like this cannot do full justice to the complexities of issues involved. Some might argue that ideology in mental health goes further back to the therapeutic community movement of Maxwell Henderson, yet others would point to the importance of the religious ideologies of compassion, which drove both Christian and Muslim societies to establish mental health care in religious institutions in long distant years. All we have attempted to illustrate here is a preliminary sketch of some ideas and developments relevant to ideology and mental health. As Powell's quote confirms, ideology is a powerful motivator for change.

Another limitation of our article is the limited analysis of ideology itself. We have aimed at what may be hopefully a reasonably clear exposition of some ideologies directly related to mental health. However, we have not attempted a review of ideologies which operate at the broader societal level. One of the interesting characteristics of developments in mental health in the last 50 years is that they commanded considerable consensus. Yet right wing libertarian ideologues have very different motivations from their more communitarian adversaries. Their differences notwithstanding, they seem to have argued for a common cause. Perhaps the more extreme elements on each side argued more fervently and therefore effectively and overcame the hesitations of their more moderate colleagues, including sceptical psychiatrists and others.

It is a common error of young psychiatrists in training to believe that concentration on the study of the brain will reveal the substance of the specialty. This belief is not supported by the evidence, yet it persists well into later practice in many. This is not entirely negative in its consequences, because of all medical specialists psychiatrists need to have the best understanding of the brain. We do not find ourselves in the relatively comfortable position of neurologists who can identify concrete lesions. We have the bigger challenge of understanding the integrative function and malfunction of the brain in a wider context and this demands deeper understanding. Others have emphasised the importance for clinical practice of placing study and understanding of the brain on a par with understanding of family, relationships and culture. Here we have attempted to add ideology to what is a long list of relevant concerns.

Psychiatrists must pay increasing attention to understanding values as expressed by ideologies, working in a collaborative way with other mental health professionals, involve service users and manage systems as well as be competent in clinical assessment and treatment.

Whether in time of plenty or in times of deprivation, ideology produces effects on practice and in the context of constantly changing knowledge and the current financial stress this is likely to be more the case (and not less) in the foreseeable future. Psychiatrists must take into consideration the new social problems seen in some high income countries with the increased availability of highly potent "street drugs", perceived threats from various immigrant and minority communities and breakdown of "social capital" such as the decline of the nuclear family. There is also an increasing emphasis on "market" models for health care-based on transactions of health "goods", provided by "suppliers" (mental health professionals) and "chosen" by "consumers (patients)" with some expectations that the "market" then takes care of quality and rationing. Psychiatric practice will no doubt continue to evolve and psychiatrists will need constant renewal of knowledge and skills to keep up to date with scientific, technical and organisational developments. Challenging though this may be, it is necessary in order to secure and develop psychiatry's contract with society, fulfil our professional role and transform public perceptions and expectations of mental health.

Ιδεολογία, ψυχιατρική πρακτική και επαγγελματισμός

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Η Ψυχιατρική, η οποία αναντίρρητα συνδέεται με κοινωνικούς και πολιτισμικούς παράγοντες, έχει υποστεί ριζικές αλλαγές κατά τη διάρκεια των τελευταίων 50 ετών. Αξίες, πεποιθήσεις και ιδεολογίες άσκησαν σημαντική επιρροή στη διαμόρφωση της σύγχρονης ψυχιατρικής. Η αποϊδρυματοποίηση, οι αρχές της ομαλοποίησης, η συνηγορία και το μοντέλο της αποκατάστασης αποτελούν ιδεολογίες που έχουν συνδεθεί στενά με τις πολιτικές, τη διαμόρφωση των συστημάτων παροχής υπηρεσιών ψυχικής υγείας και την κλινική ψυχιατρική. Ατενίζοντας το μέλλον, είναι σημαντικό για την Ψυχιατρική να αναγνωρίσει τις επιπτώσεις που μπορεί να έχουν οι ιδεολογίες στην κλινική πράξη. Οι ψυχίατροι πρέπει να δώσουν μεγαλύτερη προσοχή στην κατανόηση των αξιών όπως εκφράζονται από ιδεολογίες και να συνεργαστούν ενεργά με άλλους επαγγελματίες ψυχικής υγείας και με τη συμμετοχή των χρηστών των υπηρεσιών στη διαχείριση των συστημάτων παροχής υπηρεσιών ψυχικής υγείας, καθώς και στην κλινική πράξη και στις θεραπευτικές μεθόδους. Οι ψυχίατροι πρέπει να λάβουν υπόψιν τους τα νέα κοινωνικά προβλήματα που εμφανίζονται σε ορισμένες χώρες υψηλού εισοδήματος με την αύξηση της χρήσης των ναρκωτικών, τις προκλήσεις από διάφορες ομάδες μεταναστών και μειονοτικών κοινοτήτων, καθώς επίσης και τη μείωση του «κοινωνικού κεφαλαίου», όπως π.χ. η πυρηνική οικογένεια. Ένα σχήμα «νέου επαγγελματισμού» αναδύεται ως συνέπεια σειράς αλλαγών στον τομέα της ψυχικής υγείας που πρέπει να καθοδηγείται από τα υψηλότερα πρότυπα φροντίδας. Ο καλύτερος τρόπος για να συνοψιστεί το νέο αυτό πρότυπο επαγγελματισμού στην ψυχιατρική είναι ως ένα κοινωνικό συμβόλαιο με την κοινωνία.

Λέξεις ευρετηρίου: Ιδεολογίες, αποϊδρυματοποίηση, ομαλοποίηση, συνηγορία, αποκατάσταση, επαγγελματισμός.

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Research article
Ερευνητική εργασία

Predictors and characteristics of anxiety among adolescent students: A greek sample

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In the Greek society, there is a strong cultural tendency to overestimate the value of University studies. So students are under high emotional pressure during the long lasting period of the preparation for the university entrance exams. The aim of the present study was to evaluate the level of anxiety in a general adolescent population of senior high school students in Athens, Greece. Also to examine the association between the anxiety's severity with various demographic and socio-cultural factors, as well as with academic performance, extracurricular activities, sleep duration and presence of somatic problems. The sample consisted of 696 adolescent students of three Senior High Schools (SHS) (391 girls and 305 boys). Two of the schools were general education institutions (GE1 and GE2, N=450), while the third was a technical one (TE, N=246). The school sample was selected to reflect the proportion between the two different types of SHSs in Athens as well as other major urban areas in Greece. The State-Trait Anxiety Inventory was administered and personal data were also collected. Statistical significance was set at $p<0.05$ and analyses were conducted using STATA 7.0. 567 adolescents lived with both parents and 121 with one or none of them. Father's educational level was low for 138, middle for 154, high for 195 and mother's was low for 135, middle for 417, high for 140. The average sleep duration was 7.5 hours per day (SD=1.3). The average time per week spent in school related activities was 7.94 hours (SD=7.56) and in extracurricular activities was 9.02 hours (SD=12.44). 107 adolescents reported somatic complaints in the last year.

The academic achievement was poor for 233, good for 264, excellent for 196 students. Adolescents with extracurricular activities for more than 11 hours per week had lower scores, both on State and Trait scales. More hours in school-related activities were associated with greater levels of Trait anxiety. Adolescents whose father had a high educational level had lower scores on State anxiety compared to those whose father had a low educational level. Adolescents who reported the presence of somatic problems had a higher score in Trait anxiety. A significant negative correlation was found between sleep duration and both State ($r=-0.14$, $p<0.001$) and Trait anxiety ($r=-0.10$, $p=0.008$) scores. Stepwise linear regression analyses confirmed the association of gender and of father's educational level with both State and Trait subscale scores. The association of somatic problems with Trait anxiety was greater for girls compared to boys. The hypothesis that there is exam-related anxiety in our sample was not confirmed. There were no differences between school years and GE and TE schools. Also there was not an association of anxiety level with academic achievement and the number of parents the adolescent was living with. This study shows that girls, especially those reporting somatic problems, and adolescents coming from families with low parental education, are particularly prone to higher level of anxiety and that extracurricular activities are linked to lower level of anxiety. These findings could contribute to the planning of preventive measures for student's anxiety.

Key words: Adolescent, anxiety, extracurricular activities, school performance, sleep, gender, greek sample

Introduction

Feelings of anxiety are very common during adolescence. A wide range in the prevalence of anxiety disorders, ranging from 5.7% to 17.7% is reported.[1] As it is shown in various studies, anxiety in adolescents is related to gender, academic requirements (in particular, pending exams), sports, family structure and socioeconomic status (SES), sleep duration and somatic problems.

Regarding gender, there is a preponderance of female adolescents among current and recovered anxiety disorder cases;[2,3] female preponderance emerges early in life, and rates increase with age.[4] Prior to taking exams, students may display higher levels of anxiety and perceived stress. Stress levels experienced during school exams are correlated to low test performance and to low self-rated evaluation of self-esteem;[5,6] on the other hand, decreased anxiety is predictive of improved school performance and social functioning.[7] Physical activity promotes well-being in adolescents and reduces levels of anxiety.[8] Family status, especially divorce, impacts on symptoms of anxiety and depression during adolescence.[9] Adolescents with low family's SES are more prone to experience anxiety.[10] Finally, somatic problems and sleep duration have been found to correlate with anxiety levels in adolescents.[11,12]

In addition to the above, specifically for the Greek society, there is a strong cultural tendency to overestimate the value of University studies. So the Greek families put a considerable amount of emotional pressure on their children during the long lasting period of the preparation for the university entrance exams.[13] The last three years of Senior High School, all students prepare for these exams. Students, in parallel to school classes, usually receive private tutoring, which is financed at great cost by their family.[14] This additional economic burden contributes to an even higher pressure for achievement, which is reflected in the family's expectations.[15]

The aim of the present study was to evaluate the level of anxiety in a general adolescent population of senior high school students in Athens, Greece. We hypothesized that the anxiety level of our sample would be higher compared to those of other countries due to the Greek particularities. Another aim was to examine the association between the

anxiety's severity with various demographic and socio-cultural factors, as well as with academic performance, extracurricular activities, sleep duration and presence of somatic problems. We expected to identify which of those factors lead to increase or reduction of anxiety among adolescents. This is important for the development of therapeutic and preventive strategies.

Material and method

Participants

Our initial sample included the entire student population, consisted of 753 adolescent students (aged 15–18 years) attending Grades 1–3 of three state-run Senior High School (SHS) in the Greater Athens Metropolitan Area. 40 students did not agree to participate in the study and 17 did not complete the anxiety scales fully and thus were not included in the analysis.

Consequently, our final sample consisted of 696 adolescent students (391 girls and 305 boys, 160 in the first year, 290 in the second and 246 in the third). Two of the schools were general education institutions (GE_1 and GE_2, N=450), while the third was a technical one (TE, N=246). Students of general education schools take part in the national baccalaureate exams (National University Entrance Exams) at the end of their third year in order to apply for university entrance; students in technical education (TE) schools, also take part in national-level exams, but these are less demanding, with considerably less competition, and lead to a polytechnic-type technical higher education. The school sample was selected to reflect the proportion between the two different types of SHSs in Athens, as well as other major urban areas in Greece; at the time of the study, there were 129 general education (GE) and 85 technical education (TE) SHSs, with 28,045 and 22,450 students respectively (National Statistics of Greece, 2007).

Procedure

For the realisation of this study we obtained approval by the Ethics Committee of our Hospital. Self-administered questionnaires were distributed by a social worker or a psychologist with the mediation and assistance of the teachers to all the students of all three grades of the participating schools around the end of the first trimester (November-December). The investigators informed the students about the nature of the questionnaires and consent was obtained from each student. Time taken to complete the whole questionnaire was approximately 35 minutes.

The questionnaire had an introductory section in which the following data were recorded: school, grade, gender, living with none, one or both parents, parental educational level (low=up to six years of formal education, middle=6–12 years of formal education, high=university studies), time spent per week in school-related (tutorials, courses, etc) and extracurricular (sports etc) activities, sleep duration, presence of somatic complaints, and academic performance during the previous year (1=poor, 2=good and 3=excellent achievement) based on existing school records.

The students were then asked to complete the State-Trait Anxiety Inventory (STAI)[16] which has been validated in the Greek population[17,18] and consists of two separate, 20-item self-report scales for measuring two distinct anxiety concepts. The STAI has been widely used to measure anxiety across the world[19] and has been used in prior investigations to assess anxiety in adolescents.[20–22] The State anxiety subscale is completed in relation to how the respondent feels at present, whereas the Trait anxiety subscale is completed with regard to how the respondent usually feels.

Statistical analysis

Variables were first tested for normality using the Kolmogorov-Smirnov criterion. For State and Trait scales the aforementioned criterion indicated a $p>0.05$, so the normal assumption was satisfied. Hours in extracurricular and school-related activities were categorized into two categories using the 75th percentile of the distribution. The association of State and Trait scales with demographics and other variables of interest were explored using Student's t-tests and analysis of variance (ANOVA) with Bonferroni correction depending on the nature of data. Pearson correlation coefficients were com-

puted in order to explore the association of State and Trait scales with sleep duration. Consequently, all variables which were found to be associated with anxiety at a statistically significant level in the univariate analysis were entered in a multiple linear regression analysis using stepwise backward elimination, with p for removal equal to 0.1 and p for entry equal to 0.05, in order to find the best model fitting our data. Coefficients of determination (adjusted R_2) were reported as a measure of variation that is explained by the model. All reported p values are two-tailed. Statistical significance was set at $p<0.05$ and analyses were conducted using STATA 7.0 (STATA, College Station, TX, USA).

Results

Of our respondents, 567 lived with both parents and 121 (17, 4%) with one or none of them; for 8 data was missing. The educational level of the father was low for 138, middle for 154 and high for 195; for 9 data was missing. The educational level of the mother was low for 135, middle for 417 and high for 140; for 4 data was missing. The average sleep duration of the participants was 7.5 hours per day (SD=1.3). The average time per week spent in school related activities was 7.94 hours (SD=7.56) and in extracurricular activities was 9.02 hours (SD=12.44). 107 participants reported somatic complaints or conditions in the last year for which they have consulted a physician. The academic achievement was poor for 233, good for 264 and excellent for 196 students; for 3 data was missing.

Average scores for the State and Trait subscales were 47.4 (SD=12.8) (item score M=2.37, SD=0.64) and 46.6 (SD=10.1) (item score M=2.33, SD=0.51), respectively. Univariate analyses revealed that females compared to males had greater scores for both scales (table 1).

Adolescents with extracurricular activities for more than 11 hours per week had lower scores, both on State and Trait scales. On the contrary, more hours in school-related activities were associated with greater levels of Trait anxiety. Additionally, adolescents whose father had a high educational level had lower scores on State anxiety compared to those whose father had a low educational level, while adolescents who reported the presence of somatic problems had a higher score in Trait anxiety. A significant negative correlation was found between sleep duration and both State ($r=-0.14$, $p<0.001$) and Trait anxiety ($r=-0.10$, $p=0.008$) scores. Stepwise linear regression analyses confirmed the association of gender and of father's educational level with both State and Trait subscale scores (table 2).

Multiple analyses also revealed a significant interaction of gender by somatic problems, indicating that the association of somatic problems with Trait anxiety is greater for girls compared to boys. Hours in school-related activities (more than 14 per week) were positively associated with Trait anxiety, while hours in extracurricular activities (more than 11 per week) were negatively associated with State anxiety. Longer sleep duration in multiple analyses was found to be associated with lower State anxiety scores.

According to R_2 coefficients, the variance of the model explained by the covariates was 8% for State anxiety and 9% for Trait anxiety. As defined from the standardized regression coefficients, gender had the greatest effect on both State and Trait anxiety.

Discussion

The scores for State and Trait anxiety derived from the STAI in our population are comparable to those found in a study of adolescents in Hawaii, [mean score per item for State anxiety was 1.98 (SD=0.55) and for Trait was 2.14 (SD=0.54) 21] and in another study of post-adolescents in Portugal [mean for Trait anxiety in the sub-sample younger than 30 years old was 43.8 (SD=10.7) 20]. Our findings show a higher score than in a study of American students [where mean State anxiety was 29.95 (SD=6.19) for girls and 29.68 (SD=6.15) for boys, and mean Trait anxiety was 34.15 (SD=5.86) for girls and 31.73 (SD=7.20) for boys]; in that study, however, the mean age of the sample was 3 years lower than of ours.[22]

The hypothesis that there is exam-related anxiety in our sample was not supported by our findings. There were no differences between school classes,

Table 1. Univariate associations of State and Trait Anxiety scales with factors under investigation.

		State			Trait		
		Mean	**SD**	**p**	**Mean**	**SD**	**p**
Gender	Males	45.0	11.9	<0.001*	44.2	8.9	<0.001*
	Females	49.3	13.3		48.5	10.6	
Class	1st	46.1	12.7	0.075**	46.1	9.9	0.306**
	2nd	48.3	13.0		47.4	10.5	
	3rd	48.3	12.7		46.4	9.7	
School	TE	48.0	12.4	0.338*	46.1	10.5	0.322*
	GE1–GE2	47.0	13.1		46.9	9.9	
School record	0–13	48.0	12.2	0.334**	46.5	9.6	0.774**
	13.1–16	47.7	13.0		47.0	10.3	
	>16	46.3	13.4		46.3	10.6	
ECA(hours)	≤11	48.1	13.0	0.007*	47.1	10.1	0.026*
	>11	45.0	12.2		45.1	9.9	
SRA(hours)	≤14	46.9	12.7	0.083*	46.1	10.1	0.026*
	>14	48.9	13.2		48.1	9.9	
Number of parents living together	Both	46.9	12.7	0.070*	46.6	10.0	0.873*
	None-One	49.3	13.2		46.5	10.4	
Educational level of the father	Low A	49.3 C	14.1	0.029**	47.3	10.8	0.256**
	Middle B	47.7	12.4		46.9	9.8	
	High C	45.6 A	12.3		45.6	10.0	
Educational level of the mother	Low	47.8	13.5	0.676**	46.6	10.2	0.850**
	Middle	47.5	12.8		46.7	10.0	
	High	46.6	12.5		46.2	10.6	
Somatic problems	No	47.5	12.6	0.086*	46.6	9.7	0.014*
	Yes	49.9	13.8		49.2	10.2	
Drugs	No	47.7	12.9	0.851*	47.1	10.0	0.910*
	Yes	47.1	12.0		47.3	10.5	

*Student's t-test, **Analysis of variance (ANOVA); A, B, C indicates significant differences after Bonferroni correction

which would indicate that anxiety is worse in the last critical year before the university entrance exams. Also, there were no differences between GE and TE schools, a finding suggesting that increased anxiety is not associated with the degree of difficulty of upcoming examinations.

Our results indicate that female students had greater scores than male students in both Trait and State anxiety subscales. Our findings are similar to those reported in other studies.[2,3,12,20–24]

The results of the present study indicate that adolescents spending more time on extracurricular activities had lower scores, both on State and Trait scales compared to adolescents spending less time on extracurricular activities. In our study the majority of extracurricular activities related to physical

Table 2. Multiple linear regression models with dependent variable the State and Trait Anxiety scales.

	State				Trait			
	β	SE	β*	p	β	SE	β*	p
Gender								
Males, reference								
Females	3.43	1.02	0.13	0.001	3.37	0.93	0.17	<0.001
ECA(hours)								
≤11, reference								
>11	–2.42	1.17	–0.08	0.039				
SRA (hours)								
≤14, reference								
>14					1.98	0.94	0.09	0.036
Educational level of the father								
Low, reference								
Middle								
High	–0.95							
–2.86	1.32							
1.45	–0.04							
–0.10	0.471							
0.049								
Sleep duration	–1.29	0.39	–0.13	0.001				
Somatic problems								
No, reference								
Yes					0.26	1.56	0.01	0.865
Interaction of gender by somatic problems					4.47	2.07	0.15	0.031

Abbreviations: β=regression coefficient; SE=standard error; β*=standardized regression coefficient

activity. The physical exercise is related to psychological well being; adolescents who engaged regularly in physical activity were characterized by lower anxiety and depression scores, as well as better sleep patterns.[25,26] It has been also pointed out that there exists a strong negative relationship between the intensity of physical activity and psychological distress during adolescence.[27–29]

On the other hand, more hours of school-related activities (i.e. mainly assistive tutorials) were associated with greater levels of Trait anxiety. We have not identified any studies assessing the relationship between time spent in studying and anxiety. Our finding could be explained both ways: Students with a stronger propensity to develop anxiety (as indicated by higher Trait anxiety levels) feel more insecure about their knowledge and resort to more tutoring, or are more inclined to seek school assistance due to an orientation towards higher achievement. It is equally possible that excessive time spent studying increases anxiety.

In our study we did not observe an association of anxiety level with academic achievement. Several studies have shown that the presence of anxiety

symptoms is associated with low achievement in reading, mathematics and general measures of academic achievement.[30,31] In one study, however,[32] on a community sample of children and adolescents, the prevalence of abnormally high level of anxiety was negatively associated with school performance; nevertheless subjects with poor school performance did not display, as a group, a level of anxiety symptoms higher than subjects with better academic grades. This result, similar to our findings, might indicate that anxiety interferes with school functioning only when an abnormal anxiety level is reached, and whereas within the "normal" range, being more anxious does not automatically imply worse school functioning.

Concerning family status, we found that level of anxiety was not associated with the number of parents the adolescent was living with. This is in accordance with a recent study where family composition was not a significant risk indicator of high level of anxiety in adolescence.[3] As it is already pointed out, it seems that poor parental relationship and not family status, is associated with high anxiety in adolescents of divorced and married households.[33]

As shown by lower scores in the State anxiety subscale, the current level of anxiety experienced by adolescents was lower when the father's educational level was higher. This is in accordance with a study in which it was found that as the main wage-earner's educational level increased, the students' STAI scores tended to decrease.[21] Furthermore, father's education can be considered a proxy of the socio-economic status (SES) of the family. It has been found that youths growing up in low-income families show grater levels of depression and anxiety during adolescence.[10,34] In a systematic literature review has pointed out that the prevalence of depressed mood or anxiety was 2.49 times higher in youths from families with low SES in comparison to those with higher SES.[35]

Trait anxiety was found to be associated with seeking medical advice for somatic problems. This association was found to be stronger for girls compared to boys. In other studies, it has also been found that somatic symptoms, physical illnesses and somatisation are highly prevalent among children and adolescents with anxiety disorders and are associated with greater anxiety level.[12,36–38] Especially for girls, stomach aches and musculoskeletal problems are associated with anxiety disorders.[39] Our results are in line with the above findings and support the contention that screening youngsters seeking medical care due to unexplained physical symptoms may enhance the recognition of anxiety disorders and facilitate access to appropriate services.[40,41]

A significant negative correlation was found between sleep duration and both State and Trait Anxiety scales. Sleep-related problems of adolescents are positively associated with anxiety disorders, anxiety severity and interference in family functioning.[42,43] In a previous study we have observed that sleep is less for students spending more time in various school-related and extracurricular activities,[44] while the authors of another study have suggested that the direction of causality is that activities and stress influence sleep.[45] Similarly, it has been observed that delayed sleep phase (common among adolescents) is associated with elevated level of anxiety[46] and it has been suggested that assessment and intervention efforts targeting sleep disturbance in adolescents will exert an overall effect on reducing anxiety level.[43]

In conclusion, our findings confirm that females have more anxiety than males and that the effect of somatic problems on anxiety is greater for girls than for boys. It also supports that fathers' educational level plays a role in anxiety and that shorter sleep duration is associated with greater anxiety. Our results also provide novel evidence that time spent in extracurricular activities is negatively associated with anxiety level among adolescents students.

The limitations of our study were that the sample was restricted to an urban population of students attending state-run schools located in middle-class neighbourhoods. The self-reporting nature of the scales and the questionnaire used may have had an impact on the results. Our research did not include diagnostic clinical evaluation and therefore no diagnosis of anxiety disorders or other psychopathological conditions can be provided. Finally, in order to make the comparison of anxiety level during exam and non-exam periods, we compare students

across different years with the rationale that those in their last year would experience more stress because of university entrance exams, instead of comparing the last year students repeatedly during the year, as they approach the exams period.

One of the main contributions of our research is the identification of vulnerable adolescents. That is, our study shows that girls, especially those reporting somatic problems, and adolescents coming from families with low parental education are particularly prone to higher level of anxiety. Therefore, emphasis should be given in the identification of these adolescents in order to promote the treatment of existing anxiety and the prevention of anxiety symptoms.

Other important findings are that extracurricular activities are linked to lower level of anxiety in the adolescent population and that there was a negative correlation between sleep duration and measures of anxiety. Although the direction of causality of these associations cannot be easily established, it could be proposed that the reinforcement of extracurricular activities could result in a reduction of anxiety among students and that adequate sleep may be a protective factor against anxiety.

Προγνωστικοί δείκτες και χαρακτηριστικά του άγχους μεταξύ των εφήβων μαθητών: Ένα ελληνικό δείγμα

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Στην ελληνική κοινωνία υπάρχει μια ισχυρή πολιτισμική τάση για ακαδημαϊκή επιτυχία των εφήβων. Οι μαθητές βρίσκονται κάτω από μια συνεχή και μεγάλη συναισθηματική πίεση να ανταποκριθούν στις προσδοκίες της οικογένειάς τους, ιδιαίτερα κατά τη μακρά διάρκεια της προετοιμασίας τους για τις εισαγωγικές εξετάσεις στην τριτοβάθμια εκπαίδευση. Ο σκοπός της παρούσας μελέτης ήταν να αξιολογηθεί το επίπεδο του άγχους σε έναν γενικό πληθυσμό των εφήβων μαθητών Λυκείου στην Αθήνα. Επίσης, η διερεύνηση της σχέσης μεταξύ της σοβαρότητας του άγχους με δημογραφικούς και κοινωνικο-πολιτιστικούς παράγοντες, καθώς και με τη σχολική επίδοση, τις εξωσχολικές δραστηριότητες, τη διάρκεια του ύπνου και την παρουσία σωματικών προβλημάτων. Το δείγμα αποτελούνταν από 696 έφηβους μαθητές από τρία Λύκεια (391 κορίτσια και 305 αγόρια). Δύο Λύκεια γενικής εκπαίδευσης (ΓΕ$_1$ και ΓΕ$_2$, N=450) κι ένα τεχνικό (ΤΕ, N=246). Τα συγκεκριμένα Λύκεια επιλέχθηκαν ώστε να αντανακλούν την αναλογία μαθητών μεταξύ των διαφορετικών κατευθύνσεων. Χορηγήθηκε το ερωτηματολόγιο άγχους του Spielberg (State-Trait Anxiety Inventory) και έγινε συλλογή και καταγραφή των δημογραφικών και προσωπικών στοιχείων. Η στατιστική σημαντικότητα ορίστηκε στο p<0,05 και οι αναλύσεις έγιναν με τη χρήση STATA 7.0. Οι 567 έφηβοι ζούσαν με δύο γονείς και 121 με έναν ή κανέναν. Το μορφωτικό επίπεδο του πατέρα ήταν χαμηλό για 138, μεσαίο για 154, υψηλό για 195 ενώ της μητέρας ήταν αντίστοιχα 135, 417, 140. Η μέση διάρκεια ύπνου ήταν 7,5 ώρες την ημέρα (SD=1,3). Ο μέσος χρόνος που δαπανάται ανά εβδομάδα σε δραστηριότητες που σχετίζονται με το σχολείο ήταν 7,94 ώρες (SD=7,56) και σε εξωσχολικές δραστηριότητες ήταν 9,02 ώρες (SD=12,44). 107 έφηβοι ανέφεραν σωματι-

κές ενοχλήσεις κατά το τελευταίο έτος. Η επίδοση στα μαθήματα ήταν κακή για 233, καλή για 264, πολύ καλή έως άριστη για 196 μαθητές. Οι έφηβοι με εξωσχολικές δραστηριότητες για περισσότερο από 11 ώρες την εβδομάδα είχαν χαμηλότερα σκορ και στις δύο υποκλίμακες άγχους (State-Trait). Περισσότερες ώρες ενασχόλησης με ενδοσχολικές δραστηριότητες σχετίζονται με υψηλότερα επίπεδα άγχους στην υποκλίμακα Trait. Οι έφηβοι με πατέρα υψηλού μορφωτικού επιπέδου είχαν χαμηλότερο σκορ στην υποκλίμακα άγχους State σε σύγκριση με εκείνους των οποίων ο πατέρας είχε χαμηλό μορφωτικό επίπεδο. Οι έφηβοι που ανέφεραν την παρουσία σωματικών προβλημάτων είχαν υψηλότερο σκορ στην υποκλίμακα Trait. Σημαντική αρνητική συσχέτιση βρέθηκε μεταξύ της διάρκειας του ύπνου και στις δύο υποκλίμακες άγχους, State (r=–0,14, p<0,001) και Trait (r=–0,10, p=0,008). Η σύνδεση των σωματικών προβλημάτων με την υποκλίμακα Trait ήταν μεγαλύτερη για τα κορίτσια σε σχέση με τα αγόρια. Η υπόθεση ότι οι εξετάσεις σχετίζονται με περισσότερο άγχος δεν επιβεβαιώθηκε. Δεν υπήρχαν διαφορές μεταξύ της σχολικής τάξης και της διαφορετικής κατεύθυνσης. Επίσης, δεν υπήρχε συσχέτιση του επιπέδου του άγχους με την ακαδημαϊκή επίδοση και τον αριθμό των γονέων με τους οποίους ζούσε ο έφηβος. Τα ευρήματα αυτά θα μπορούσαν να συμβάλουν στον σχεδιασμό προληπτικών μέτρων για την αντιμετώπιση του μαθητικού άγχους. Ιδιαίτερη προληπτική αξία έχουν εκείνα που δείχνουν ότι τα κορίτσια με σωματικά προβλήματα, καθώς και οι έφηβοι που προέρχονται από οικογένειες με χαμηλό μορφωτικό επίπεδο των γονέων, είναι ιδιαίτερα επιρρεπείς σε υψηλότερα επίπεδα άγχους. Αξιοσημείωτο είναι και το γεγονός ότι οι εξωσχολικές δραστηριότητες συνδέονται με χαμηλότερο επίπεδο άγχους.

Λέξεις ευρετηρίου: Έφηβος, άγχος, εξωσχολικές δραστηριότητες, σχολική απόδοση, ύπνος, φύλο, ελληνικό δείγμα

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Special article
Ειδικό άρθρο

Greek mental health reform: Views and perceptions of professionals and service users

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The Greek mental health system has been undergoing radical reforms for over the past twenty years. In congruence with trends and practices in other European countries, Greek mental health reforms were designed to develop a community-based mental health service system. The implementation of an extensive transformation became possible through the "Psychargos" program, a national strategic and operational plan, which was developed by the Ministry of Health and Social Solidarity. The Psychargos program was jointly funded by the European Union by 75% of the cost over a period of 5 years and the Greek State. After the period of 5 years, the entire cost of the new services became the responsibility of the Greek National Budget. Over the years the Psychargos program became almost synonymous with the deinstitutionalisation of long term psychiatric patients with the development of a wide range of community mental health services. The Psychargos program ended in December 2009. This article presents the views of service providers and service users as part an ex-post evaluation of the Psychargos program carried out in 2010. Data derived for this part of the evaluation are from the application of the qualitative method of focus groups. The outcomes of the study identified several positive and noteworthy achievements by the reforms of the Greek mental health system as well as weaknesses. There was considerable similarity of the views expressed by both focus groups. In addition the service users' focus group emphasized more issues related to improving their mental health wellbeing and living a satisfying, hopeful, and contributing life.

Key words: Psychiatric reform, service users, focus groups

Introduction

The greek psychiatric reforms started in 1984 with the European Community regulation 815, having the following main aims in transforming the existing mental health system:

a. Mental health professionals training.

b. Development of a decentralized community network of preventive and treatment services.

c. Deinstitutionalisation of chronic mental patients and a reduction of admissions to mental hospitals.

Over a 10 year period since 1984 and with the implementation of time limited projects, new policies and substantial financial assistance from the European Union, several positive outcomes were achieved,[1] such as:

- Reduction of psychiatric beds
- Development of community mental health services (mental health centres, day centres, supported residential services)
- Reduction of the average length of stay in mental hospitals
- Increase of staff numbers.

It was, however, the Psychargos program that accelerated and expanded developments for community based services. The Psychargos program started initially as a ten-year plan (from 1997 to 2006) continuing of the psychiatric reforms with the deinstitutionalisation of long term psychiatric patients and their resettlement into the newly established community mental health network of services. In 1999, however, serious damage was caused by a strong earthquake in the Athens area, making a large part of the existing long stay mental hospital uninhabitable. This unexpected adverse event forced the authorities to extend the initial time-frame and imposed a re-distribution of the available budget. Therefore the Psychargos program was reviewed and implemented in two periods. The first phase was in 2000–2001 and the second lasted from 2001 to December 2009. There are studies that have described different phases of the psychiatric reforms in Greece e.g.[2–7] There have also been several studies in Greek.

The actions of the first phase included: training of mental health professionals, infrastructure improvements, and intervention to improve patients' daily living and employment skills in preparation for community living.

Deinstitutionalisation and the development of community-based mental health services remained core targets and began to be implemented during the second phase of Psychargos programme. For the first time the Greek mental health system set specific targets towards the closure of mental hospitals, the development of psychiatric services located in general hospitals, and an expansion of specialist mental health services, e.g. for children and adolescents, people with substance and alcohol dependency, for people with autistic spectrum disorders, those with Alzheimer disease, etc. An important core target was the sectorisation of mental health services, i.e. focusing and coordinating care in relatively small discrete geographical areas across the country.

Methodology

An "Ex post" evaluation of the implementation of the "National Action Plan Psychargos 2000–2009" of the psychiatric reforms was commissioned in 2010 by the Greek Ministry of Health at the request of the European Union. The main aim of the ex post evaluation was to assess the effectiveness of actions and interventions in relation to selected targets and the implementation of the overall strategies and policies that were developed for the psychiatric reform in Greece.

The methodology applied for this ex-post evaluation aimed at gathering information about the structure, operation and outcomes of the overall mental health service system, as well as in depth assessments of selected specific services and units. For this purpose quantitative and qualitative data were collected based on multiple research methods and tools through diverse sources and participants.[8] An important factor in assessing the quality of a system is to collect information on the views and perspectives of those managing and working in the system and those who ultimately use it. The incorporation of a qualitative dimension broadened the evaluation's scope to include dimensions such as the organization, operation, coordination of the service system and the impact of changes to health care personnel, to service users' and their families. This article is concerned with qualitative data relating to

the views of service providers and service users derived by employing focus groups. Focus groups have been increasingly used in qualitative mental health research. Focus groups allow people to build on others' responses and come up with ideas they might not have thought of in a one on one interview.[9] They are very cost effective in terms of gathering primary data and they are also very much time efficient.

Two separate focus groups were carried out, one with service providers with diverse backgrounds and expertise and a second with service users. Both focus groups dealt with the overall operation and effectiveness of the mental health system as well as with the process of the psychiatric reforms. Communication was supported by an interpretation service.

The service providers' focus group consisted of 30 people, from diverse mental health disciplines (adult and child psychiatry, psychology, social work, and managers) who represented the broad spectrum of mental health services (public sector, NGOs, university departments, scientific committees, special committees, etc). The private sector was not included in the specifications of the commission of the evaluation. During the five hour procedure, participants were asked to present their views on a list of subjects that the evaluation team had prepared. For the selection of service providers' focus group, attention was given to the representativeness of participants according to the following criteria:

- Degree of engagement to the planning and implementation of the Psychargos program. Preference was given to those with longer involvement with the Psychargos program
- Professional background from diverse mental health disciplines and practical knowledge related to the provision of mental health services that were developed through the Psychargos program
- Category of service provided (Mental hospitals, Community Mental Health Centers, Mobile Units) and legal status (Public sector, NGOs, voluntary organizations) of the mental health service that participants were representing
- Geographical distribution of the participating services across different areas of the country.

The second focus group consisted of 15 service users and users' families and lasted 2 hours. The same process was followed for this group as with the first one.

Sampling for the users' focus group involved taking a random selection of members of organizations developed by users and users' families throughout Greece. Attempts to include users who did not belong to such organizations were not successful.

Participants were also asked to respond anonymously in writing to the following questions: what are the necessary future actions, what are or should be the bodies undertaking the implementation of these actions and objectives, what incentives should be given and what are the current difficulties of the mental health system. Although such task is not fully compatible with the meaning and purpose of the focus group method, it was thought to be necessary in order to allow participants' personal opinions to be expressed, unaffected by any possible social pressure. In this way comparisons between written and group answers could be made, that would further lead to more reliable data.

Results

Service Providers Focus Group

All participants acknowledged that there had been a vast increase in the number of new mental health services, which were dispersed geographically across the whole country, even in rural areas. The newly developed services specialized in a range of mental health care, and were provided in a broad range of locations such as day centers, community mental health centers, psychiatric units in general hospitals, children's mental health centers and included some highly specialized services such as for cancer and for postpartum depression. The group unanimously identified as an important result of the program the positive changes of the attitudes of the general public towards mental illness and patients. This cultural change was exemplified through improvements in the living conditions of people suffering from severe and persistent mental illness, schemes of advocacy by service users, initiatives to safeguard service users' rights and to combat stigma. These achievements were made possible through the operation of community based mental health services and the introduction of mental health as an integral aspect of public health.

Participants, however, were critical about several aspects of the implementation of the Psychargos program. While acknowledging that services were now provided in areas where there was no mental health care provision, they also reported significant shortages of staff and services in several parts of the country, particularly in rural areas. One participant stated that "the target of the Psychargos program to develop services in rural areas had been forgotten". Participants referred to major shortages in child mental health and pointed out that there was only one child psychiatrist for the whole Region of Peloponnese. Further in the Ionian island of Kefalonia, when inpatient treatment was required, patients had to be transferred to the town of Tripoli in the main land a long distance away. Participants were particularly critical of the lack of mental health services for children and adolescents and stated that there were grossly underdeveloped with over 20 areas having been without any kind of mental health service for children. The perceptions regarding staff and professionals' training were conflicting, despite the implementation of many staff development activities. For example, these were widely thought to lack a practical focus in community mental health methods.

A major problem was said to be the incomplete implementation of sectorization and the lack of coordination between mental health services and central government, local authorities, social services and other relevant public sector organizations. Participants argued that the lack of coordination had further adverse implications for the efficient management of resources within a coherent system model and continuity of care. This problem appeared to be worse in urban areas and particularly in Athens, where there were more services but less mutual communication and cooperation even in a defined geographical area. Another issue that was brought up prominently by participants was the absence of evaluation and monitoring for the provided services as well as an unclear quality assurance framework.

Participants made the following suggestions necessary for future action that fall within the following four main clusters:

a. The organization of the service system. Almost all participants indicated that the complete implementation of sectorization and the redefinition of the role of the Ministry of Health were fundamental issues needing to be resolved. Although the sectors for mental health services were defined according to geographical criteria and even the sectoral committees had been appointed, only a few were in operation and with limited effectiveness. This dysfunctional status of the sectors necessitated that the Ministry of Health take a centralized managerial role. Hence participants' requested a decentralized operational system with the Ministry of Health, focusing on its policy and planning role.

b. The coordination of the service system across central, regional and local levels. At central level, participants referred to the need for developing strong cooperation between the mental health system and primary health care, the judiciary and the education systems. At regional and local level co-operation was necessary with local administration and social services. It was suggested that mental health services should become coterminous with newly introduced organizational and administrative alterations of the country's Municipalities and Prefectures that were brought in by a new law known as (New Architecture for Local and Decentralized Administration "Kallicrates Program").

c. The accomplishment of full coordination for all mental health services by an identified core service in each geographical area. Most participants suggested that this role should be undertaken by the local community mental health centre, though some expressed reservation unless the role of the community mental health centers was redefined.

d. The development of a monitoring system that would indentify and record the mental health needs of the local population (there is a lack of epidemiological data) but would also build up methods of outcome measurements for all provided services. There was a debate as to who should adopt this role. Some suggested that this role should be undertaken by a commissioned support and monitoring service, while others favoured the establishment of a Central body.

The main feature of the written responses was the high degree of consensus in all four questions. This uniformity could be justified by the similarities par-

ticipants shared in terms of their professional background or –and more probable– by mental health system's salient problems and needs. Extracts of the written responses are clustered in following three categories:

a. *Training and staff development*: "The strategies of the Psychargos programme have not been fully embraced by mental health professionals". "The resettlement to community care with independent living has not been fully achieved". "Training has not gone far enough due to staff shortages and lack of skills and knowledge, particularly for community care, rehabilitation and recovery". "More preparation was needed, as changes were introduced very fast".

b. *Sectorization*: "Lack of comprehensive services to meet all needs". "Sectroral committees are advisory and have no management role". "Reforms started from tertiary care instead of primary care". "There is no coordination of services".

c. *Services*: "Lack of integration of services networks". "A lot of emphasis was given to develop residential services and supported housing". "There is a lack of services for children and adolescents". "Several of the actions have been incomplete". "There are major gaps in trained and experienced staff".

Users' Focus Group

The general perception of the participants in this focus group was that there has been an improvement in the overall conditions of mental health services, better relationships between service users/carers and staff (described as "our voice is heard now") and improvement in public perceptions about mental illness. All participants recognized the following positive aspects of the Psychargos programme:

- The reduction of psychiatric beds and the development of residential and rehabilitation services in the community
- The improvement of service users' conditions in mental hospitals and in outpatient services
- The empowerment of service users' to express themselves and to defend their rights by participating in "mental health organizations and institutions"
- The opportunities of vocational rehabilitation of service users' through the establishment of Social Enterprises (KoiSPE) and thereby of paid work.

The Service users' focus group also expressed concerns related to administrative and operational problems of the implementation of the Psychargos program. Service users pointed out that the deinstitutionalised patients resettled in community services represented only a small proportion of people suffering from mental ill health, with the larger number of sufferers still living with their families or were homeless and in poverty or ended up in private clinics whose quality standards are questionable. They described a heavy reliance on families who often become exhausted and a great difficulty in accessing the service system (especially if they needed residential care/support). Furthermore, service users were concerned about the absence of any system of quality assurance of services. Service users argued that residential services do not fully meet the principles and objectives upon which their purpose and function was based. Hence, for many users boarding and guest houses are viewed as "relocation sites without radical alterations, or complete abolishment of the asylum-model of care".

An additional issue concerned the funding of residential and other types of services. Service user participants were critical about the way budgets were distributed and stated that they thought money were spent "thoughtlessly" and "inefficiently". Other problems expressed by service users were related to their inability to understand the administrative complexities of how to access the service system, the lack of information about the available services, delays in deinstitutionalised patients being resettled in community and residential services, the unacceptable conditions in the remaining mental hospitals, particularly in the use of physical restrain and their exploitation by some of the vocational cooperatives. The service users' focus group summarized their concerns by stating that there was a lack of "vision" and realistic planning, for the future of mental health services.

Service users were straightforward and clear in their suggestions for future actions. These included, focusing 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 care pathways, emphasis on rehabilitation and recovery, vocational support and employment, separate services for adults and

children, appropriate crisis responses, support by general hospitals supporting to mental health services and development of primary mental health care services. Specifically, the service users group suggested the need to:

- Redefine the priorities of the Psychargos program but with the active involvement of all stakeholders, including service users and their families
- Upgrading the participation of families by recognizing their important contribution to patients' care and support
- Develop new service models related to patients' vocational rehabilitation
- Enriching mental health centers' role and immediate operation of crisis intervention teams
- Introduction of quality assurance systems for all mental health services, including those provided by private clinics
- Develop a model of social care for service users who have no financial resources
- Effective implementation of sectorization, with a comprehensive network of services across the country.

Discussion

The development of community care-led systems 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 different forms and continues to be a key question for policy-makers. Overall the transformation of the mental health services in Greece has adopted the prevailing philosophy on values and principles of modern mental health care to local populations.

A remarkable similarity of views was found among service providers and service users in the ex post evaluation of the psychiatric reforms of the Psychargos program. Both focus groups agreed on several positive elements of the reforms, including an extensive service transformation concentrated on deinstitutionalisation with widespread reduction of hospital-based long stay accommodation and the complete closure of some mental hospitals. A large number of community services have been developed in many parts of the country, including Community Mental Health Centres, different types of residential provision, day centres and hospitals, mobile mental health units and vocational services. Local communities have become gradually more accepting of people with mental illness. There are also positive changes in the attitudes of staff towards a more person-centred care.

But both focus groups commented on the fragmented nature of the reforms with a marked lack of coordination, patchy and inadequate provision on the ground, while some reprovision plans enforced timeframes that did not allow for thoughtful planning and implementation. There is inequity in the development of services between different areas around the country and as a consequence some areas are now relatively well provided for 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. Another overarching identified theme relates to staff training and professional development. Important service gaps were described for child and adolescents as well as other specialist mental health services. There is very little interaction among the different components of the services and from a service user and carer point of view this means lack of information about locally available services and poor information flow between different services. There are no quality assurance mechanisms and systems for clinical governance. There is also a paucity of 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.

There was an important difference in the views expressed by service users versus those of service providers. The service users' focus group emphasized more additional issues related to living a satisfying, hopeful, and contributing life and improving their mental health and wellbeing. This is compatible with current trends in mental health care for recovery model[10] and person centre approach that places the whole person of the patient at the centre of mental health care.[11]

Problems with coordination of services have also been described with psychiatric reforms in other

European countries.[12–14] In a recent comprehensive study of several European countries[15] it was reported that while a few countries lead the way of the successful implementation of community based mental health services, according to an "evidenced-based balanced care model" that integrate elements of community and hospital services, in may others, access to community based services is still very limited and may commonly consist of small pilot projects.

The views of service providers and service users elicited by the described focus groups offer very valuable information about the psychiatric reforms in Greece and can be taken into consideration for future planning.

Ελληνική ψυχιατρική μεταρρύθμιση: Απόψεις και αντιλήψεις επαγγελματιών και χρηστών υπηρεσιών

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Η παροχή υπηρεσιών ψυχικής υγείας στην Ελλάδα έχει υποστεί ριζικές μεταρρυθμίσεις τα τελευταία είκοσι χρόνια. Σε αντιστοιχία με τις τάσεις και τις πρακτικές σε άλλες ευρωπαϊκές χώρες, οι μεταρρυθμίσεις στην ψυχική υγεία στην Ελλάδα είχαν ως βασικό σκοπό την ανάπτυξη υπηρεσιών στην κοινότητα. Η υλοποίηση εκτεταμένου μετασχηματισμού των υπηρεσιών ψυχικής υγείας έγινε δυνατή μέσω του προγράμματος «Ψυχαργώς» του Υπουργείου Υγείας και Κοινωνικής Αλληλεγγύης και χρηματοδοτήθηκε από κρατικά κονδύλια και από το Επιχειρησιακό Πρόγραμμα «Υγεία-Πρόνοια». Με την πάροδο του χρόνου το πρόγραμμα Ψυχαργώς αποτέλεσε τον κύριο μηχανισμό για τον εκσυγχρονισμό ενός πεπαλαιωμένου συστήματος υπηρεσιών ψυχικής υγείας, το οποίο βασιζόταν αποκλειστικά στην ασυλική φροντίδα και έγινε σχεδόν συνώνυμο με την αποϊδρυματοποίηση των ασθενών με χρόνιες ψυχικές ασθένειες και την ανάπτυξη ενός ευρύτατου φάσματος κοινοτικών υπηρεσιών ψυχικής υγείας. Το άρθρο αυτό αναφέρεται στην εκ των υστέρων αξιολόγηση του προγράμματος Ψυχαργώς 2001–2009 και παρουσιάζει τις απόψεις των φορέων παροχής υπηρεσιών ψυχικής υγείας και των χρηστών των υπηρεσιών ως μέρος της ποιοτικής μεθόδου αξιολόγησης. Η περιγραφόμενη ποιοτική μέθοδος εντόπισε σημαντικές θετικές και αξιοσημείωτες επιτυχίες από τις μεταρρυθμίσεις του ελληνικού συστήματος παροχής υπηρεσιών ψυχικής υγείας, αλλά και αδυναμίες. Υπήρξε σημαντική ομοιότητα των απόψεων που εκφράστηκαν και στις δύο ομαδικές συζητήσεις (focus groups). Η ομαδική συζήτηση των χρηστών των υπηρεσιών τόνισε, επιπλέον, θέματα που σχετίζονται με παράγοντες οι οποίοι αφορούν στη βελτίωση της ψυχικής υγείας τους ως απαραίτητη προϋπόθεση για τη βελτίωση του επίπεδου της ποιότητας της ζωής τους.

Λέξεις ευρετηρίου: Ψυχιατρική μεταρρύθμιση, χρήστες υπηρεσιών, ομαδικές συζητήσεις

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Special article
Ειδικό άρθρο

Evidence based mental healthcare and service innovation: Review of concepts and challenges

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Health provision systems in the developed western nations are currently facing major financial challenges. In order to meet these challenges, a number of new approaches used to assist the provision of health have been introduced, including the practice of health professionals. These approaches utilize specific methods of data capture and summarization such as: evidence based medicine (EBM) and practice guidelines. Evidence is generated from systematic clinical research as well as reported clinical experience and individually case based empirical evidence. All types of research though (quantitative or qualitative) have limitations. Similarly all types of evidence have advantages and disadvantages and can be complimentary to each other. Evidence-based individual decision (EBID) making is the commonest evidence-based medicine as practiced by the individual clinician in making decisions about the care of the individual patient. It involves integrating individual clinical expertise with the best available external clinical evidence from systematic research. However this sort of evidence-based medicine, focuses excessively on the individual (potentially at the expense of others) in a system with limited budgets. Evidence-based guidelines (EBG) also support the practice of evidence-based medicine but at the organizational or institutional level. The main aim is to identify which interventions, over a range of patients, work best and which is cost-effective in order to guide service development and provision at a strategic level. Doing this effectively is a scientific and statistical skill in itself and the quality of guidelines is based primarily on the quality research evidence. It is important to note that lack of systematic evidence to support an intervention does not automatically mean that an intervention must instantly be abandoned. It is also important

that guidelines are understood for what they are, i.e. not rules, or complete statements of knowledge. EBM will never have enough suitable evidence for all and every aspects of health provision in every locality. Innovation signifies a substantial positive change compared to gradual or incremental changes. Innovation using inductive reasoning has to play a major role within health care system and it is applicable to all three level of service provision: clinical practice, policy and organisation structure. The aim of this paper is to examine critically the above concepts and their complimentary role in supporting provision of health care systems which are suitable for the requirements of the population, affordable, deliverable, flexible and adaptable to social changes.

Key words: Evidence based medicine, practice guidelines, innovation

Introduction

The UK NHS (National Health System) was launched in 1948. It was seen as a major step towards the reduction of inequalities in accessing health services after the Second World War. Seventy years later, it is undergoing a period of rapid and continuous change. The UK government has made "Governance" proposals to guide organizations and maintain standards of service by the NHS and by the private/independent sector. Clinical governance can be defined as a framework through which organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. Health provision systems in the developed western nations are currently facing major financial challenges, which are ironically in part the result of their own success. These challenges are also consequent to other social changes, some of which have significantly improved the patients' quality of life.

In order to face these challenges, a number of new approaches have been introduced to assist, including an influence on the practice of health professionals. These approaches utilize specific methods of data capture and summarization, such as: evidence based medicine, evidence based practice, practice guidelines and a general category we might conveniently call "innovation". The aim of this paper is to explore aspects of the nature of these concepts, their potential utility and challenges in their potential implementation. Our recent experience of the introduction of some of these approaches within the UK National Health Service (NHS) will be used to illustrate some issues.

Current challenges for health care systems

Every health care system (public or independent) needs to be suitable for the requirements of the population that it serves. Reason suggests that health care systems should be affordable, deliverable, flexible and adaptable to social changes. We identify the following main challenges to the implementation of future healthcare:

i. The demographic characteristics of the population in the western world indicate that more people survive until they are older. In the UK there is a significant increase in population over 65 years old with the prediction of a 63% increase over the next 25 years (from 2006), with the number of those aged over 85 years predicted to double.[1]

ii. Despite this increase of life expectancy, the longevity is not associated with better quality of life during those added years. Although life expectancy consistently increased during the decade 1981–1991, the years of "healthy life expectancy" actually fell during the decade 1991–2001. This means that for many people, years of added life are potentially years of increased levels of morbidity. It is also predicted that the demographic pattern of diseases will continue to change significantly, with a consequent increased incidence of chronic illness and co-morbidities often involving people having several areas of illness.[2]

iii. As science progresses, new treatments are developed at a considerable rate and potential expense. These treatments usually generate new costs, which then leads to a need for increased investment for the appropriate implementation of the

treatment. Furthermore, although the previous treatments might not be as effective as some new treatments, the new treatment may actually not be cost-effective or cannot be implemented without costly adaptation of service structures and provision which then has indirect implications for total cost.

Over the last 15 years there has been a revolution in Information Technology (IT), potentially allowing everyone with a computer to have rapid access to a broad range of health information. As a result, there is an overwhelming plethora of scientific research, opinions, advertisements and seemingly relevant publications, which can be contradictory, conflicting and confusing to clinicians and other stakeholders. Modern clinicians (and arguably the public with access to the same information) therefore need to have appropriate appraisal skills in order to quickly and effectively critically appraise this new evidence and in the case of professionals, modify their practice accordingly.

The Royal College of Psychiatrists rapidly recognized this challenge and incorporated the relevant training (Evidence Based Medicine and critical appraisal) to its curriculum and examination schedule. By implementation of these processes, it was hoped that the research to practice gap would be reduced. A range of evidence based procedures have been designed to aid clinicians with the process of finding information, critically appraising it and to guide them towards best practice. These processes include use of IT search strategies and implementation of Evidence Based Medicine (EBM). This includes two related but ultimately different EBM processes, firstly individual decision making for a single patient and secondly guidelines for clinicians as well as purchasing bodies and management, in order to guide the treating of a patient group.

Types of evidence

Two main types of external clinical evidence feature predominantly when clinicians are considering changes to treatments or practice: (1) systematic clinical research evidence, and (2) other forms of evidence, such as reported clinical experience and individually case based empirical evidence. It is crucial to emphasize that both types of evidence have advantages and disadvantages and can be complimentary to each other.

Research evidence has the advantage of strength in numbers, a better methodological base, and provides a standardized scientific approach to treatment. It can usefully guide service provision, but might miss an individual patient's needs and cannot be entirely prescriptive. On the other hand, clinically based empirical evidence takes into account the individual patient, the unique circumstances around him/her, and the clinical expertise of the clinician involved. However, in comparison to research evidence, clinical experience/expertise and consequent individual case effectiveness, cannot be automatically generalized to all patients and cannot or should not guide general service development as such.[3] Clinical expertise in these circumstances refers to the clinician's cumulated experience, education and clinical skills. It is also recognised that the patient brings his or her own personal and unique concerns, knowledge expectations, and values to the clinical encounter. Nevertheless, overall it is recognised that the best general evidence is usually found in clinically relevant research that is systematic. There is an agreed predetermined hierarchy of quality to aid acceptance of evidence.[4]

Types of research methodology

Well conducted Randomised Controlled Trials (RCT) (and their resulting systematic reviews and meta-analyses) have become the gold standard for establishing treatment efficacy in the last 70 years. For issues relating to diagnosis, both RCTs and cross-sectional studies are used, whereas for issues around prognosis RCTs and cohort studies of representative patients may be considered the best sources of evidence.[5] Qualitative research is a more recently developed type of research, originating from anthropological methodology and used mostly to explore service users' and staff experiences, attitudes and perceptions.[6]

All types of research (quantitative or qualitative) have limitations related to sample size, sample representation, rate of follow up and statistical analysis, to name just a few of them.[3] Recently there has

been significant criticism regarding the reliance on RCTs as the main if not, only source of evidence for the majority of clinical issues, because it bypasses important aspects of clinical experience or service user perspectives.[7] Qualitative research has been used to bridge this gap and several large funded studies have now included a qualitative arm in their methodology.[8] Another major issue is the link between biological sciences and treatment application for human diseases. This is the topic of Translational Medicine, which aims to increase the efficiency of determining the relevance of novel discoveries in the biological sciences to human disease and to help clinical researchers to identify, through direct human observation, alternative hypotheses relevant to human disease.[9]

A systematic review is a review in which specified predetermined and appropriate a priori methods have been used to identify, appraise, and summarise studies addressing a defined question. It can, but does not need to involve meta-analysis. The Cochrane database (http://www.cochrane.org) is probably the most accessible and widely used for this purpose in the UK. A Meta-analysis is a statistical technique that summarises the results of several studies in a single weighted estimate, in which more weight is given to results of larger studies, and sometimes to studies of higher quality. More recently, an evidence-based minimum set of items for reporting in systematic reviews and meta-analyses has been introduced.[10]

Evidence-based individual decision making (EBID)

Evidence-based individual decision (EBID) making is the commonest evidence-based medicine as practiced by the individual clinician. Evidence based individual decision making is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It involves integrating individual clinical expertise with the best available external clinical evidence from systematic research.[11] For the treatment of an individual patient the process involves six steps (table 1). In these circumstances, evidence based practice starts and ends with the needs of an identified patient and takes into account individual clinician's skills. However, there is managerial and budgetary concern that this sort of evidence-based medicine focuses excessively on the individual (potentially at the expense of others in a system with limited budgets), even though it has been conducted using sound scientific methodology.[11]

Evidence based medicine guidelines

Evidence-based guidelines (EBG) are also the practice of evidence-based medicine but in an organizational or institutional level. This process includes the production of guidelines, policy, and regulations. This approach has also been called evidence based healthcare. Evidence-based health care extends the application of the principles of Evidence-Based Medicine to all professions associated with health care, including commissioning and management. EBM at this level remains the practice of integrating the best available research evidence with clinical expertise and patient values in making decisions about the care of individual patients, but uses the information to inform service provision in terms of patient groups, using guidelines, protocols and care pathways. In order to achieve this, the guidelines utilize a synthesis of a broad range of research studies and opinions. Doing this effectively is a scientific and statistical skill in itself and the quality of guidelines is based primarily on the quality research evidence as already identified above. The processes used in this "service delivery" form of Evidence Based Medicine (EBM) still share some of the characteristics of Individual Evidence Based Practice, but there are

Table 1. Steps of evidence-based individual decision making (EBID) (Sackett et al 1996)

i. Start with the patient – a clinical problem or question arises from the care of the patient
ii. Construct a well built clinical question derived from the case
iii. Select the appropriate resource(s) and conduct a research
iv. Appraise that evidence for its validity (closeness to the truth) and applicability (usefulness in your clinical practice)
v. Return that evidence to the patient-integrate with your clinical expertise, this patient's preferences and apply it to practice
vi. Evaluate your performance with this patient

fundamental differences. The main aim in this type of EBM is to identify what interventions, over a range of patients, work best and what is cost-effective in order to guide service development and provision at a strategic level.

Economic analysis is a set of formal, quantitative methods used to compare two or more treatments, programs or strategies, with respect to their resource use and their expected outcomes. If two strategies are analyzed but only costs are compared, this comparison would inform only the resource-use half of the decision and is termed a cost analysis. Comparing two or more strategies only by their consequences (such as in a randomized trial) informs only the outcomes portion of the decision. A full economic comparison requires that both the costs and consequences be analyzed for each of the strategies compared. A cost benefit analysis assesses whether the cost of an intervention is worth the benefit, by measuring both in the same units (usually monetary). A cost effectiveness analysis measures the net cost of providing a service as well as the outcomes obtained. Outcomes are reported in monetary units per Absolute Risk Reduction (AAR) (single unit of measurement). A cost-utility analysis converts effects into personal preferences (or utilities) and describes how much it costs for some additional quality gain (e.g. cost per additional quality-adjusted life-year or QALY).

Examples of guidelines in the UK include those in the Cochrane database and the National Institute of Health and Clinical Excellence (NICE) technology appraisals, which are compulsory for the NHS and clinical guidelines, which are not compulsory, though adherence to their recommendations is a strong indicator of high quality service provision. NICE guidelines are developed independently from commissioners, providers and politicians and guide the provision of evidence based practice. Therefore, they provide easy access to quality evidence, promote the scientific approach in clinical practice, reduce political interference in service provision and promote quality and accountability.[5] There are examples of NICE guidelines that have not been implemented because of adverse press coverage, such as the implementation of Contingency Management in substance misuse.[5] There are also instances of examples in which guidelines have been reviewed and revised without the required evidence base, due to pressure by professionals or service users, such the guidelines on the use of medication in Alzheimer's disorder.[12]

Despite their importance, Guidelines have potential limitations, because they can only base their recommendations on quality of pre-existing research,[13] i.e. what has been looked at already. It is important to note that lack of systematic evidence to support an intervention does not automatically mean that an intervention must instantly be abandoned. It may just mean that this intervention or clinical issue has not been researched adequately. Some therapeutic techniques, for instance those requiring specific human attachments such as psychotherapy, cannot be randomized, blinded or be subject to RCTs. Also factors such as the complexity of design (Simple trial designs being more readily performed), current research trends and available methodologies, affect what research is actually carried out, analyzed and ultimately published. RCTs in psychosocial interventions in particular are more methodologically challenging and expensive than pharmacological interventions.[14] In fields such as the psychological field individual and manualised interventions are easier to study than dynamic, group or unstructured humanistic interventions.

In studies of the effects of health care, the main types of bias arise from systematic differences in the groups that are compared (selection bias), the care that is provided, exposure to other factors apart from the intervention of interest (performance bias), withdrawals or exclusion of people entered into a study (attrition bias), or how outcomes are assessed (detection bias). Reviews of studies may also be particularly affected by reporting bias, where a biased subset of all the relevant data is available. High quality guidelines are developed in a way that minimises the risk of bias. The quality of such development can itself be subject to guidelines and critical appraisal.

It is important to note that guidelines emanating from different professional bodies with separate aims use different methodologies (for example NICE and Cochrane are analyzing data from the original studies, whereas Canadian Network for Mood and Anxiety treatments (CANMAT) or British Association for Psychopharmacology (BAP) use existing meta analysis studies and are written for different pur-

poses in different systems. It should come as no surprise that different guidelines differ from or even contradict each other. For example, the BAP and the CANMAT do not take cost factors into account, whereas NICE does. BAP does not take complimentary medicine into account, whereas CANMAT does. Comparing NICE, BAP and to CANMAT guidelines for depression therefore, an increasing range of medications is supported.[15–17]

It is also important that guidelines are understood for what they are, i.e. not rules, or complete statements of knowledge. They are based on a statistical abstraction of what happens in the 'population' with that diagnosis. They only apply to individuals in a probabilistic way.[18] This challenge increases when evidence originates from a different country. Ethnic, local and cultural differences can make evidence implementation impractical or too expensive. This challenge is well recognized with psychosocial interventions.[14] Novice doctors base their prescribing decisions on guidelines, whereas senior doctors base their management on a sophisticated holistic assessment of the individual patient that goes far beyond "diagnosis".[19] Because of the impracticality of providing guidelines covering all the important patient characteristics (independent variables), guidelines can only be a highly generalized starting point. Expert doctors adapt guidelines to the individual patient in the consultation; this is a complex, partly automatic and unconscious activity that is developed through years of study, training and practice.

Innovation

Within the UK, NHS innovation has been defined as an "idea, service or product, new to the NHS or applied in a way that is new to the NHS, which significantly improves the quality of health and care wherever it is applied".[20] Innovation is more than simply an improvement in performance. The NHS definition acknowledges two further important aspects of innovation:

1. It refers to the whole process of development, implementation and diffusion of innovations into widespread use.
2. It needs to be replicable.

Innovation signifies a substantial positive change compared to gradual or incremental changes. In the NHS organizational context, innovation may be linked to positive changes in quality of care, efficiency or safety. The simplest form of health service innovation is where a local team alters a component/practice of the local care system, according to local needs. A team develops an innovation for their own (in-house) use, because existing systems or products do not meet their needs. Such an example is the development of a preparation for detoxification Cognitive Behaviour Therapy group intervention, part of a three stage community treatment programme for alcohol dependence, as a response to local needs despite the lack of existing evidence.[21]

EBM and associated guidelines will never have enough suitable evidence for every aspect of health provision in every locality. Innovation using inductive reasoning has to play a major role within the NHS and any other health care system.[22] It is applicable to all three levels of service provision: clinical practice, policy and organisation structure.[23]

Innovation in clinical practice attempts to cover the gaps in scientific knowledge and provide pragmatic solutions with suitable implementation challenges. However, it can be risky, especially if untested or untried. It is crucial for any innovative practice to be monitored for adverse effects to the individual (relevant also to innovation in psychosocial interventions), and negative effects on service provision such as exclusion of vulnerable patients or unacceptability to patients and staff. It is also important for innovation to be evaluated for effectiveness and cost-effectiveness, using robust research methods audits or other techniques.[24]

Innovation in policy, although pragmatically necessary due to the accumulation of new evidence (evidence based policy), can also be problematic. Whenever an innovative policy is required, either because of gaps in evidence or because of convenient political choices, there is a risk of a service embarking in a rollercoaster of trying to generate the

missing "supportive" evidence post hoc at all costs (policy based evidence).[25]

Evaluations of medical innovations in practice suggest that success is more likely where interventions are relatively simple and well-designed and where there is strong evidence of the clinical benefits.[26] Compare, for example, prescribing a new psychotropic medication with what is involved, with say the introduction of Early Intervention Teams. In practice innovations require significant organisational effort to overcome inertia and fear, in order to succeed and become embedded in routine.[27] Bearing these factors in mind, the following summarises some of the main challenges in service innovation in mental healthcare:

1. Innovations will not always meet conventional standards of evidence criteria consistent with an EBM model. This is particularly the case with values based service innovations, such as the introduction of the Recovery Approach into a local service, where the evidence supporting is equivocal or still emergent. Such service innovations raise the questions of the type of evidence that is appropriate, what criteria should be applied and what procedures does this involve.

2. Many service innovations are not primarily concerned with the application of technical interventions. All innovations have service implications, but some of them can be highly complex and involve equally complex approaches to be successfully implemented.

3. A further challenge is that many innovations are not uni-professional. Their successful implementation involves multi-disciplinary team members working jointly. This requires an organisational approach to change, including high quality leadership.[18]

4. Service user experiences and user priorities for their own care and treatment should increasingly impact on both the focus and process of service innovations. Approaches to service innovation need to develop effective ways of involving service users in informing agendas and the processes of innovation.

Implementing EBM and Innovation in the NHS and other health care systems

Commitments to improvement and excellence and ever increasing financial challenges have lead to innovations and changes of service delivery and philosophy. Some of these changes in the NHS have appeared to be political and driven by aspiration rather than scientific evidence, resulting in division of opinion between professionals, service users and carers. These changes at times have appeared "populist", or only superficially rational and as not necessarily having satisfactory evidence based grounds. In our view, although EBM and Innovation look potentially contradictory, they may be combined productively and compliment each other in order to promote better health services for the population, if judiciously monitored.

For example, the early stage in the implementation of a recovery orientated approach in substance misuse services had given the false impression that recovery is related only to exit from substitution treatment. In other words, recovery could only be achieved when people get "detoxified" from their medication. This created a deep division between substitution treatment services and recovery and community re-integration innovations. This has been modified by the acceptance of the evidence based harm minimization interventions within the overall recovery orientated treatment system.[28]

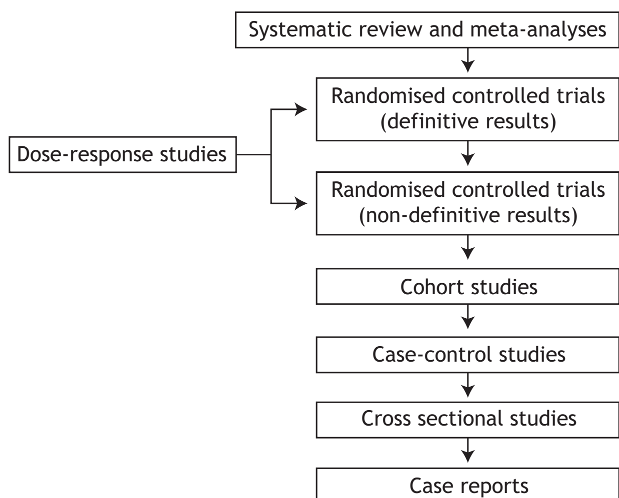

Figure 1. Hierarchy of evidence (Greenhalgh 2010)

A major factor in innovation failure can be information and change overload. There may be concerns about ethical implications of change and parallel concerns about legal implications. These need to be identified, addressed and overcome. Crucially, not innovating also carries potentially grave risks. It is easy for clinical staff and administrators to be complacent and carry on, as they have done for a long time, in the belief that this provides best and most cost effective care when, in fact, better alternative ways of doing things have emerged.

One means by which EBM has been promoted in the NHS has been through top down implementation in the form of clinical guidelines and standardised protocols, sometimes underpinned by a strong policy imperative. Although such guidelines are important, the evidence of their routine application is less certain.[29] There is often limited time for decision making. Often there is a lack of political power in a locality. There may also be a lack of resources and skills for policy analysis and evaluation and a lack of consensus. Identified evidence is sometimes not fully relevant to the case in hand and evidence is only part of the basis of any decision. There may be an inability to release resources from current budgets.

A recent poll of the Royal College of Psychiatrists showed that 64% of responding UK psychiatrists agreed that NICE or Scottish Intercollegiate Guidelines Network (SIGN) guidelines have improved the quality of mental health care for their patients.[30] The question of whether EBM or innovation as described above have had any positive influence on the quality of care provided and whether they have increased patients satisfaction, is a major topic for further debate. This is definitely linked with the major issue of the definition of patient-centred services and the potential conflict between patients' and professionals' definitions of good care and their associated expectations.

Conclusions

In the second decade of the 21st century it is imperative that health systems aspire to meet both patients' and society's needs. Health care delivery systems consequently need to be suitably flexible and adaptable. Emphasis on the provision of critically appraised evidence-based medicine is recommended. This is an approach that aims to reduce unnecessary variation in treatment, promote cost-effective interventions and support national health services to meet the health needs of the population. The role of high quality clinical guidelines is considered central for its implementation. Every effort should be made to reduce unnecessary idiosyncratic (and therefore prone to mistakes) practice and meet the justifiable request for patient choice and public accountability of managing public health system resources. A judicious mixture of evidence based practice, evidence based medicine and guidelines with local tailoring and innovation, combined with strong clinical expertise and patient's values, is recommended.

The medical profession has tended to emphasise profession-specific training and clinical leadership. However, a more holistic approach is essential for successful service innovation and the need to consider transforming organisational contexts and promoting cultural change, in turn creating an environment conducive to transformation of practice. The nursing literature has been helpful in relation to service innovation in evaluating evidence to inform a 'practice development' model of service change and innovation, which takes such an holistic approach.[31] The evidence suggests that successful practice development approaches apply equal importance, not just to the innovation itself and the evidence supporting its efficacy, but also to two other components of service innovation: the context of the environment into which the innovation is to be introduced and, secondly, facilitation of the process of introducing and implementing the innovation. It is the process of implementation that addresses the components of service innovation which are associated with successful implementation.

Note

This paper is based on the presentation entitled "Adapt and Survive: Innovation in Mental Health Services in the National Health Service in England", given by CK at the 21st Pan-Hellenic Congress of Psychiatry, Athens, May 2011.

Τεκμηριωμένη ψυχιατρική φροντίδα και καινοτόμες υπηρεσίες: Ανασκόπηση των εννοιών και αμφισβητήσεων

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Τα συστήματα υγείας των αναπτυγμένων χωρών καλούνται να αντιμετωπίσουν μεγάλες οικονομικές δυσκολίες. Νέοι τρόποι συγκέντρωσης και σύνθεσης δεδομένων, όπως η «τεκμηριωμένη ιατρική πράξη» και η χρήση «κλινικών οδηγιών», χρησιμοποιούνται για την αντιμετώπισή τους. Η τεκμηρίωση στηρίζεται στη συστηματοποιημένη κλινική έρευνα, στα δημοσιευμένα περιστατικά και στην προσωπική κλινική εμπειρία. Η τεκμηρίωση μπορεί να στηρίξει τις ατομικές αποφάσεις του κάθε κλινικού στη θεραπεία του κάθε ασθενούς. Οι κλινικές οδηγίες από την άλλη, χρησιμοποιούνται σε επίπεδο οργάνωσης και σχεδιασμού παροχής υπηρεσιών. Σκοπός τους είναι να υποδείξουν ποιες παρεμβάσεις και για ποιες πληθυσμιακές ομάδες είναι πιο αποτελεσματικές και οικονομικές. Δεν υπάρχει όμως τεκμηρίωση για όλα τα ζητήματα που αφορούν στην παροχή υπηρεσιών. Καινοτομίες βασισμένες σε λογικά βήματα μπορεί να παίξουν σημαντικό ρόλο. Καινοτομίες μπορούν να εφαρμοστούν και στα τρία επίπεδα παροχής υπηρεσιών υγείας: κλινική πράξη, πολιτική και φιλοσοφική κατεύθυνση και οργανωτικές δομές. Σκοπός του παρόντος άρθρου είναι να εξετάσει κριτικά τις παραπάνω έννοιες και τον συμπληρωματικό τους ρόλο στην ανάπτυξη συστημάτων υγείας τα οποία ανταποκρίνονται στις ανάγκες του πληθυσμού, είναι οικονομικά, εφαρμόσιμα, ευέλικτα και προσαρμόσιμα στις κοινωνικές αλλαγές, χρησιμοποιώντας παραδείγματα από την εμπειρία μας στη Μεγάλη Βρετανία.

Λέξεις ευρετηρίου: Τεκμηριωμένη ιατρική πράξη, κλινικές οδηγίες, καινοτομίες

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Special article
Ειδικό άρθρο

Suicide in the Byzantine Empire

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Studying the suicide in the Byzantine Empire is difficult due to the limited number of references to it. Their number is greater in the early years of the Empire, mainly because of the persecution of Christians and gradually decreases. The attitude of the Church also gradually hardens, as well as the law. The law was strictly followed to the West, but as far as the Eastern Empire is concerned there are no references of punishment, confiscation of property or vandalism of dead bodies mentioned. Avoiding public humiliation after a public crime or a military defeat, religious redemption, emotional disturbance and debts, are the main cause of suicide. There are some references of mass suicides, while women suicides are relatively fewer, if the early Christian years are excluded. Suicide is more acceptable to the pagans because of their lifestyle. The therapeutic approach comes mainly through the treatment of depression. Aretaeus and Galen cite some ways to deal with the disturbance in the internal balance of black bile. Their view echoes through the centuries and the subsequent doctors embrace it. At least after the 9th century, more importance is given to the patient's bliss. Gemistus Pletho tried to revive the Platonic view of suicide shortly before the end of the Empire. The Church forbids Christian burial and troubled soul hovers in an intangible journey.

Key words: Byzantium, suicide, melancholy, black bile

Introduction

The references to suicide from the 4th to the 15th century in the Byzantium are extremely limited, which explains the reason why the issue has not been studied extensively.[1–2] The attitude of most religions towards the suicide is negative, so the Jewish and Christian religion condemn suicide. These religions, being the antipode of individualism, accept reality as a single entity, focusing on the divine element, around which all the other elements are developed, that is the human and the cosmic, the animate and the inanimate, the rational and the irrational. Life belongs to the divine factor of the reality, which determines the rhythm of beings throughout the whole range of their existence. Each one adapts and submits to the cycle of life and death, determined by the divine element. The human thus is not entitled to disrupt the cycle of life and therefore killing another human being or himself is prohibited and considered as the highest contempt for God who created him.[3–6] Suicide has been studied only in the references of re-

moval of own life in the Greek Novel from Antiquity to the Comnenian period.[2] According to the Romans, nobles' suicide shortly before an inevitable death, as in the end of lost a battle or after a disgraceful act, is an acceptable fact,[1] although by the 3rd AD century the Roman law punishes suicides strictly.[7] Since the 5th century AD the references get fewer and are mainly confined to the hagiographic literature.

The sources mentioning suicides or suicide attempts are primarily religious or secular discourses, in which suicide is generally and often referred as an irreverent act. The Byzantine law punishes self-destruction as well as those who lead others to forced suicide, such as a ruler that leads to suicide a slave who has done some penal offense.[1] The therapeutic approach to prevent suicide is found in the treatment of depression and mania and is mainly expressed by Aretaeus and Galen, even if they lived earlier than the creation of the Empire.[8]

Suicide in the early Christian years of the Empire

Despair is a terrible evil and unhealable passion that erodes the human soul. It destroys everything sound in him, it delivers him to the disaster and pushes him to end his life.[9] The despair of the Christian martyrs during the persecutions led some of them to suicide in order to avoid rape or humiliation. John Chrysostom says that the three witnesses Bernike, Prosdoke and Domnine, fell into the river near the city of Hierapolis and drowned to avoid humiliation.[10] He even connects their act to a Cristian baptism.[1] The tendency of Christians to end their life or cause death because of the pagans, during their persecution, was not considered as suicide in the early years of the Church. It is certain that Christianity invites suicide in a way in which other major religions do not. In the early years of Christianity the faithful Christian can commit suicide if he believes that the time of sin is close, while the suicidal death of a martyr is treated with sympathy by the Church to such an extent that it is not considered as suicide.[9]

The reason of suicide and the causes that led to self-destruction were often attributed to the forces of evil, and which overcome those with weak faith. There are however quotes like this from the teaching of St. Athanasius, in which the Saint, trying to explain what leads a man to self-destruction, simply says "these are only known by God".[11]

Suicide in the Byzantine Empire

During the first centuries of the Byzantine Empire the references to suicide are associated with political upheavals and the change in the fate of the aristocracy members. The defeat in a battle or the guilt for a public crime led militaries or politicians of the Empire to choose suicide over public humiliation. The act is equivalent to common murder and the suicide's property is confiscated.[7] Then the law changed and the property was confiscated only in cases where suicide was committed to avoid the consequences of the law.[12]

The Church condemns suicide and forbids Christian burial, provided the perpetrators were of a sound state of mind, as in this case the suicide has surrendered his soul to the devil. Those who commit suicide on account of distress, grief or lack of courage have no right to Christian burial.[13] The first mention of a suicide burial ban is cited in Lausiac History at about 419, where a priest forbids the burial of two nuns who had committed suicide.[14] The suicide's widow is excluded from bereavement and can get married immediately, while in the case of instigator, the punishment was a 10-year exile.[1] Regarding the suicides' corpses, called "viothanon" or "viothanaton" buried in Kynegion, an area where those executed in Istanbul were buried.[15] Relatives should not face penance, except for abstaining from meat, they should attend the Divine Liturgy from the antechamber and finally raise a cross at the point of death of the suicide.[2]

Over the years the nobles' or militaries' suicides continued, with examples the suicides of Maximinianus Augustus, Magnentius, Arbogastes and Gerontios. For Gerontios especially, because of the fact that he was British, it was considered that he perceived "the insane of the barbarian kind" and preferred to be burned alive than surrender.[16] To the antipode suicides of the ordinary people were confined among the Christians, due to the reaction of the Church, but were increased among the pagans as they were more vulnerable to violence, or because the act was considered as a form of reaction.[1] The philosopher Iamblichus, having been involved in the pagan apposition, was captured by Christians and drank poison to die.[1] We have

now reached the time when pagans commit suicide to save themselves from Christians. The most prominent cases are those of Maximos of Ephesus, patrician Phocas, Asclepiodotos. Ordinary soldiers are often victims of depression and attempted suicide. In this case, an enquiry is conducted and in case of cowardice follows a disgraceful retirement or death.[17–18] Suicides of women were also reduced and limited mainly to emotional reasons, such as loss of a loved one.[1] Thus Miroslava, the daughter of the Bulgarian ruler Samuel, threatened to commit suicide if not allowed to marry her lover Ashot. There were also cases of suicides of women who could not stand living anymore with their husbands, whom they abhorred.[2,19]

There are references of mass suicides like those in the time of Theodosius II, when many were unable to collect the tax required by Attila,[20] or when the Phrygian Montanists refused to change their religion coerced by Justinian.[1] The exploitation of the poor by the rich or the debt burden often led to suicide. Since the middle Byzantine period and later, suicides are rarely mentioned in relation to the later years of the empire. This means either that there were generalized and thus ceased to be a memorable event, or that they had become more acceptable since the transition of pagans to Christianity. Perhaps suicides simply were not recorded anymore. The few references concern plots and plans of revolution in the army, as in the cases of Agallianos Kontoskelles and Eustathios Argyros.[1]

Suicide was rarely mentioned in medical books of the time, and according to them the reason was depression, mania or the imbalance of one of the four bodily humors.[1,18] In the last centuries of the Empire the references are even more rare and the causes more accidental, such as intolerable life, avoiding execution, demons and passions. Georgios Plethon Gemistos (1360–1452) had a strange vision about suicide, which he recorded in his essay "Book of Laws". Suicide kills only what is mortal in the immortal soul. The soul is separated from the body and thus all the vicissitudes that can affect its well being, the so-called "eudaemony".[1,21] Plethon proposes in his writings a way of "rational withdrawal", probably influenced by the course of the Empire, a conscious attempt to escape from the grim realities of the years immediate before the Fall.[1]

Suicide in literature

Except from the love romances, drama and humorous texts, suicide as a literary motive is encountered in poetry. In humorous poems a crummy husband begs to drink poison in order to avoid his talkative wife.[1] The bulk of reports relating to suicide were found in hagiographic literature, which is caused by demonic forces, when the victim is under spell having lost his mind and the control of himself.[1] Saint Pachomius says many eremites committed suicide since they did not realize that they had been possessed by unclean.[22]

The therapeutic approach to suicide

Aretaeus, in his work entitled "On melancholy and On Mania", correlates mania with crisis of melancholy and projects their periodicity, and the fact that mania frequently affects the youngsters whereas depression the elders.[23] He thinks that the cause of the disease is found in the blood and bad humors,[23] while especially melancholy implicates the black bile.[24] However, he indicates that the main cause of the disease can be found on the nerves. Patients are calm or very serious or unreasonably inert, they get furious, they are smelly, they have agitated sleep, insomnia, irrational fear, they change opinion easily, they are shameless, petty, simplistic, prodigal, exaggerated, they avoid people, they get frightened by dreams, they complain about life, they wish death. Many people's mental state leads to derangement and stupefaction and the feeling ends up in sorrow and depression, causing resolute anger, sadness and melancholy. Patients are suspected of poisoning and misanthropy, they are considered superstitious, they feel hatred for life and may lead to suicide.[23] He is also the first to recognize the impaired function of neurovascular centers in the hypothalamus and the reticular formation,[8] indicating that the patients are very slim while eating a lot, their intestines are dry without stools, their skin breaks down, the color is dark green, the pulses are small, inert, inactive, frequent as due to cold, and the urine is sparse, containing acids and bile.[23]

For its treatment he suggests an etiopathologic approach to the disease. Thus he removes blood from the liver, in which the black bile is produced, while, at the same time, he administers drugs that inhibit its

production, such as absinthe juice. Concurrently, he places a suction cup to the head, so that a direct effect on diseased nerves is created. He also suggests a supportive treatment with proper diet, often warm baths, gentle rubbing, swinging and administration of laxatives.[8,24] Vomitives are also provided for the elimination of black bile.

Aretaeus also considers that melancholy is the beginning and part of the mania, leading to convulsions and paralysis and in this case hellebore should be administered. In advanced disease asphalt, sulfur and astringent soil that contains aluminum and hydrochloric acid should be used.[24] Mania is a chronic confusion of mind and the cause lies in the head and the area of hypochondria. Nocturnal emissions, lust and venereal pleasures are also characteristic symptoms. Eventually, they isolate and lament for their plight, which also can lead to suicide.[23]

Galen generally agrees with Aretaeus that suffering, fear, unwillingness to eat or drink, dark thoughts, are all associated with causes and symptoms of melancholy and self-destruction is a major risk.[25] Galen recognised emotional states as factors in disease. Some problems were for Galen purely emotional in origin: one patient worried obsessively that the mythical Atlas would grow tired or sick and drop the sky, crushing the earth. This patient's anxiety, according to Galen, had developed into melancholia, an overabundance of black bile, which, when accumulated in the brain, caused delirium, aggressive or suicidal behaviour and other psychological problems. Anxiety is, along with anger, the emotion Galen mentions most often as a cause of disease. Both could cause or exacerbate epilepsy; along with diet, temperament, lifestyle and environmental factors could contribute to any number of feverish illnesses; anxiety, in particular, could trigger a sometimes fatal syndrome of insomnia, fever and wasting, or transform into melancholy.[26]

Although Aretaeus and Galen lived on the early Byzantine Empire, their views on depression and mania survived through the centuries, and marked the therapeutic approach of these diseases.

Due to the fact that love often led to suicide, Ovid gave the remedies for love, or *Remedia amoris*. Some of them are that the lover should cure the wound of love when it is still fresh and new, without waiting, because being on time is almost a medicine. Moreover a lover should be busy and avoid idleness and excessive sleep. Going to the country could also help, but the lover should know that the recovery process will be very painful, mainly because he needs to forget his beloved and think ill of her, and no pills or witchcraft will alleviate the pain. A lover who wants to recover from the lovesickness should pay attention to his beloved's faults and show no grief. Most importantly, the lover should not avoid intercourse, because if he remains alone he will become sad. Finally, a certain diet should be followed, where onions should be avoided, he should eat rue because it sharpens the eyesight and drink wine, but only the perfect amount only, otherwise the lover might feel too drowned by alcohol, or the wine might have prepared his heart for love.[27]

The next generation of physicians having a great influence on Byzantine thoughts was that of the Arabic physicians. Among them were Rhazes (865–923), Haly Abbas (994) and Avicenna (980–1037), whose thoughts were developed from the Byzantine compilers. Avicenna's work gained notice to the West by the second quarter of the thirteenth century. The thoughts of these Arabic physicians and philosophers influenced the whole world because they were translated into Latin by Constantinus Africanus (1010–1087) Constantinus recognized the three types of melancholy as indicated by Galen, and added a variety of causes and symptoms related to melancholy. With him, the association of lovesickness, acedia, and mourning with melancholy was introduced. As for the cures for all illnesses associated with melancholy, purgatives and coitus were recommended. It should be noticed that the same cures are recommended for all the illnesses likened to melancholy.[28] One observes a circle with the Arabs being affected by the Byzantines and the knowledge returning filtered and refreshed to the West and Byzantium.

The seriously ill sought their healing often in sanctuaries and if their situation persisted they resorted to sacred grounds of the church, seeking treatment by the patron Saint at the crucial moment.[1] The patient's treatment in hospitals, as for example in the Guesthouse of the Pantocrator in Constantinople, where there was a remote psychiatric ward, can be derived indirectly through the reports of the hospi-

tal of the city of Cairo (873 AD). The hospital operated according to Byzantine standards and the mentally ill were treated with extreme caution, always focusing in the bliss of the patient, that is his mental tranquility.[29]

Epilogue

The references to suicide in the Byzantine empire are numerically much less than expected and their largest number is recorded between 4th and 6th century. In late antiquity, in many cases, such as military defeat or disgrace, suicide was considered an offense consistent with the code of honor, a moral duty. During the early Christian period, suicides proliferate and sometimes are treated with sympathy. Then the attitude of both the church and the legislature hardens. Despite the strict laws though, in Greek literature resources it is not mentioned any case of indignities inflicted upon the suicide's body or ravages and arbitrary confiscation of his property, in contrast to what happened in the Western Empire.[1–2] Perhaps the attitude of the society or the medical influence in favour of the victim, overrode the law. Mental patient or mentally ill, the suicidal always triggered the society, creating feelings of sympathy or repulsion, depending on the reason and time of commitment of the act. Melancholy, mania, depression, emotional frustration, shame, demonic forces, redemption, loss, debts, religion, tortures, such diverse concepts which still all resulted in their zenith in the self-destruction of the mortal body, with the hope of a better trip of the soul in the "afterlife."

Η αυτοκτονία στη Βυζαντινή Αυτοκρατορία

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Η μελέτη για την αυτοκτονία στη Βυζαντινή Αυτοκρατορία καθίσταται δύσκολη λόγω του περιορισμένου αριθμού σχετικών αναφορών. Ο αριθμός τους είναι μεγαλύτερος στα πρώτα χρόνια της Αυτοκρατορίας, κυρίως λόγω των διωγμών των Χριστιανών, ενώ σταδιακά μειώνεται. Η στάση της Εκκλησίας επίσης ολοένα σκληραίνει, όπως και η νομοθεσία. Το γράμμα του νόμου τηρείται αυστηρά στη Δύση, αλλά όσον αφορά στην Ανατολική Αυτοκρατορία οι περιπτώσεις τιμωρίας, δήμευσης περιουσίας ή βανδαλισμού των πτωμάτων δεν αναφέρονται. Η αποφυγή εξευτελισμού μετά από δημόσιο έγκλημα ή στρατιωτική ήττα, θρησκευτική λύτρωση, συναισθηματική διαταραχή και χρέη, είναι οι κύριες αιτίας αυτοκτονίας. Υπάρχουν ορισμένες αναφορές μαζικών αυτοκτονιών, ενώ οι γυναίκες αυτόχειρες είναι σχετικά λιγότερες, εφόσον εξαιρεθούν τα πρωτοχριστιανικά χρόνια. Η αυτοκτονία είναι περισσότερο αποδεκτή από τους παγανιστές, κυρίως λόγω του τρόπου ζωής τους. Η θεραπευτική προσέγγιση της αυτοκτονίας προέρχεται μέσα από την αντιμετώπιση της μελαγχολίας. Ο Αρεταίος και ο Γαληνός παραθέτουν τρόπους αντιμετώπισης της διαταραχής της εσωτερικής ισορροπίας της μαύρης χολής. Η θεώρησή τους αντηχεί στους αιώνες και την ασπάζονται οι μετέπειτα ιατροί. Μετά τουλάχιστον από τον 9ο αιώνα δίδεται μεγαλύτερη σημασία στην ευδαιμονία του πάσχοντα. Ο Γεμιστός Πλήθων προσπάθησε να επαναφέρει την πλατωνική θεώρηση της αυτοκτονίας λίγο πριν το τέλος της Αυτοκρατορίας. Η Εκκλησία απαγορεύει τη Χριστιανική ταφή και η ταλαιπωρημένη ψυχή αιωρείται σε ένα άυλο ταξίδι.

Λέξεις ευρετηρίου: Βυζάντιο, αυτοκτονία, μελαγχολία, μαύρη χολή

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Future scientific meetings
Προσεχείς επιστημονικές εκδηλώσεις

- **8ο Πανελλήνιο Διεπιστημονικό Συνέδριο νόσου Alzheimer και συγγενών διαταραχών, Θεσσαλονίκη**
  28 Φεβρουαρίου – Μαρτίου 2013
  Οργάνωση: Πανελλήνιο Ινστιτούτο Νευροεκφυλιστικών Νοσημάτων
  Συνεργασία: Ελληνική εταιρεία ν. Alzheimer και συγγενών διαταραχών
  Επικοινωνία: κ. Μ. Τσολάκη
  Τηλ: (+30) 2310 35 14 51-1, (+30) 2310 810 411
  Fax: (+30) 2310 35 14 56, (+30) 2310 92 58 02, Website: Alzheimer-hellas.gr
- **1ο Θεματικό Συμπόσιο: «Η συμβολή γονιδιακών αναλύσεων στην προδιάθεση, διάγνωση, πρόγνωση και ορθή φαρμακολογική προσέγγιση ασθενειών», Αθήνα**
  2–3 Μαρτίου 2013
  Οργανωτικό Γραφείο: Alpha Public Relations (APR)
  Ακαδημίας 28, Κολωνάκι, 10671 Αθήνα
  Τηλ: (+30) 210-3645629, Fax: (+30) 210-3644441
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  E-mail: k.antonopoulou@apr.com.gr, n.apostolakou@apr.com.gr
- **Διεθνές Συνέδριο της Παγκόσμιας Ομοσπονδίας Ψυχικής Υγιεινής (WFMH). 3ο Μονοθεματικό Συνέδριο της Ελληνικής Ψυχιατρικής Εταιρείας «Κρίση και καταστροφές: Ψυχοκοινωνικές επιπτώσεις»**
  6–9 Μαρτίου 2013
  Ξενοδοχείο Royal Olympic, Αθήνα
  Οργάνωση: Ελληνική Ψυχιατρική Εταιρεία, World Federation for Mental Health, Εταιρεία Προληπτικής Ψυχιατρικής
  Πληροφορίες: Επιστημονική Γραμματεία: ΕΨΕ, Παπαδιαμαντοπούλου 11, 115 28 Αθήνα, Τηλ: (+30) 210-72 14 184, Fax: (+30) 210-72 32 042
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  E-mail: info@era.gr, Website: www.era.gr
- **11th Workshop on Costs and Assessment in Psychiatry - Mental Health Policy, Economics and Health Care Reforms, Venice, Italy**
  22–24 March 2013
  Organizer: WPA Section on Mental Health Economics
  Contact: Dr Massimo Moscarelli
  E-mail: moscarelli@icmpe.org, Website: www.icmpe.org
- **3ο Συνέδριο Βιοψυχοκοινωνικής Προσέγγισης στην Ιατρική Περίθαλψη, The Met Hotel, Θεσσαλονίκη**
  28–30 Μαρτίου 2013
  Οργανωτικός Φορέας: Γ΄ Ψυχιατρική Κλινική ΑΠΘ
  Επικοινωνία: Καθ. Α. Ιακωβίδης, Οργανωτική Γραμματεία: Praxicon
  Tel: (+30) 2310-460 682, 469 652, Fax: (+30) 2310-435 064
- **28ο Βορειοελλαδικό Ιατρικό Συνέδριο, Θεσσαλονίκη**
  4–6 Απριλίου 2013
  Οργάνωση: Ιατρική Εταιρεία Θεσσαλονίκης
  Οργανωτικό Γραφείο: PRAXICON
  Εθνικής Αντιστάσεως 101, Καλαμαριά Θεσσλονίκης 55134
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  Website: www.praxicon .gr/voreioellaiko.html
- **WPA Regional Congress "Facilitating Mental Health, Primary Care and Public Health Integration", Bucharest, Romania**
  10–13 April 2013
  Contact: Prof Eliot Sorel, Tel: (+40) 212105814, Fax: (+40) 212122702
  E-mail: secretariat@wpa2013bucharest.org
  Website: www.wpa2013bucharest.org
- **WPA Regional Congress, Bucharest, Romania**
  10–13 April 2013
  Organizer: Romanian Psychiatric Association
  Contact: (a) Dr. Dan Prelipceanu, (b) Dr. Eliot Sorel
  E-mail: (a) Dr Dan Prelipceanu, prelipceanudan@yahoo.com
  (b) Dr Eliot Sorel, esorel@gmail.com,
  Website: www.wpa2013bucharest.org
- **1ο Πολυθεματικό Συνέδριο Ψυχιατρικής & 2η Διεπιστημονική Συνάντηση σχέσεων Ψυχιατρικής και Δικαίου, Κοζάνη**
  19–21 Απριλίου 2013
  Οργάνωση: Ελληνική Ψυχιατροδικαστική Εταιρεία
  Οργανωτικό Γραφείο: PRAXICON
  Εθνικής Αντιστάσεως 101, 551 34 Καλαμαριά Θεσσαλονίκης
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  Website: www.praxicon.gr/psychiatrodikastiko.html
- **ESST International Conference for Tourette Syndrome and Related Disosrers, Athens**
  24–26 April 2013
  Organizers: (a) European Society for the study of Tourette Syndrome (EEST_(b) European Network for the study of Gilles de la Tourette Syndrome (COST Action BM0905)
  Contact: Dr Christos Androutsos
  E-mail: candroutsos@yahoo.com, Website: http://tourette-eu.org
- **6th Geneva Conference of Person-Centered Medicine, Geneva, Switzerland**
  27 April 2013–1 May 2013
  Organizers: (a) Geneva University Hospital ,(b) World Health Organization
  Conference Secretariat: ICPCM Secretariat, 5th Ave & 100 str, Box 1093, New York, NY 10029, USA
  E-mail: ICPCMsecretariat@aol.com
  Website: personcenteredmedicine.org
- **3ο Πανελλήνιο Διεπιστημονικό Συνέδριο «Ψυχική υγεία και Τηλεματικές εφαρμογές», Αθήνα**
  16–17 Μαΐου 2013
  Οργάνωση: «Ομπρέλα»
  Εριφύλης 2, 11634 Αθήνα, Επικοινωνία: κ. Ο. Γιωτάκος
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  E-mail: info@ obrela.gr, Website: www.obrela.gr
- **2nd Bullying Conference: Managing the impacts of Bullying: prevention, policy and practice, Australia**
  22–23 May 2013
  Organizer: Australian & New Zealand Mental health Association
  Contact: Mrs C. Axisa
  Tel.: +07 5502 2068, Fax: +07 55227 3298
  E-mail: register@No2Bullying.org.au,
  Website: http://www.no2bullying.org.au
- **A perfect vision for Mental Health 2020, Dublin, Ireland**
  24 May 2013
  Organizers: (a) European Federation of Associations of families of people with mental illnesses (Eufami),
  (b) Supporting People affected by Mental health (Shine)
  Tel.: +32 16745040, Fax: +32 16745049
  E-mail: info@eufami.org, Website: www.eufami.org
- **3rd Congress of Neurobiology, Psychopharmacology and Treatment Guidance, Thessaloniki, Greece**
  30 May–2 June 2013
  Organizer: International Society of Neurobiology & Psychopharmacology
  Contact: Ast. Prof. K.N. Fountoulakis,

Organizing Secretariat: Global Events Ltd
Tel: (+30) 2310-313 631, Fax: (+30) 2310-247 746
Website: www.globalevents.gr

- **8ο Πανελλήνιο Παιδοψυχιατρικό Συνέδριο με θέμα «Ψυχική Οδύνη και ανθεκτικότητα σε συνθήκες κρίσης», Αθήνα**
31 Μαΐου–1 Ιουνίου 2013
Οργάνωση: Παιδοψυχιατρική Εταιρεία Ελλάδος-Ένωση Ψυχιάτρων Παιδιών και Εφήβων
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- **IASP 2013, World Congress on suicide, Montreal, Canada**
10–13 June 2013
Organizers: (a) Quebec Suicide Research Network (RQRS), (b) American Foundation for Suicide Prevention
Contact: Elise Beaudry
E-mail: ebeaudry@legroupevidal.com, Website: www.suicide2013.org

- **"WPA Third Thematic Conference on Legal and Forensic Psychiatry, Madrid, Spain**
12–14 June 2013
Organizer: Spanish Society of Legal Psychiatry
Contact: Dr Alfredo Calcedo Barba
E-mail: alfredocalcedo@gmail.com

- **"WPA International Congress", Istanbul, Turkey**
19–23 June 2013
Organizer: (a) Psychiatric Association of Turkey, (b) Turkish Neuropsychiatric Society, Contact: Dr Levent Kuey
E-mail: kueyl@superonline.com

- **21st World Congress of Social Psychiatry "The bio-psycho-social Model: the Future of Psychiatry", Lisbon, Portugal**
29 June–3 July 2013
Organizer: World Association for Social Psychiatry
Contact: Professor Driss Moussaoui
E-mail: drissm49@gmail.com, Website: www.wasp2013.com

- **1ο Πανελλήνιο Συνέδριο Ψυχολογίας Κύπρου, Λευκωσία, Κύπρος**
5–7 Ιουλίου 2013
Οργάνωση: Παγκύπριος Σύλλογος Ψυχολόγων
Χριστοδούλου Καρύδη 20, 3031 Λεμεσός
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- **2013 World mental Health Congress of the World Federation for Mental Health, Buenos Aires, Argentina**
25–28 August 2013
Organizers: (a) The Argentinean Association for Mental health (AASM) (b) World Federation for Mental Health
Conference Secretariat: The Argentinean Association for Mental health (AASM), Ayacucho 234, Buenos Aires, Argentina,
Tel/Fax: +541149521923, E-mail: info@wmhc2013.com

- **"4th European Conference on Schizophrenia Research (ECSR)", "Together for better treatment and care", Berlin, Germany**
26–28 September 2013
Organizers : (a) European Scientific Association on Schizophrenia and other Psychoses, (b) Competence Network on Schizophrenia (CNS), (c) European Psychiatric Association and its Section on Schizophrenia, (d) German Association for Psychiatry and Psychotherapy (DGPPN)
Collaboration: WPA section on Schizophrenia
Contact: Viktoria Toeller
E-mail: toeller.viktoria@uni-duesseldorf.de
Website: www.schizophrenianet.eu

- **IV Παγκύπριο Συνέδριο, Λάρνακα Κύπρος**
26–29 Σεπτεμβρίου 2013
Οργάνωση: Ψυχιατρική Εταιρεία Κύπρου
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- **"WPA Thematic Conference", "Human Factors in Crisis and Disasters - Future proofing of crisis and disaster management", Melbourne, Australia**
30 September–3 October 2013
Organizer: Indo Australasian Psychiatry Association Collaboration: (a) WPA Section on Disaster Psychiatry, (b) UNESCO Chair in Bioethics
Contact: Dr Russell D'Souza
E-mail: russell.f.dsouza@gmail.com, Website: www.wpadisasterpsych.com

- **4ο Πανελλήνιο Συνέδριο Αυτισμού, Θεσσαλονίκη**
4–6 Οκτωβρίου 2013
Οργάνωση: Ελληνική Εταιρεία Προστασίας Αυτιστικών Ατόμων-Παράρτημα Θεσσαλονίκης
Γραμματεία συνεδρίου: Κέντρο Ημέρας ΕΕΠΑΑ Θεσ/νίκης, Βερατίου 5
Τηλ./Fax: 0030 2310 241287, E-mail: 4opanelinio@autismgreece.gr

- **"26th ECNP Congress, Barcelona, Spain**
5–9 October 2013
Organizer: European College of Neuropharmacology (ECNP)
Contact: ECNP Office
Tel: (+31) 302538567, E-mail: nice2012@ecupeu, Website: www.ecnp.eu

- **2nd Congress on Treatment in Psychiatry, Ostrava, Czech Republic**
10–13 October 2013
Organizer: Czech Psychiatric Association
Contact: Prof. Jiri Raboch, M.D.
E-mail: lecbavpsychiatrii2013@guarant.cz
Website: www.lecbavpsychiatrii2013.cz

- **"WPA International Congress", "Future Psychiatry: Challenges and Opportunities", Vienna, Austria**
27–30 October 2013
Organizer: Austrian Association for Psychiatry and Psychotherapy
Contact: Prof. Michael Musalek
E-mail: wpaic2013@guarant.cz, Website: www.wpaic2013.org

- **3rd International Congress of Dual Disorders: addictions and other Mental Disorders, Barcelona, Spain**
23–26 October 2013
Organizer: Spanish Society of Dual Pathology
Co-sponsorship: (a) National Institute on drug abuse (NIDA) (b) World Psychiatric Association (WPA)
Tel.: (+34) 91 3612600, Fax: +34 91 3559208
E-mail: secretariat@cipd2013.com, Website: www.cipd2013.com

- **"WPA Regional Meeting", "Addressing mental health needs in the Alps-Adria-Danube Region: Stigma, Community Based Care, Stress and Suicidality", Ljubljana, Slovenia**
9–12 April 2014
Organizer: Psychiatric Association of Slovenia
Contact: Dr Peter Pregelj/Dr. Jurij Bon
E-mail: peter.pregelj@psih-klinika.si/, jurij.bon@pb-begunje.si, Website: www.wpaljubljana2014.org

- **Congress of World Association for Dynamic Psychiatry "Multidisciplinary Approach to and Treatment of Mental Disorders: Myth or Reality?", St. Petersburg, Russia**
14–17 May 2014
Organizer: World Association for Dynamic Psychiatry
Contact: Dr Maria Ammon, General Secretary WADP
E-mail: DAPBerlin@aol.com, Website: www.wadp-congress.de

- **"WPA 16th World Congress of Psychiatry", "Focusing on Quality, Access and Humane Care", Madrid, Spain**
14–18 September 2014
Organizer: Spanish Society of Psychiatry (SEP)
Collaboration: (a) Spanish Association of Neuropsychiatry (AEN), (b) Portuguese Society of Psychiatry and Mental Health (SPPSM)
Contact: Ms Carolina G. Sicilia
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ΨΥΧΙΑΤΡΙΚΗ

Τριμηνιαία έκδοση της Ελληνικής Ψυχιατρικής Εταιρείας

ΤΟΜΟΣ 23
ΙΑΝΟΥΑΡΙΟΣ–ΔΕΚΕΜΒΡΙΟΣ 2012

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2. Alford J, Nemiah J. Peptic ulcer in childhood. In: Sodeman WA (ed) *Pathologic Physiology*. Saunders, Philadelphia, 1970:457–472 (Chapter in Book).
3. Kinden A. *Stress and emotion*. Springer, Berlin, 1990 (Book).
4. Larsen E, Elliot B. Fatigue in major depression. *Psychiatriki* 2007, (Suppl 1):S143–S144 (Journal Supplement)
5. Silverstone A, Leman H, Stark J. *Attempted suicide by drug-overdose*. Paper presented at 2nd Congress on Suicide behaviour, 4–6 May 2002, Rome, Abstracts Book, pp 212–213 (Conference Presentation - Abstract Book)
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Εκτός από την έντυπη έκδοσή του, το περιοδικό διατίθεται ελεύθερα στην ηλεκτρονική του έκδοση από τις ιστοσελίδες: www.psych.gr ή www.betamedarts.gr

Το περιοδικό "ΨΥΧΙΑΤΡΙΚΗ" δέχεται προς δημοσίευση εργασίες που αφορούν σε πρωτότυπο υλικό που δεν έχει δημοσιευθεί προηγουμένως (εκτός σε μορφή περίληψης) ή δεν έχει υποβληθεί για δημοσίευση κάπου αλλού.

Κατά την υποβολή της εργασίας όλοι οι συγγραφείς πρέπει να υπογράψουν στο τυποποιημένο έντυπο υποβολής ότι συμφωνούν με το περιεχόμενο και αποδέχονται την υποβαλλόμενη προς δημοσίευση εργασία και μεταβιβάζουν τα συγγραφικά δικαιώματα στο περιοδικό "ΨΥΧΙΑΤΡΙΚΗ". Οι συγγραφείς ακόμη, δηλώνουν ότι: (α) δεν υπήρξε οικονομική υποστήριξη από διάφορες πηγές (εάν υπήρξε πρέπει να δηλωθεί), (β) δεν υπήρξαν αντικρουόμενα συμφέροντα σχετικά με το υλικό της έρευνας που υπεβλήθη προς δημοσίευση, (γ) το πρωτόκολλο της έρευνας εγκρίθηκε από την Επιτροπή Βιοηθικής του Νοσοκομείου ή του Ιδρύματος όπου πραγματοποιήθηκε η έρευνα σύμφωνα με τις προδιαγραφές της Διακήρυξης του Ελσίνκι (1995) όπως αναθεωρήθηκαν στο Εδιμβούργο (2000) και (δ) ότι όλοι οι ασθενείς έδωσαν τη συγκατάθεσή τους πριν συμπεριληφθούν στην έρευνα αφού προηγουμένως ενημερώθηκαν για την ερευνητική διαδικασία.

Τα κριτήρια αποδοχής των εργασιών περιλαμβάνουν την ποιότητα και την πρωτοτυπία της έρευνας, όπως επίσης τη σημαντικότητα και χρησιμότητα των δεδομένων στους αναγνώστες του περιοδικού.

Όλες οι εργασίες υπόκεινται σε μια αρχική εκτίμηση από τον Εκδότη ή μέλη της Συντακτικής Επιτροπής του περιοδικού προκειμένου να εκτιμηθεί η καταλληλότητα και η ποιότητά τους. Εάν η εργασία κριθεί καταρχήν κατάλληλη για δημοσίευση στο περιοδικό, εκτιμάται από δύο ανεξάρτητους κριτές, ειδικούς στο αντικείμενο της έρευνας. Οι κριτές δεν γνωρίζουν τους συγγραφείς της εργασίας και παραμένουν ανώνυμοι για τους συγγραφείς.

Τα σχόλια των κριτών μαζί με τις υποδείξεις και διορθώσεις τους αποστέλλονται στους συγγραφείς. Οι συγγραφείς ενημερώνονται εγγράφως για την τελική απόφαση της Συντακτικής Επιτροπής του περιοδικού όταν η διαδικασία αξιολόγησης ολοκληρωθεί. Τα ονόματα των κριτών του προηγούμενου έτους εμφανίζονται στο πρώτο τεύχος του επομένου έτους. Η Συντακτική Επιτροπή διατηρεί το δικαίωμα να κάνει φραστικές διορθώσεις στα κείμενα προκειμένου να μειώσει ασάφειες και επαναλήψεις και να βελτιώσει τη δυνατότητα επικοινωνίας ανάμεσα στους συγγραφείς και τους αναγνώστες του περιοδικού.

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* Οι οδηγίες προς τους συγγραφείς και το «συνοδευτικό έντυπο υποβολής» υπάρχουν στο 1ο τεύχος κάθε έτους του περιοδικού και στο website της ΕΨΕ: www.psych.gr.

Το περιοδικό «ΨΥΧΙΑΤΡΙΚΗ» καταχωρείται και περιλαμβάνεται στα MEDLINE/PubMed, Index Copernicus, Google Scholar,
EMBASE/Excerpta Medica, GFMER, CIRRIE,
SCIRUS for Scientific Inf., EBSCOhost™ και στο Iatrotek

ΕΙΔΗ ΑΡΘΡΩΝ

1. **Άρθρα Σύνταξης**: Σύντομα άρθρα γραμμένα ταυτόχρονα στην ελληνική και αγγλική γλώσσα που αναφέρονται σε επίκαιρα θέματα ιδιαίτερης σημασίας. Γράφονται από τη Συντακτική Επιτροπή ή από μέλη της Διεθνούς Συμβουλευτικής Επιτροπής ή μετά από πρόσκληση της Συντακτικής Επιτροπής (μέχρι 500 λέξεις και 5–7 βιβλιογραφικές αναφορές).
2. **Ανασκοπήσεις:** Ενημερωτικά άρθρα που αφορούν σε κριτική ανάλυση ψυχιατρικών θεμάτων ή θεμάτων συγγενών προς την Ψυχιατρική Επιστήμη. Οι ανασκοπήσεις γράφονται από έναν ή δύο συγγραφείς. Η έκτασή τους δεν πρέπει να υπερβαίνει τις 7.500 λέξεις (25 δακτυλογραφημένες σελίδες, διπλό διάστημα γραφομηχανής).
3. **Ερευνητικές εργασίες:** Προοπτικές ή αναδρομικές εργασίες που βασίζονται σε ερευνητικό πρωτόκολλο. Πρέπει οπωσδήποτε να έχει γίνει στατιστική επεξεργασία των αποτελεσμάτων. Οι ερευνητικές εργασίες δεν πρέπει να υπερβαίνουν τις 3.000 λέξεις (10 δακτυλογραφημένες σελίδες, διπλό διάστημα γραφομηχανής).
4. **Σύντομα άρθρα:** Στην κατηγορία αυτή υπάγονται ερευνητικές εργασίες που μπορούν να καταχωρηθούν σε περιορισμένο χώρο. Η έκταση των άρθρων αυτών δεν πρέπει να υπερβαίνει τις 1.500 λέξεις (5 δακτυλογραφημένες σελίδες, διπλό διάστημα γραφομηχανής).
5. **Ειδικά άρθρα:** Γράφονται μετά από πρόσκληση της Συντακτικής Επιτροπής και αναφέρονται σε θέματα, με τα οποία έχει ιδιαίτερα ασχοληθεί ο συγγραφέας π.χ. θεραπεία συμπεριφοράς, παθολογική ζηλοτυπία, ψυχοθεραπεία μεταιχμιακών καταστάσεων (μέχρι 6.000 λέξεις).
6. **Ενδιαφέρουσες περιπτώσεις:** Η κατηγορία αυτή περιλαμβάνει ενδιαφέρουσες αναφορές περιπτώσεων και περιγραφές περιπτώσεων όπου εφαρμόσθηκαν νέες διαγνωστικές ή/και θεραπευτικές μέθοδοι (μέχρι 1500 λέξεις).
7. **Γενικά άρθρα:** Η *ΨΥΧΙΑΤΡΙΚΗ* δέχεται και άρθρα που εκφράζουν θεωρητικές απόψεις στον χώρο της Ψυχιατρικής, γνώμες για τα συστήματα παροχής ψυχιατρικής περίθαλψης, απόψεις για τους χώρους επαλληλίας μεταξύ Ψυχιατρικής και άλλων επιστημών και άλλα άρθρα ανάλογου περιεχομένου. Τα άρθρα αυτά δεν πρέπει να υπερβαίνουν τις 2.000 λέξεις (περίπου 7 δακτυλογραφημένες σελίδες). Η Συντακτική Επιτροπή μπορεί να προτείνει τη συντόμευση των άρθρων αυτών προκειμένου να δημοσιευθούν ως «Επιστολές προς τη Σύνταξη».
8. **Επιστολές προς τη Σύνταξη:** Περιλαμβάνουν σχόλια και κρίσεις πάνω σε ήδη δημοσιευμένες εργασίες, παρατηρήσεις σε επίκαιρα ψυχιατρικά θέματα, πρόδρομα ερευνητικά αποτελέσματα, κ.λπ. Δεν πρέπει να υπερβαίνουν τις 400 λέξεις (συνοδεύεται από σύντομη Αγγλική περίληψη).
9. **Βιβλιοκριτική:** Η παρουσίαση και κριτική βιβλίων γίνεται μετά από πρόσκληση της Συντακτικής Επιτροπής (μέχρι 600 λέξεις - συνοδεύεται από σύντομη αγγλική περίληψη).
10. **Άρθρα στην αγγλική γλώσσα:** Η *ΨΥΧΙΑΤΡΙΚΗ* θα κυκλοφορεί στην Ελληνική γλώσσα πάντα με Αγγλική περίληψη των εργασιών. Ένα ή δύο τεύχη ετησίως θα κυκλοφορούν εξ ολοκλήρου στην Αγγλική (με εκτεταμένη ελληνική περίληψη, 400–500 λέξεις). Στα τεύχη αυτά θα δημοσιεύονται εργασίες ξένων συναδέλφων, αλλά και Ελλήνων. Οι εργασίες Ελλήνων συναδέλφων μπορούν να υποβάλλονται στην Ελληνική ή την Αγγλική γλώσσα. Όσες εργασίες προκρίνονται για δημοσίευση και έχουν υποβληθεί στην Ελληνική γλώσσα θα μεταφράζονται μετά από συνεργασία του περιοδικού με τους συγγραφείς.

ΥΠΟΒΟΛΗ ΕΡΓΑΣΙΩΝ

Οι εργασίες υποβάλλονται στο πρωτότυπο και σε τρία φωτοαντίγραφα, στη διεύθυνση:

Περιοδικό ΨΥΧΙΑΤΡΙΚΗ
Ελληνική Ψυχιατρική Εταιρεία,
Παπαδιαμαντοπούλου 11, 115 28 Αθήνα
e-mail: editor@psych.gr

Το δακτυλογραφημένο κείμενο πρέπει να συνοδεύεται από CD με το κείμενο της εργασίας ή να αποστέλλεται ηλεκτρονικό αντίγραφο με e-mail. Το κείμενο πρέπει να έχει γραφεί με επεξεργαστή συμβατό με πρόγραμμα Windows ή με οποιοδήποτε πρόγραμμα για υπολογιστή Macintosh.

Μαζί με τα υποβαλλόμενα άρθρα πρέπει να υποβάλλεται συμπληρωμένο το «Συνοδευτικό έντυπο υποβολής εργασίας». Οι υποβαλλόμενες εργασίες χαρακτηρίζονται με κωδικό αριθμό, που γνωστοποιείται στους συγγραφείς και ο οποίος χρησιμοποιείται σε κάθε επικοινωνία με το περιοδικό. Τα άρθρα γράφονται στη δημοτική γλώσσα. Η δακτυλογράφηση γίνεται στη μία όψη του φύλλου, με διπλό διάστημα και περιθώριο τουλάχιστον 3,5 cm.

Στην άνω δεξιά πλευρά της πρώτης σελίδας πρέπει να υπάρχει ο χαρακτηρισμός κάθε άρθρου (π.χ. Ανασκόπηση, Ερευνητική εργασία κ.λπ.).

ΔΙΑΤΑΞΗ ΤΗΣ ΥΛΗΣ

Όλες οι σελίδες αριθμούνται, αρχίζοντας από τη σελίδα τίτλου.

Σελίδα τίτλου: Περιλαμβάνει τον τίτλο του άρθρου (μέχρι 12 λέξεις), τα ονόματα των συγγραφέων στην ονομαστική, το κέντρο προέλευσης, τη διεύθυνση και το τηλέφωνο του συγγραφέα που θα επικοινωνεί με το περιοδικό. Στην ίδια σελίδα αναφέρονται επίσης άτομα, οργανισμοί, ιδρύματα κ.λπ., που ενδεχομένως συνέβαλαν στην πραγματοποίηση της εργασίας.

Περίληψη: Στη δεύτερη σελίδα γράφεται η ελληνική περίληψη, (περίπου 400–500 λέξεις). Στην περίληψη ανακεφαλαιώνονται τα κύρια μέρη της εργασίας. Φράσεις όπως «τα ευρήματα συζητούνται» πρέπει να αποφεύγονται. Στο τέλος της περίληψης αναγράφονται 4–6 λέξεις ευρετηρίου.

Αγγλική περίληψη: Στην τρίτη σελίδα γράφεται η αγγλική περίληψη, που πρέπει να έχει έκταση 400–500 λέξεων, ο τίτλος του άρθρου τα ονόματα των συγγραφέων και η προέλευση του άρθρου (ίδρυμα). Στο τέλος της περίληψης αναγράφονται 4–6 λέξεις ευρετηρίου. Η περίληψη πρέπει να δίνει ουσιαστικές πληροφορίες.

Κείμενο: Χωρίζεται σε κεφάλαια. Για τις ερευνητικές εργασίες είναι: Εισαγωγή, Υλικό και μέθοδος, Αποτελέσματα, Συζήτηση. Όσα αποτελέσματα παρατίθενται στους πίνακες δεν επαναλαμβάνονται λεπτομερώς στο κείμενο.

Βιβλιογραφικές παραπομπές: Αριθμούνται με αύξοντα αριθμό, ανάλογα με τη σειρά εμφάνισής τους στο κείμενο (σύστημα Vancouver). Π.χ. *Ο Birley*[1] *βρήκε ότι..., αλλά ο Afford*[2] *διαφώνησε...* Αναφέρονται τα ονόματα όλων των συγγραφέων. Στον βιβλιογραφικό πίνακα περιλαμβάνονται μόνον οι βιβλιογραφικές παραπομπές που υπάρχουν στο κείμενο. Στα άρθρα ανασκόπησης και τα ειδικά άρθρα οι βιβλιογραφικές παραπομπές δεν πρέπει να υπερβαίνουν τις 100, στις ερευνητικές εργασίες και τα γενικά άρθρα τις 50, στα σύντομα άρθρα και τις ενδιαφέρουσες περιπτώσεις τις 15 και στα άρθρα σύνταξης και τις επιστολές προς τη σύνταξη τις 8. Ο βιβλιογραφικός κατάλογος συντάσσεται με αύξοντα αριθμό, που αντιστοιχεί στη σειρά εμφάνισης των βιβλιογραφικών παραπομπών στο κείμενο, όπως στα ακόλουθα παραδείγματα:

1. Birley JLT, Adear P, Singer D, Rosenberg M. Electrogastrographic studies in elderly patients. *Gastroenterology* 1980, 79:311–314 (Περιοδικό)
2. Alford J, Nemiah J. Peptic ulcer in childhood. In: Sodeman WA (ed) *Pathologic Physiology.* Saunders, Philadelphia, 1970:457–472 (Κεφάλαιο βιβλίου)
3. Kinden A. *Stress and emotion*. Springer, Berlin, 1990 (Βιβλίο)
4. Larsen E, Elliot B. Fatigue in major depression. *Psychiatriki* 2007, (Suppl 1):S143–S144 (Παράρτημα περιοδικού)
5. Silverstone A, Leman H, Stark J. *Attempted suicide by drug-overdose*. Paper presented at 2nd Congress on Suicide behaviour, 4–6 May 2002. Rome, Abstracts Book, pp 212–213 (Παρουσίαση σε Συνέδριο - Τόμος Πρακτικών)
6. Henry A, Andrews B. *Critical issues for parents with mental illness*. N.Y. Centre for Mental Health Services 2001 (Cited 2 June 2005) Available from www. mentalorg/publications (Ιστοσελίδα)

Οι συντμήσεις των περιοδικών πρέπει να γίνονται με βάση το *Index Medicus*.

Πίνακες: Γράφονται με διπλό διάστημα γραφομηχανής σε ξεχωριστή σελίδα. Αριθμούνται ανάλογα με τη σειρά εμφάνισής τους στο κείμενο, με αραβικούς αριθμούς (πίνακας 1), ακολουθεί σύντομη κατατοπιστική λεζάντα (π.χ. Ασθενείς που νοσηλεύθηκαν για ψευδοκύηση στο Νοσοκομείο «Αλεξάνδρα» κατά το 1988) και σε κάθε στήλη υπάρχει κατατοπιστική επικεφαλίδα. Αποφεύγονται οι κάθετες γραμμές.

Εικόνες: Πρέπει να στέλνονται είτε τα πρωτότυπα των σχεδίων (με σινική μελάνη) είτε φωτογραφίες. Στο πίσω μέρος πρέπει να αναγράφεται με μολύβι ο αριθμός της εικόνας, οι συγγραφείς και ο τίτλος της εικόνας. Όλες οι εικόνες πρέπει να αναφέρονται στο κείμενο και να αριθμούνται με αραβικούς αριθμούς.

Ονοματολογία και μονάδες μέτρησης: Για λεπτομέρειες, βλ. Ιατρική 1980, 37:139.

Διόρθωση τυπογραφικών δοκιμίων: Οι συγγραφείς είναι υποχρεωμένοι να κάνουν μία διόρθωση των τυπογραφικών δοκιμίων. Εκτεταμένες μεταβολές δεν επιτρέπονται.

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ΣΥΝΟΔΕΥΤΙΚΟ ΕΝΤΥΠΟ ΥΠΟΒΟΛΗΣ ΕΡΓΑΣΙΑΣ ΣΤΟ ΠΕΡΙΟΔΙΚΟ *"ΨΥΧΙΑΤΡΙΚΗ"*

(Υποβάλλεται μαζί με την εργασία, τρία φωτοαντίγραφα της εργασίας και την αντίστοιχη δισκέτα ή με την αποστολή ηλεκτρονικού αντιγράφου με e-mail)

- Παρακαλώ συμπληρώστε/τσεκάρετε όλα τα σημεία του εντύπου
- Είδος εργασίας (σημειώστε με Χ):

❑ ΑΝΑΣΚΟΠΗΣΗ ❑ ΕΡΕΥΝΗΤΙΚΗ ΕΡΓΑΣΙΑ ❑ ΣΥΝΤΟΜΟ ΑΡΘΡΟ

❑ ΕΙΔΙΚΟ ΑΡΘΡΟ ❑ ΓΕΝΙΚΟ ΑΡΘΡΟ ❑ ΠΑΡΟΥΣΙΑΣΗ ΠΕΡΙΠΤΩΣΕΩΣ

- Τίτλος εργασίας ....

....

- Ονοματεπώνυμα συγγραφέων ....

....

....

....

- Φορέας ή Κέντρο (α), από το οποίο προέρχεται η εργασία ....

....

....

- Υπεύθυνος συγγραφέας για την αλληλογραφία ....

Ονοματεπώνυμο ....

Διεύθυνση ....

Τηλέφωνο .... Fax: .... E-mail: ....

- Επιβεβαιώστε (σημειώστε με Χ) όλα τα παρακάτω σημεία της εργασίας σας:

❑ Περίληψη της εργασίας στα ελληνικά και αγγλικά, σύμφωνα με τις προδιαγραφές του περιοδικού

❑ 4–5 λέξεις ευρετηρίου στα ελληνικά και στα αγγλικά

❑ Αντιστοιχία των βιβλιογραφικών αναφορών του κειμένου με τον κατάλογο της βιβλιογραφίας, που παρατίθεται στο τέλος του άρθρου

❑ Καταγραφή των βιβλιογραφικών αναφορών σύμφωνα με τις προδιαγραφές της *«Ψυχιατρικής»*

Οι συγγραφείς της εργασίας συμφωνούν με το περιεχόμενο της, τη δημοσίευσή της στο περιοδικό "Ψυχιατρική" και τη μεταβίβαση των συγγραφικών δικαιωμάτων στο περιοδικό. Το ίδιο κείμενο δεν έχει δημοσιευθεί ούτε έχει υποβληθεί για δημοσίευση σε άλλο περιοδικό. Οι συγγραφείς δεν έχουν αντικρουόμενα συμφέροντα σε σχέση με το περιεχόμενο της εργασίας και δηλώνουν ότι το πρωτόκολλο της έρευνας εγκρίθηκε από την Επιτροπή Βιοηθικής του Ιδρύματος όπου πραγματοποιήθηκε η έρευνα. Όλα τα άτομα που συμμετείχαν έδωσαν τη συγκατάθεσή τους πριν συμπεριληφθούν στην έρευνα. Οι συγγραφείς ακόμη δηλώνουν ότι δεν υπήρξε πηγή οικονομικής υποστήριξης (εάν υπήρξε πρέπει να δηλωθεί).

Υπογραφές συγγραφέων Ημερομηνία