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Perspective

The Contribution of Society of Social Psychiatry P. Sakellaropoulos to the Psychiatric Reform in Rural Greece

Harilaos Papachristou *, Iliana Lazogiorgou-Kousta, Vasilis Chronopoulos and Athena Fragouli-Sakellaropoulou

The Society of Social Psychiatry P. Sakellaropoulos, 17673 Kallithea, Greece
* Correspondence: harisun15@hotmail.com

Abstract: The present paper aims to describe the structure, function, and goals of two of the oldest Mobile Mental Health Units in Greece, namely, the Mobile Mental Health Unit in Fokida (MMHU-F) and the Mobile Mental Health Unit in Thrace (Alexandroupolis, MMHU-T). Information about their historical background, catchment areas, and current staffing, as well as the services provided by each MMHU is discussed. The focus of the paper is slightly biased towards the MMHU-F because it is the only available mental health service in the whole Fokida prefecture. The major goals of the MMHUs are the diagnosis, treatment, and prevention of relapse of severe mental illness within the community. Other important goals of the MMHUs are psychoeducation, psychological support for the family/caregivers, as well as vocational training and support for patients with severe mental illness. Statistical data depicting the demographic characteristics and diagnostic profiles of patients in each MMHU is also provided, and the differences between the two MMHUs are briefly discussed.

Keywords: community mental health; mobile mental health unit; rural areas; severe mental illness

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1. Historical Background and Goal of the MMHUs

In 2005, the Mental Health Declaration for Europe and the Mental Health Action Plan for Europe created the conditions for mental health reform in Europe [1]. Mental health was recognized as a priority across European countries and there was a need for evidence-based policies and practices to support mental health reform. A goal of the mental health reform has been to develop community-based mental health services in all European countries and to downgrade large mental institutions. However, the development of community-based mental health services has not been homogenous within Europe. Evidence shows that there is a gap in their development between Western and Eastern/South-Eastern parts of Europe [1,2]. The lack of adequate community-based mental health services in Eastern/South-Eastern European regions may result in the social isolation of mental health patients and may enhance the negative impact of mental health stigma. Some of the reasons for the delayed development of community-based mental health services in these European regions are the lack of formulation of adequate mental health legislation, the lack of funding for mental health policies, and the shortage of specialized and well-trained staff [1,2]. High-quality research could strengthen the evidence that supports the clinical outcomes and the cost-effectiveness of community-based mental health services [3]. Randomized controlled trials and systematic reviews indicate that in general, community-based mental health services are effective. However, such studies have been conducted mostly in the UK and there is a scarcity of high-quality research for the effectiveness of community-based mental health services in most European countries [1].

A line of research from Eastern Europe demonstrates that access to mental health services is limited due to several reasons, such as location/distance, age, gender, socio-economic and educational background, and employment status [1,2]. In these countries, mental health services are concentrated in urban areas while there is a scarcity of mental health services in rural settings. Similarly, research evidence suggests that there is a dearth

of mental health staff and services in rural regions of Greece [4]. Early efforts to overcome this problem led to the introduction of Mobile Mental Health Units (MMHUs) in the 1980s [5]. However, in the last two decades, there has been increasing effort by the Greek State, and a number of Mobile Mental Health Units (MMHUs) have been introduced on the mainland and on several islands [6]. MMHUs are a form of community-based mental health service that can cover the mental health needs of people in these rural and remote areas [7]. Most importantly, MMHUs are low-cost services because they utilize the infrastructure of the primary health care system that is well-developed in rural Greece [8].

The Mobile Mental Health Unit in Fokida (MMHU-F) and the Mobile Mental Health Unit in Thrace (MMHU-T) were established in the early 1980s. The nongovernmental organization (NGO), namely the Society of Social Psychiatry P. Sakellaropoulos, has been running both MMHUs since 1980s. Both MMHUs were founded by Panagiotis Sakellaropoulos, who was a professor of psychiatry at the University Psychiatric Department at Democritus University of Thrace. Both MMHUs are funded entirely by the Greek State. In addition, the provision of their therapeutic services is being monitored on a monthly basis by the Greek State. Both MMHUs have been operating according to the basic principles of social and community psychiatry, following the psychiatric reform in Europe. As a result, both MMHUs are organized by similar goals and functions, yet there are differences stemming from the socio-cultural elements of the different regions. The MMHUs resemble the Community Mental Health Models in Europe (UK, Fact Model in Netherlands) and the Assertive Community Treatment in the US and other countries [9].

2. The Catchment Areas of the Mobile Mental Health Units

The Fokida prefecture is situated in middle-central Greece. It has an estimated population of 48,284 inhabitants [10]. It is a rural area, mostly mountainous, with many small and remote towns and villages. Access to capital cities and large urban centers, e.g., Athens, is relatively difficult. Amfissa (population 6946) is the capital city of the Fokida prefecture, where the headquarters of the MMHU-F is located [10]. The MMHU-F delivers services in eleven towns and villages of its catchment area: Amfissa, Itea, Galaxidi, Eratini, Efpalio, Delfi-Chrisso, Gravia-Polydroso, Amfiklia, and Lidoriki. The MMHU-F is the only mental health service available in the whole region. As a result, it takes responsibility to meet the mental health needs for the majority of the population in this rural region.

The MMHU-T covers the regional units Evros (population 149,354) and Rodopi [10]. The MMHU-T delivers services in six geographical areas of the Thrace Prefecture. In the regional unit of Rodopi, the MMHU-T visits Sapes-Filira and Comotini-Iasmos. In the regional unit of Evros, the MMHU-T delivers services in Soufli-Tihero, Didimotiho, Orestiada and Alexandroupolis. The headquarters of the MMHU-T is in the city of Alexandroupolis. Alexandroupolis is the capital city of the regional unit of Evros, with an estimated population of 48,885 [10]. It is an important port and a commercial center in North-eastern Greece. In the city of Alexandroupolis, there are various mental health services and facilities which are integrated in the health care system of the Thrace Prefecture.

3. The Multidisciplinary Teams

Both MMHUs are multidisciplinary teams. Each multidisciplinary team usually consists of adult and child psychiatrists, adult and child psychologists, social workers, speech and language therapists, teachers and special education teachers, nurses, and administrative staff. In 2022, the MMHU-T team for adult patients consisted of 4 part-time psychiatrists, 2 part-time psychologists, 1 full-time social worker, 1 full-time nurse, 1 full-time assistant nurse, 1 part-time teacher, 2 full-time administrative officers, 1 full-time accountant, and 1 full-time manager. Moreover, during the same year, the MMHU-T for children and adolescents consisted of 1 part-time child psychiatrist, 2 part-time child psychologists, 1 full-time social worker, 1 full-time speech and language therapist, and 1 part-time special education teacher.

In 2022, the MMHU-F team for adult patients consisted of 1 part-time psychiatrist, 1 part-time psychiatrist supervisor, 1 full-time medical doctor, 4 full-time psychologists, 1 full-time social worker, 2 part-time speech and language therapists, 1 full-time art therapist, 1 part-time social scientist, 1 full-time professional driver, 2 full-time administrative officers, and 1 full-time accountant. Furthermore, during 2022, the MMHU-F team for children and adolescents consisted of 1 part-time child psychiatrist, 1 full-time child psychiatrist (resident), 1 part-time child psychologist, and 2 part-time speech and language therapists.

4. Goals and Function of the MMHUs

The main goal of the MMHUs is to provide accessible mental health services to all people in need, to prevent relapse and hospitalization in patients with severe mental health disorders, and to offer psychoeducation and implement mental health prevention programs in the community. A graphical representation of the function of the MMHUs is depicted in Figure 1.

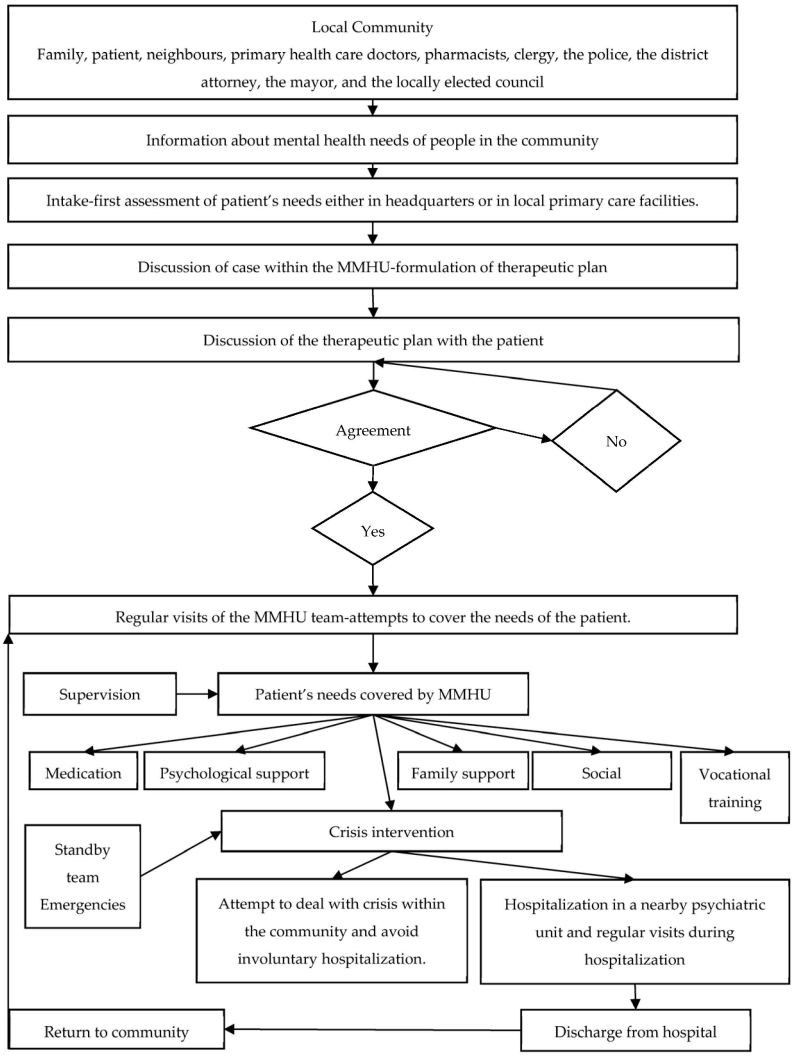

Figure 1. A graphical representation of the main functions of the MMHUs.

Each MMHU provides a wide range of mental health services such as diagnosis of mental health disorders, crisis interventions, follow-up psychiatric treatment, self-support groups, speech and language therapy, and psychological interventions. Psychological interventions include psychotherapy sessions, enhancement of social skills, art therapy,

psychoeducation, and support to the local community and to caregivers. Additionally, MMHUs provide community sensitization and work reintegration interventions. The services provided by the MMHUs are free of charge. Both MMHUs provide treatment for mental health disorders, except for addictive disorders. Patients diagnosed with addictive disorders are referred to mental health services specialized in addiction treatment.

Both MMHUs deliver mental health services in the remote towns and villages of their own catchment areas of responsibility. Mostly, they use the infrastructure of the local primary health system. However, domiciliary care is also provided to those patients who need it. Each patient has a follow-up treatment either weekly or fortnightly according to their own treatment plan. However, the session frequency increases according to the patient's needs. Unlike the prefecture of Thrace, in the prefecture of Fokida, the MMHU-F is the only provider of mental health services.

The clinical staff in both MMHUs undergo regular and ongoing external supervision once per month by experienced psychiatrists and psychologists. The multidisciplinary team meets weekly to share information about clinical work, to create treatment plans, to coordinate activities, and to report on clinical cases.

5. MMHU Data on Mental Health Illness

Although both MMHUs provide treatment for most mental health disorders, the focus is on long-term mental health illness, especially on psychotic disorders and severe mood disorders. Referrals are made by the public healthcare system and the local authorities such as law enforcement agencies and social service agencies. Moreover, referrals are also made by the family and caregivers as well as by the patient themselves. In the prefecture of Thrace, referrals are also made by the University Psychiatric Department at Democritus University of Thrace. Table 1 shows the raw numbers and the percentage of patients with an ICD diagnosis in the MMHU-T according to their age group. The main diagnosis for each patient is depicted in the table below.

Table 1. MMHU-T, Year 2021 Beneficiaries, ICD Code Range with Age *(N* = 636).

	Age									
	0–17 (*N* = 0)		**18–34 (*N* = 60)**		**35–49 (*N* = 172)**		**50–64 (*N* = 244)**		**65 and Older (*N* = 160)**	
	n	**%**	***n***	**%**	***n***	**%**	***n***	**%**	***n***	**%**
ICD Code Range										
[F00–F09] Mental disorders due to known physiological conditions	0	0.0	1	1.7	2	1.2	5	2.0	1	0.6
[F10–F19] Mental and behavioral disorders due to psychoactive substance use	0	0.0	1	1.7	0	0.0	1	0.4	0	0.0
[F20–F29] Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	0	0.0	14	23.3	69	40.1	83	34.0	37	23.1
[F30–F39] Mood [affective] disorders	0	0.0	11	18.3	46	26.7	94	38.5	84	52.5
[F40–F48] Anxiety, dissociative, stress-related, somatoform, and other nonpsychotic mental disorders	0	0.0	19	31.7	37	21.5	45	18.4	33	20.6
[F50–F59] Behavioral syndromes associated with physiological disturbances and physical factors	0	0.0	0	0.0	0	0.0	1	0.4	0	0.0
[F60–F69] Disorders of adult personality and behavior	0	0.0	1	1.7	4	2.3	9	3.7	3	1.9
[F70–F79] Intellectual disabilities	0	0.0	8	13.3	5	2.9	1	0.4	1	0.6
[F80–F89] Pervasive and specific developmental disorders	0	0.0	1	1.7	0	0.0	1	0.4	0	0.0
[Z60–Z63] Persons with potential health hazards related to socioeconomic and psychosocial circumstances	0	0.0	4	6.7	9	5.2	4	1.6	1	0.6

Table 2 shows the raw numbers and the percentage of patients with an ICD diagnosis in the MMHU-T for male and female patients, respectively. Only the main diagnosis for each patient is depicted in the table below.

Table 2. MMHU-T, Year 2021 Beneficiaries, ICD Code Range with Gender (*N* = 636).

	Gender			
	Male (*N* = 244)		**Female (*N* = 392)**	
	n	**%**	***n***	**%**
ICD Code Range				
[F00–F09] Mental disorders due to known physiological conditions	5	2.0	4	1.0
[F10–F19] Mental and behavioral disorders due to psychoactive substance use	2	0.8	0	0.0
[F20–F29] Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	105	43.0	98	25.0
[F30–F39] Mood [affective] disorders	71	29.1	164	41.8
[F40–F48] Anxiety, dissociative, stress-related, somatoform, and other nonpsychotic mental disorders	37	15.2	97	24.7
[F50–F59] Behavioral syndromes associated with physiological disturbances and physical factors	0	0.0	1	0.3
[F60–F69] Disorders of adult personality and behavior	12	4.9	5	1.3
[F70–F79] Intellectual disabilities	9	3.7	6	1.5
[F80–F89] Pervasive and specific developmental disorders	1	0.4	1	0.3
[Z60–Z63] Persons with potential health hazards related to socioeconomic and psychosocial circumstances	2	0.8	16	4.1

Similarly, Table 3 exhibits the raw numbers and the percentage of patients with an ICD diagnosis in the MMHU-F according to their age group. Only the main diagnosis for each patient is shown in the table below.

Table 3. MMHU-F, Year 2021 Beneficiaries, ICD Code Range with Age (*N* = 582).

	Age									
	0–17 (*N* = 90)		**18–34 (*N* = 78)**		**35–49 (*N* = 128)**		**50–64 (*N* = 163)**		**65 and Older (*N* = 123)**	
	n	**%**	***n***	**%**	***n***	**%**	***n***	**%**	***n***	**%**
ICD Code Range										
[F00–F09] Mental disorders due to known physiological conditions	0	0.0	0	0.0	2	1.6	0	0.0	13	10.6
[F10–F19] Mental and behavioral disorders due to psychoactive substance use	0	0.0	0	0.0	0	0.0	3	1.8	0	0.0
[F20–F29] Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	0	0.0	14	17.9	26	20.3	43	26.4	20	16.3
[F30–F39] Mood [affective] disorders	1	1.1	7	9.0	29	22.7	61	37.4	56	45.5
[F40–F48] Anxiety, dissociative, stress-related, somatoform, and other nonpsychotic mental disorders	17	18.9	28	35.9	45	35.2	44	27.0	27	22.0

Table 3. *Cont.*

	Age									
	0–17 (*N* = 90)		**18–34 (*N* = 78)**		**35–49 (*N* = 128)**		**50–64 (*N* = 163)**		**65 and Older (*N* = 123)**	
	n	**%**	***n***	**%**	***n***	**%**	***n***	**%**	***n***	**%**
ICD Code Range										
[F50–F59] Behavioral syndromes associated with physiological disturbances and physical factors	1	1.1	2	2.6	0	0.0	1	0.6	2	1.6
[F60–F69] Disorders of adult personality and behavior	1	1.1	8	10.3	7	5.5	5	3.1	2	1.6
[F70–F79] Intellectual disabilities	1	1.1	5	6.4	8	6.3	2	1.2	0	0.0
[F80–F89] Pervasive and specific developmental disorders	37	41.1	2	2.6	0	0.0	0	0.0	0	0.0
[Z60–Z63] Persons with potential health hazards related to socioeconomic and psychosocial circumstances	7	7.8	8	10.3	7	5.5	4	2.5	1	0.8
[F90–F98] Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	17	18.9	4	5.1	1	0.8	0	0.0	0	0.0
[F99] Unspecified mental disorder	0	0.0	0	0.0	1	0.8	0	0.0	2	1.6
[Z70–Z76] Persons encountering health services in other circumstances	8	8.9	0	0.0	2	1.6	0	0.0	0	0.0

Finally, Table 4 exhibits the raw numbers and percentages of patients with an ICD diagnosis in the MMHU-F for male and female patients, respectively. The main diagnosis for each patient is reported in the table below.

Table 4. MMHU-F, Year 2021 Beneficiaries, ICD Code Range with Gender (*N* = 582).

	Gender			
	Male (*N* = 227)		**Female (*N* = 355)**	
	n	**%**	***n***	**%**
ICD Code Range				
[F00–F09] Mental disorders due to known physiological conditions	5	2.2	10	2.8
[F10–F19] Mental and behavioral disorders due to psychoactive substance use	2	0.9	1	0.3
[F20–F29] Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	66	29.1	37	10.4
[F30–F39] Mood [affective] disorders	45	19.8	109	30.7
[F40–F48] Anxiety, dissociative, stress-related, somatoform, and other nonpsychotic mental disorders	48	21.1	113	31.8
[F50–F59] Behavioral syndromes associated with physiological disturbances and physical factors	3	1.3	3	0.8
[F60–F69] Disorders of adult personality and behavior	7	3.1	16	4.5
[F70–F79] Intellectual disabilities	8	3.5	8	2.3
[F80–F89] Pervasive and specific developmental disorders	25	11	14	3.9
[Z60–Z63] Persons with potential health hazards related to socioeconomic and psychosocial circumstances	3	1.3	24	6.8
[F90–F98] Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	10	4.4	12	3.4
[F99] Unspecified mental disorder	0	0.0	3	0.8
[Z70–Z76] Persons encountering health services in other circumstances	5	2.2	5	1.4

In the MMHU-T, the greatest proportion of patients have been diagnosed with a psychotic disorder, followed by an ICD diagnosis of a mood disorder. The third group of ICD diagnoses are the anxiety and stress-related non-psychotic disorders. On the other hand, the greatest proportion of patients in the MMHU-F have been diagnosed with an anxiety and stress-related non-psychotic disorder, followed by a diagnosis of a mood disorder. Psychotic disorders are the third most common category of ICD diagnoses in the MMHU-F. Unlike the MMHU-T, a substantial proportion of patients in the MMHU-F have been diagnosed with pervasive and specific developmental disorders, and there is a small percentage of MMHU-F patients with behavioral and emotional disorders with their onset in childhood and adolescence. Moreover, in both MMHUs, more men than women have been diagnosed with a psychotic disorder. In addition, in the MMHU-T, the greatest proportion of patients with a psychotic disorder belong to the 35–49 year age group, whereas in the MMHU-F, the proportion of patients with a psychotic disorder is more evenly distributed across age. Furthermore, in both MMHUs, more women than men have been diagnosed with a mood disorder. Finally, in both MMHUs, the greatest proportion of patients with a mood disorder belong to the age group of 65 and older.

6. Continuity of Care

Continuity of care is a complex and multidimensional concept that has been associated with clinical and social functioning in severe mental illness [3,6,11–13]. There is evidence that continuity of care contributes to relapse prevention and decreases the number and the length of hospitalizations in psychotic patients [6]. In addition, continuity of care has been associated with an improvement in quality of life in severe mental illness [14]. Consequently, it is a basic goal of the MMHUs as it is thought to help the patient to integrate into the community and pursuit their own personal goals in education, work, and family life.

In a recent qualitative study conducted in Norway, [15] it was argued that there is no uniformity in existing definitions of continuity of care, and they attempted to explore its dimensions. Five dimensions of continuity of care emerged from their data analysis. One of the most important dimensions of continuity of care was feeling safe in an ongoing personal relationship. Mental health patients valued a trusting relationship with the same mental health professional or a team of mental health professionals over time. Frequent breaks with therapists and having to relate to new therapists elicits anxiety, feelings of rejection, and frustration. Another important dimension of continuity of care was timeliness; that is, mental health patients feel relief when they do not have to wait too long to get help for their problems. Mutuality was the third dimension of continuity of care. People with mental health problems need reliable professionals who take the initiative to contact them first, and even between scheduled appointments. A further dimension of continuity of care was choice; e.g., the patient would like to be able to make choices about treatment place or treatment type, or the time and day of the meeting with their therapist. Finally, the last dimension of continuity of care was knowledge; in other words, the patient needs to be informed about decisions and their consequences in order to feel safe [15].

To achieve the goal of continuity of care, the MMHU staff is divided into smaller subgroups of relatively stable composition. Each subgroup consists of a psychiatrist, psychologists, a social worker, a speech and language therapist, and a nurse. For therapeutic reasons, efforts are made to keep the structure of each subgroup stable over time. The stable composition of the subgroup plays a key role in the establishment of a long-term therapeutic relationship between the clinical staff and the patients, and ensures the continuity of mental health care [6,11,15,16]. As described above, continuity of care consists of multiple dimensions, and the MMHUs aim to improve each of these dimensions. For example, each patient knows their own treatment plan and has an array of options regarding where to be treated; e.g., domiciliary care when needed, or the local primary care facility. As mentioned above, the session frequency increases according to the patient's needs, and as a result, the patient does not need to wait too long to get the support they need. Finally,

the team members take the initiative to get in touch with the patient when the patient misses scheduled appointments, as they acknowledge that patients often feel confused and exhausted due to their mental health problems [15].

The MMHUs' services include crisis interventions and follow–up sessions to psychotic patients and to their caregivers. Furthermore, the follow-up sessions include psychological interventions and support, psychiatric care, family support, psychosocial rehabilitation, and vocational training. In a typical follow-up session, the therapist evaluates the patient's mental state and treatment adherence. The patient is allowed to discuss their mental health concerns and concerns about their medication with their therapists. The therapist uses positive reinforcement to improve the patient's medication adherence. Furthermore, the multidisciplinary team aims to increase the motivation of the patient to participate in social activities. In addition, the multidisciplinary team implements educational programs to improve the patient's social skills and to strengthen their integration into the community. Finally, the clinical staff supports the patients to better manage their needs while living in the community.

7. MMHU, Crisis Intervention, and Relapse Prevention

A priority of the MMHU is to reduce avoidable hospitalizations and prevent relapse both in psychotic patients and in patients with severe mood disorders. Intervention in a psychotic crisis is a rather challenging procedure and it requires professional expertise, team working skills, active listening, and empathy skills. As a result, ongoing supervision and training are essential to the team. Although there are guidelines for good clinical practice, crisis interventions often require some flexibility and improvisation.

The crisis intervention takes place within the community, and it is usually home-based. During the crisis period, the team visits the patient daily until their symptoms subside and the patient feels safe or at least less overwhelmed. The family is also supported and encouraged to get involved in the crisis management process. Work with the community is prioritized so that the patient and their family feel accepted and supported by the community.

The aim of crisis intervention is to alleviate or reduce the psychotic stress of the patient. The team actively listens to the patient in order to build trust in the relationship. When trust has been established, the team emphasizes the need to adhere to pharmacological treatment. Furthermore, the multidisciplinary team supports the family of the patient and works with them to alter any negative attitudes and help them cope with feelings of guilt and anger.

Although the goal of the MMHUs is to deal with the crisis within the community, sometimes hospital admission is unavoidable, and in fact, it may be beneficial to the patient. In such cases, patients in the Fokida prefecture are referred to the psychiatric units of general hospitals nearby, etc., in Patra, Lamia, and Athens. Similarly, patients in the Thrace prefecture are referred to the psychiatric unit of the University hospital of Alexandroupolis. During hospitalization, members of the interdisciplinary team maintain regular visits to the psychiatric unit and collaborate with the medical staff in charge until the patient is discharged and returns home. Maintaining contact during hospitalization further strengthens the therapeutic relationship, enhances treatment adherence, and results in relapse prevention in the long-term [16].

8. Standby Procedure for Emergency Situations in Fokida Prefecture

The MMHU-F, as the only available mental health service in the Fokida prefecture, has implemented a standby (on call) procedure during weekends for emergency situations. Emergency situations mostly refer to patients with severe psychiatric disorders who face a relapse. The therapists involved in the standby procedure are experienced and well-trained psychologists, nurses, social workers, and psychiatrists. The psychiatrist supervises and guides the crisis interventions in psychiatric emergencies.

In relapse, the patient may become dangerous to themselves or to others, and there may be a risk for self-harm or suicide. During the crisis intervention, the team follows a standard procedure. Efforts are made to increase safety and to develop a strong therapeutic alliance that will support both the patient and the family. A major goal is to manage the crisis within the community and to avoid involuntary admission. However, when there is a need for involuntary admission to the hospital, the emergency team collaborates with the local police authorities and the District Attorney.

9. Vocational Training and Psychosocial Rehabilitation

The MMHUs offer vocational training and counseling to mental health patients. Work reintegration is important to mental health patients who have lost their jobs or who have never had the opportunity to find a job due to their mental illness. The procedure begins with the assessment of the patient with the use of structured interviews and questionnaires. The patient's mental health state, motivation, interests, previous working experience, and soft skills are evaluated. Social support and counseling are offered to encourage the entrance or re-entrance of the patients into the labor market. The goal is to motivate the patient and to offer them the choice of finding a suitable job either on an open labor market or in a supported/sheltered sector such as in the example of social cooperatives [17].

When suitable work has been found, the therapist arranges for a visit to the work environment together with the patient. As a result, the patient familiarizes themselves with the work environment; e.g., the location of work, time schedule, colleagues, and the regulations. Working under supported employment conditions enables the patient to work without pressure at an appropriate pace. In addition, the patient is offered both supervision and assistance. The MMHU-F cooperates closely with the social enterprise of Limited Liability Volikas, which is considered to be an example of a local supported work environment.

Similarly, the patient is provided with supervision and assistance when the job is in an open labor market or in the public sector. In such cases, the MMHU staff advises and informs the patient's employer and colleagues about the nature of the patient's illness and difficulties; e.g., difficulty in concentration, impaired decision making, etc. Finally, the team evaluates work progress and satisfaction.

10. Working with the Community

Another major goal of the MMHUs is to inform and sensitize the local community about mental health issues in order to reduce mental health stigma and to change negative attitudes towards patients with mental health disorders. Implementation of mental health promotion programs is more effective when it is organized in collaboration with local authorities and local institutions. To this end, the multidisciplinary team keeps contact with local key figures, such as the mayor and the locally elected council, the District Attorney, the police authorities, the local pharmacist, primary health care doctors, and the clergy.

Furthermore, the MMHUs develop education programs targeting specific groups in the local community, such as general practitioners, medical doctors and nursing staff in hospitals, police authorities, schoolteachers, social workers, prison guards, and the clergy. Moreover, the MMHUs provide psychological support to police officers, prison officers, and firefighters. In addition, the multidisciplinary team has been offering seminars to parents of the local community to empower their parenting role. Finally, priority is given to work in primary and secondary schools. Courses and seminars on mental health issues, such as bullying and test anxiety, are scheduled every year [18].

11. Conclusions

In summary, the MMHU-F and the MMHU-T are two community-based services that cover the mental health needs of the population in two rural areas in Greece. Both MMHUs consist of multidisciplinary teams. Their main goal is to provide accessible mental health services to all people in need, to prevent relapse and hospitalization in patients with severe mental health disorders, and to implement mental health prevention programs in the community. To this end, emphasis is given to continuity of care, as it is thought to contribute to relapse prevention and to facilitate the integration of the patient into the community. Furthermore, both MMHUs offer vocational training and work reintegration services to mental health patients in the community. Finally, informing and sensitizing the community about mental health issues in order to reduce stigma is a major goal of the MMHUs. To achieve that, the multidisciplinary teams work together with local key figures and institutions in the community.

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