OPEN MINDS II

Coercion: The Culture of Institutionalization in Greece

The culture of institutionalization governs the entire mental health system in Greece

The logic of institutionalization is well-established in Greece and further consolidated by the conditions of the economic crisis and the memoranda, the dramatic reduction of qualified human resources and the underfunding of mental health services, the complete dissolution of any social state.

But it wasn't born of them. Institutional psychiatry, as it itself was transferred from psychiatric clinics to general hospitals, was also the pre-crisis model, with much more staff and funding. The issue is the dominant psychiatric culture and practice[1].

Credit: Alexia Tsagari

The in-country doctors' regime has been extremely suspicious of psychiatric reform since ' 90. In fact, there was an informal separation in the ranks of psychiatrists, whether they are of "community psychiatry" or of "old Psychiatry". Due to conservatism, due to faith in the model of incurable diseases...

The majority of the leadership of the psychiatric community had the international experience of Community psychiatry (and accesses to the political and academic system). But there was another part of doctors, nurses, etc., that by using pseudo-scientific arguments did not discuss the de-institutionalisation, neither back then, nor now. Their perspective focuses practically on "managing the disability of the mentally ill", even if they create it. The de- institutionalisation model is based on the need "to prevent such disabilities - it is feasible". On the basis of the first argument, which was "building souls ' warehouses," the purgatory of Leros was created.

Challenging the "dominant psychiatric paradigm" and moving beyond it, towards a radically alternative psychiatric culture, practice and organization of services, obviously does not concern those who serve the "existing order of things" (political, social, institutional)-although they predominantly use the terminology ("paradigm change" etc.) as a verbal firework.

On the contrary, it is a case of a "bottom-up" social movement: mental health practitioners who daily struggle in this direction, people with psychiatric experience, independently organized associations of families, social cooperatives and unions, that not only envision, but actively fighting towards another, radically alternative "social order"[2].

Facts & Figures

- Greece is counting almost 4 decades of Mental Health reform. Still, it continues to maintain 3 big psychiatric hospitals where restriction measures and coercion takes place on a daily basis while the continuity of care is not being ensured. (13), (14), (15), (16), (17).
- After 30 years of "reforms", 55% of hospitalizations in psychiatric units are still involuntary, by order of the prosecutor.
- The "closed" hospitalization is needed to treat, with the appropriate medications, the acute symptoms of mental illness. And that's always temporary, planned and depending on the severity of the incident.
- The deinstitutionalization -i.e. caring for the mentally ill within the community's framework- ultimately costs less than having the patient locked up in an asylum.
- In the vast majority of cases, people who are locked in an asylum are there to be taken care of. And the doors are locked so they can only have one nurse per 40 hospitalized and not one per 5 as foreseen in open community structures, where the doors are open, and patients make their walk in the city, take a day off etc. Consequently, institutionalization is a cheaper and less responsible model of care that is however worsening the situation of the patients themselves.

If I was to get sick, if one of my relatives was sick, I would never want to be found in a situation like this, behind a locked door for a long time. I would like a treatment near my home, with my family and friends involved and with the prospect of getting my life back from where I left it when I experienced the mental health problem

There is no one-size-fits-all approach to prevent, reduce and eliminate coercion. Many examples, however, do share some common aspects such as:

- Focusing on the will and preferences of service users, devoting more time and involving staff and peers in initiatives
- Training staff members, but also police forces and other public officials, with the involvement of experts by experience.
- Devoting time to improving communication with users in the context of their families and social networks and focusing on collaboration in a recovery-based and human-rights approach
- Improving physical environments
- Implementing effective work at territorial level and collaboration between different services (for example, social services, health authorities, employment services, local leisure opportunities)
- Monitoring and data collection on the use of coercion and jointly reviewing incidents to see what can be learned

A holistic mental health system is crucial to truly eliminating coercion. It is not about changing individual practices but about implementing a new culture. A lack of integration of mental health in primary care services, and insufficient availability and continuity of care leads to forced hospitalisation.

Prevention of crisis situations is key to avoiding coercion. It appears that the best answer to prevent hospitalisation and coercion is effective work at the territorial level with good quality outpatient and community services. When any real strategy towards the reduction of coercion is lacking, evaluating national trends is challenging. A combination of both territorial work and overarching strategies seems the best way forward to end coercion and fully implement a human rights approach to mental health[3].

Figure 1: Freedom is therapeutic (cover m. 3-4, 1984 και m.9, 1989): the magazine of the «movement for psychiatric patients' rights» that played crucial role towards rendering psychiatric issues to policy issues in relation to the mainstream

The so-called "Psychiatric Reform" in Greece is linked to the country's' European integration process. EU has provided significant support to Greece for completing the Psychiatric Reform. Several national programs funded by EC have been implemented in order to develop a universal community based mental health system. The projects "Leros I" & "Leros II" (from 1990 to 1994), "Psychargos I" programme (from 1997 to 2001), Psychargos II Revised -also known as "National Action Plan Psychargos 2000 – 2010" (from 2001 to 2010)- achieved the closure of long stay psychiatric hospitals, the deinstitutionalisation of the majority of the patients, the establishment of psychiatric services in general hospitals and the geographical and administrative sectorisation of mental health services. (6), (7), (8).

The last revised phase of Psychargos was supposed to cover the period from 2011 to 2020. In 2012, 65 non-profit organizations were involved with 220 MH units and absorbed a total budget of € 45 million to cover 4,207 patients in the context of deinstitutionalisation, a number that approximately represents the 50% of the capacity of national system in beds for the patients. However, this reform plan remains incomplete, given that the sectorisation, adequate primary care policies, intersectoral coordination and specialised services such as those for children and adolescents, and for people with autism, intellectual disabilities and geriatric services, case management and judicial support remain underdeveloped (9), (10), (11), (12).

"Psychargos" Phase II in numbers[4]

3rd EC Support Framework	Target	Operational Sept 2009
Shelters	42	14
Boarding Houses	109	105
Protected apartments	119	92
Accommodation structures -total	**270**	**211**
Psychiatric clinics in General Hospitals	50	8
Child-psychiatric units in General Hospitals	9	2
Shelters for short-term accommodation	31	3
Mental Health & Psychosocial support Centers + Health Education Centers	55	16
Day Centers Day hospitals	29	25
Mobile Units	19	14
Mobile Units for home care	-	2
Mental Health Services in Health Centers	-	(10-12*)
Total-Community mental health and psychosocial support structures	**193**	**70**
Centers for alcohol abuse	9	0
Centers for substances abuse	21	0
Autism Centers	19	7
Alzheimer Centers	7	4
Total – Community-based specialized structures	**56**	**11**

Stopped being operational following the end of the 3rd EC support Framework

Refugee and Migrants Crisis: The false dimension of an Emergency

European countries cannot define as an emergency the situation represented by the massive refugee flows.

The number of people moving to European countries has significantly declined over the last years. Compared to 1,015,877 people who arrived in Europe in 2015, the corresponding figure in 2018 amounted to just 116,647.

As societies of the European Union, we must consider that both the refugee and migration problems are a ' systemic ' problem and must be tackled in the context of a long-term political, economic and social planning for its essential solution.

This is a real change of direction: we must abandon the culture of "concentration camps" and the provision of direct humanitarian aid and design a structural culture of intervention, guaranteeing rights, Health, housing, education, social inclusion.

KEY FIGURES 2015-2018

	2015	2016	2017	2018
Arrivals via the Mediterranean Sea to Europe	1,015,877	363,425	172,324	116,647
Deaths at sea	3,771	5,096	3,139	2,275
Number of arrivals by sea in Europe per death at sea	One death for every 269 arrivals	One death for every 71 arrivals	One death for every 55 arrivals	One death for every 51 arrivals
Number of deaths recorded along land routes at Europe's borders	144	72	75	136
Number resettled to Europe	11,175	18,175	27,450	24,885**
Number evacuated from Libya	-	-	389	2,404

Daily stressors play a pivotal role in mental health outcomes of populations affected by collective violence and statelessness.

Chronic anxiety, loss of control and prolonged fear are often encountered among refugees and there is broad consensus that chronic exposure to these emotional states can have a detrimental effect on their health status[5].

A dimension of the refugee issue that stays in the dark is the tendency to understand and describe of these people's behaviour with psychiatric terms. Their understanding is done in terms of psychopathology ("It is the trauma, it is the psychologic consequences of trauma"), while it obscures the effect of reality that we have created for them. This is characterised by a lack of elementary respect for human dignity (see the conditions of reception on the islands), denial of their rights (see the non-implementation of relocation and family reunification policies), uncertainty about the present and the future (see the inexistence of integrated integration policies). Instead of answering their pressing questions, we are providing fragmented, inappropriate, uncoordinated interventions from bodies that act competitively with each other, causing greater chaos. In the chaos of the crisis, the chaos of interventions is added. In addition, access to human rights and services due to refugee status is only allowed to the most vulnerable.

> *Upholding the basic protection principles, human rights approaches and coordination mechanisms between different actors during a crisis, are guarantors of an improved mental health status among the people of concern.*

Closing the gap: Comprehensive, integrated and responsive mental health services in community-based settings, with attention to vulnerable populations

There is a need for a demand-oriented Mental Health System for refugees as well as other vulnerable populations:

Figure 2: Models / best practises available in Europe: Open Minds project – Greece, BafF centres – Germany

Refugees and migrants provoke political and cultural changes in our countries and the entire world. Within the current social and political polarization between pro- and anti-refugee movements and countries, refugees themselves become the new scapegoats while they also present an opportunity for the relativization of fundamental human rights. Under the burden of the new populist discourse against migrants and refugees expressed by many prominent political figures across Europe, politicians and national health systems are (and will be) neither able nor willing to correspond to this new reality in the short and medium term. Political stakes are too high for new politicians while the rise of the far right and extremism across Europe places the progressive civil society in a state of defence.

Universal health coverage (UHC) is defined as ensuring that all people have access to needed health services (including prevention, promotion, treatment (WHO)). The dominant biomedical model in the field of mental health and the pursuit of psychiatry remains sterile and ineffective against the complexity of human psychopathology and broader social and mental suffering.

Basic parameters such as the fact that pathologies -psychiatric, medical and social- are connected to each other and that the agony is meta-atomic -that is it exceeds the individual anguish and enters in the social, cultural and economic realm- are ignored.

Responses remain fragmented and ineffective to the vast majority of cases (Saraceno, 2019) as there is a decoupling of health promotion and well-being by the respect of human rights (Stylianidis et al., 2017. Stylianides & Panagou, 2018).

Cross-sectoral cooperation between services and resources, the transfer of skills from one service to another and the ability to synergise in order to promote community mental health are a necessity. This requires flexibility of approaches and budgets, which must focus and accompany the needs of service users (person-oriented), rather than focusing on the needs of those who offer the services (provider-oriented).

MDM-EL experience on the field

MDM-Greece has identified anxiety, stress and depression, psychological trauma and difficulties in addressing the parenting role in the majority of cases undertaken. As well, the psychological service has dealt with comorbidity of a mental health problem and a substance misuse behaviour. A range of therapeutic approaches, psychotherapy, psychoeducation and counselling techniques have been applied in order to deal with each case's specific difficulties and needs. However, what has proved to be the most effective tool is to be a good listener and not ignoring the basic protection standards and needs of this population. Interestingly enough, most of our beneficiaries dealt with a complete lack of a supportive system and most of their basic needs such as food, housing were being ignored.

The idea that people need the right tools, assets and skills to deal with an increasingly complex, interconnected and evolving risk landscape, while retaining the ability to seize opportunities to increase overall well-being, is widely accepted. Trying to operationalize this concept, MdM strive to build its beneficiaries' resilience i.e. to improve their absorptive, adaptive and transformative capacities. We actively work towards supporting beneficiaries to smoothly absorb potential shocks that a sudden interruption of services in combination with other changes (e.g. transfers to alternative accommodation) may cause and to undergo a smooth transition from humanitarian aid to state oriented services.

The recent spike in new arrivals on the Greek islands in combination with an intensification of conservative and deterrence policies – also manifested in the recent draft law on asylum, reception and detention of those seeking international protection in Greece- are expected to further challenge the resilience of our beneficiaries and staff, the access to quality MHPSS services for all and ultimately the public narrative in relation to vulnerability. There's thus a risk that any positive momentum towards reforms will be lost and/or will be replaced by a more discriminatory and xenophobic perception in relation to refugees, migrants and mental health issues. The recent statements of the Greek Minister of Public Order in relation to vulnerability falsely granted on the basis of PTSD, certainly point out towards that direction.

It is thus imperative that civil society remains vigilant and united towards advocating for positive change.

"Today 5/7/2019 our fellow-prisoner Sophia K. left her last breath in the toilets of chamber 2 on the ground floor of the women's prison Korydallos. We - her cell mates - found her hanged and despite the SPR we performed (one inmate is a doctor), she never came back to life. Sophia K. was detained a few days ago and was experiencing chronic psychiatric problems. The investigator and prosecutor who decided that he should be detained, did not order a psychiatric evaluation before detention while they knew she had recently attempted suicide. A psychiatric ward for female prisoners does not exist, as there is no hospital, a fact we have denounced many times in the past. We have also denounced the fact that women with serious psychiatric problems are thrown in prisons, in an environment that not only is unsuitable for such cases, but aggravates any mental health problems. Their fellow inmates are "obliged" to watch over and take care of these women, as it was the case with Sophia. This is what we always do for the sake of humanity and solidarity, and there are few cases that certain deaths of women who are trying to commit suicide have been prevented.

However, as we have already stated in the past, we cannot not always be there to intervene in time. Two days ago, Sophia had been scheduled to be transferred to the psychiatric ward, but once again the responsible dept of transfers did not execute the transfer. We have also denounced the criminal negligence of the said department («metaggogon») in the past. As we had specifically written, 9 out of 10 health incidents are not served. The result of this tactic is that scheduled medical appointments and surgeries with hospital doctors are to be cancelled or indefinitely postponed.

5/7/2019
Signed by the women
who live on the basement of Korydallos prison (K2)

Body of Evidence

There are the data upon which MdM-Greece advocacy in relation to Mental Health and Psychosocial reforms in Greece is based. The "Open Minds" project, targeting the most vulnerable -such as refugees, migrants and Greek below poverty level- provided the organization the opportunity to continue much needed service provision while, at the same time, further building a body of evidence upon which additional advocacy initiatives are designed. They -partially- represent the profiles of MdM-Greece beneficiaries as well as the quantity and type of services provided between 01.10.2018 – 31.10.2019.

Total Beneficiaries	392	
Gender	Total	%
Men	234	59.69%
Women	158	40.31%

Age	Total	Men	Women	%/Total	Men/Total	Women/Total
0-59 months	0	0	0	0.00%	0.00%	0.00%
5-17 yrs	31	20	11	7.91%	5.10%	2.81%
18-49 yrs	318	194	124	81.12%	49.49%	31.63%
>=50 yrs	43	20	23	10.97%	5.10%	5.87%
Total	392	234	158	100.00%	59.69%	40.31%

Total Consultations	2,850
Psychiatrist	880
Phycologist	983
Social Worker	987

Mental disorder code range
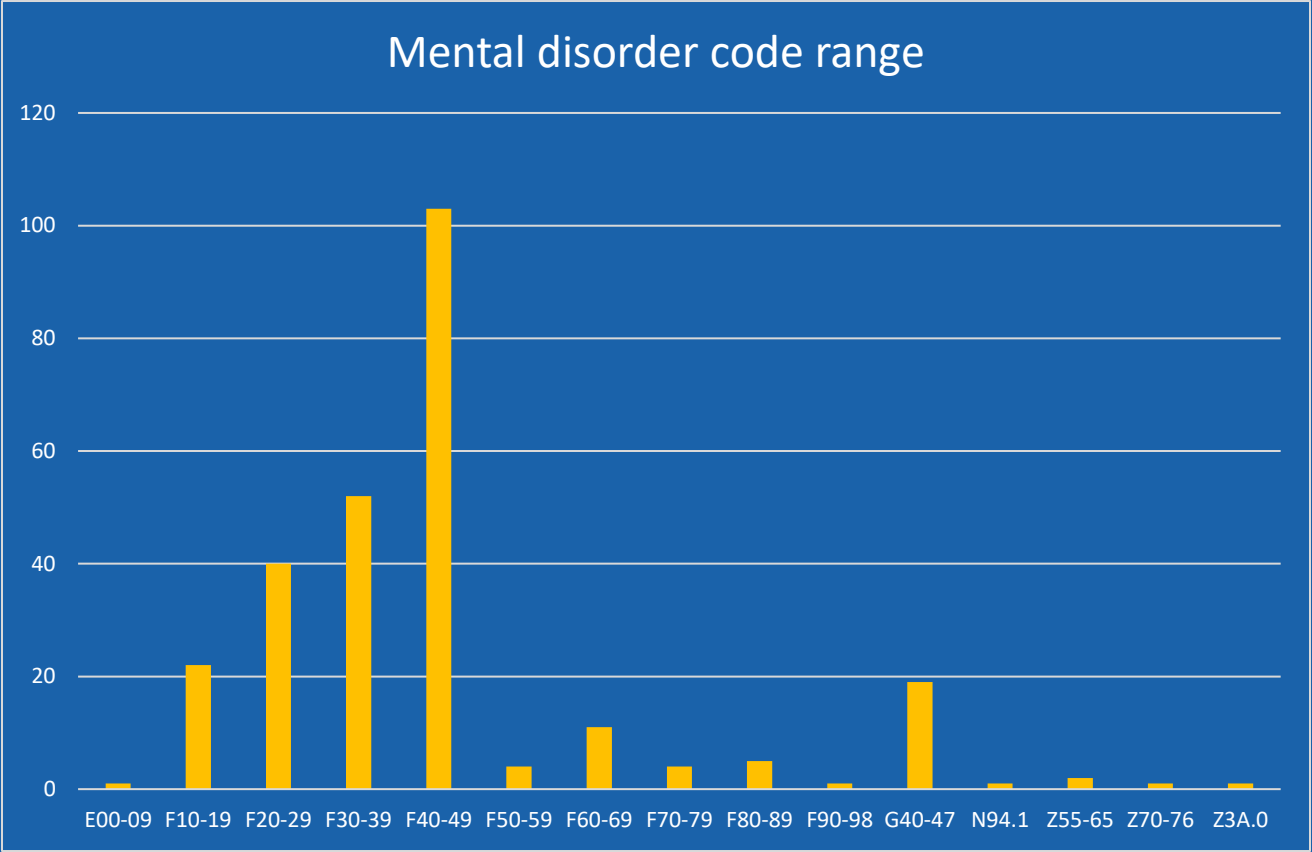
Annex

E00-E09	Endocrine, nutritional and metabolic diseases
F10-19	Disorders related to drug use and addiction
F20-29	Psychotic disorders
F30-39	Mood disorders
F40-49	Anxious, somatoform and stress related disorders
F50-59	Behavioral problems regarding normal body functions
F60-69	Personality and behaviour disorders
F70-79	Intellectual disabilities
F80-89	Disorders of psychological development
F90-98	Behavior and emotional disorders of childhood and adolescence
G40-47	Episodic and paroxysmal disorders
N94.1	Dyspareunia
Z55-65	Persons with potential health hazards related to socioeconomic and psychosocial circumstances
Z70-76	Persons encountering health services in other circumstances
Z3A.0	Weeks of gestation of pregnancy, unspecified or less than 10 weeks

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