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Deinstitutionalisation of patients with Severe Mental Illness in Greece: Comparing and contrasting issues of treatment in mental health institutions vs community care units

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Abstract

The research study presented in this article (based on my PhD dissertation), aimed to explore the shifting meaning of "asylum", for people with severe mental illness (SMI), who are residents of community care units (CCUs), by comparing and contrasting participants' experiences of CCUs with their previous lives in institutions. Semi-structured interviews were conducted with residents (N=35) and staff members (N=20) of four CCUs run by Klimaka (a non-governmental organisation) in Attica, the legal advisor of Klimaka, two mental health officers, a psychologist and a psychiatrist from Dromokaition Mental Health Hospital. Data were analysed thematically. Most residents felt that institutions provided a "temporary asylum" based on: 1) financial security; 2) stress-free daily routine; 3) segregation from the pressures of the outside world; 4) good or neutral relationships with staff; and 5) trust in their treatment. But most felt that the hospital had never become their actual home. All residents felt that CCUs offered them a temporary or permanent asylum, based on: 1) financial security; 2) enriched daily routine; 3) wider social networks; 4) an increased degree of freedom; 5) good relationships with staff; 6) trust in treatment, with increased awareness; and 7) absence of abuse. Twelve residents felt that the CCU was their permanent residence, while for seven of them it was a temporary one, before moving to more autonomous living conditions. The study concludes that "Asylum" as a place offering safety and security, does not represent a physical entity, but a set of interrelated criteria which, if met by services, can be achieved for people with SMI anywhere. In relation to treatment, residents' experiences revealed increased awareness of the pharmaceutical treatment, increased monitoring by staff members and increased participation in psychotherapy, while in CCUs.

Keywords

Deinstitutionalisation, Severe Mental Illness, Community Care Units, Community Care, Mental Health Institutions, Asylum, Pharmaceutical Treatment, Monitoring of Treatment, Psychotherapy

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1. Issues of treatment while in mental health institutions

1.1. Pharmacological treatment while in mental health institutions: limited awareness concerning medication, but with trust in treatment

Medication as a psychiatric intervention has been known to be the first and frequently the major line of intervention for patients with SMI hospitalised in mental health institutions (2, 3, 4). Under the biomedical model of practicing psychiatry, medication is the major form of intervention, with psychosocial therapies supplementing the scheme, but always with an emphasis on drugs [(4)]. The emphasis on medication has been revealed in my previous research as being dominant in institutions in the Greek context [(5)], and through this research the same finding appeared strong from residents' experiences. This section explores issues of pharmacological treatment that residents received while in mental health institutions.

a) Residents who did not know what kind of treatment they were receiving while in mental health institutions

About two thirds of the thirty residents, who participated in this study, did not know what kind of pharmaceutical treatment they were receiving while in mental health institutions, although in most cases they believed that the pharmaceutical treatment was helpful for them. The comments of Mr. Kerkyraios [42 y/o] were representative for this group:

> **R:** …I don't know what kind of drugs they were exactly. They were drugs for tachycardia – for the heart and for the nerves, I believe for my nerves. I was also taking some drugs for my neurological coolness. I don't know the drugs' names though, because they were in a foreign language... The pharmaceutical treatment helped me very much.... I got liveliness, and with the drugs I was able to take some bad thoughts out of my mind in a short period of time.

Similar was the perception of Mr. Leonidopoulos [64 y/o], a resident of the psychogeriatric boarding house, who also did not know what kind of medication he was receiving while in the hospital. However, he thought that the medication really helped him to take unpleasant memories from the time he was homeless out of his mind:

> **R:** It helped me tremendously. It helped me to get away from the thought of the period I was homeless and suffered very much. When I was not getting the drugs I used to turn in the past, turn in the past remembering all the suffering I have experienced as homeless.

Also similar was the perception of Mr. Dimoulas [53 y/o], a resident of the boarding house Afaia, who was getting the medication that the doctor ordered, showing complete confidence in the prescription process. He believed that the pharmaceutical treatment really helped him to overcome the traumatic experience of his divorce:

> **R:** My divorce was a really painful experience for me… With the pharmaceutical treatment I started feeling calm and thinking positively on how to live my life, and that was very helpful for me.

In this group of residents, some of them, although they did not know the names of the drugs they were receiving while in hospital or the active substance they contained, they *recognised* the drugs of their everyday treatment from their number, their shape and their colour, in other words from the *morphology* of the pills they were getting. Mrs. Maragakis' comments [58 y/o], a resident of the boarding house Afaia, were typical:

> **R:** At the beginning I was getting a few drugs, after a while a bit more... I don't know [what kind of drugs they were]. If I see them, yes, I would recognise them, but I don't know their names. From the shape and the colour I recognise them, I recognise them this way.

Although this morphological recognition of drugs has helped residents while in mental health institutions to identify drugs, nowdays, with the great financial crisis that Greece is experiencing, it is very difficult for this to continue, because there is a major replacement of prototype drugs by their generics. The Ministry of Health in Greece has taken several serious measures in order to increase the use of generics, and this is happening because Greece has one of the lowest rates of generic penetration in Europe (6). The goal of the Ministry of Health has been for generics to manage to reach the percentage of 50% of all medicines used in hospitals (7). The replacement of neuroleptic drugs by their generics has brought though serious confusion to patients experiencing SMI, because they cannot recognise morphologically the drugs they have been receiving for years in mental health institutions. Up until now, patients in mental health institutions have been more acquainted with the morphology of pills than psychiatrists themselves. Dr. Stalris' comments from Dromokaition Mental Health Hospital are very characteristic:

> **R:** Patients recognise them [the pills] mainly from the colour. In many cases patients recognise the pills and I don't, because I know the name, what it contains, the active substance, but not the morphology of the pill, because nowdays they change all the time, now with the generics there is great confusion. For example a patient comes to me and says: "I want the yellow pill".

In conclusion, residents in this group did not know which drugs they were receiving while in the institution, however they had faith in the prescribing process by the hospital's psychiatrist. It seems though from residents' comments that although they had faith in the prescription of the doctor, at the same time they themselves did not have any particular say in the configuration and shaping of the pharmaceutical treatment that was ordered for them. This was supported by

the comments of Klimaka's staff members who had previous working experience in mental health institutions. Mrs. Alikaki, nurse at the psychogeriatric boarding house, stated:

> **R:** Patients knew the quantity of drugs they were getting, and they knew the colours [that pills had]… Now, the names [of the drugs]? ... Some of them were asking, but I don't think they were getting any answers: "Just drink the drugs and don't ask too much" was the usual reply. But patients would firstly look at the pills and then they would swallow them, and if there was something unusual or something that they didn't like, they would just say it. Or, the ones that were not very talkative, they would show them [the pills]. They were showing them.

It is obvious that the way the shaping and administration of pharmaceutical treatment works, lies within the boundaries of paternalism, leaning closer to a strong paternalism approach. Much of the traditional psychiatric practice has been based on an unequal power relation: the doctor being in the superior position (sometimes even supreme), and the patient in the helpless role (8). However, in more recent years, with information more readily available through the Internet, patients are becoming more knowledgeable (9), and consequently involved in their own health care management, prompting doctors to recognise the prudence of not imposing their views, unless they want to become the subject of a lawsuit (8). The real question behind this argument should be how one human being should treat another if both are to maintain integrity and humanity in their intercourse.

Internationally, there has been a paradigm shift from a doctor-directed to a more patient-centered approach, with the aim to correct the traditional imbalance of power between doctor and patient (10). It appears that *achieving* a purely patient-centered approach in the Greek context and in particular shared decision making is still a long way from becoming the norm, particularly in mental health institutions, that have a long history of functioning in an authoritarian way, practicing psychiatry under a paternalistic model (5). However, achieving a middle ground could be a good starting point *towards* that direction. So a good start for practicing psychiatry could be the "guided paternalism model that moves from strong to weak paternalism on the doctor's end, and towards a more "enhanced autonomy" at the patient's end"(8). This model recognises that the doctor is professionally equipped to give informed advice, while at the same time respecting the patient and the wishes he/she has (8). It appears that in order to achieve this middle ground approach, much work is still needed in the context of Greek mental health institutions.

b) Residents who knew which drugs they were receiving while in mental health institutions

About one third of the residents who participated in this study knew which drugs they were getting while in mental health institution. Very typical is the case of Mr. Papadopoulos [49 y/o], a resident of the psychogeriatric boarding house, who knew in detail the drugs he was receiving in the hospital. He felt though that besides the help that the pharmaceutical treatment offered him in order to feel better, what mostly helped him was the support of his parents, who used to visit him every day in the institution. He stated:

> **R:** I was getting Largactil [Chloropromazine] and Depakine [Valproic acid]. Now I am talking to you about a time period of eight years – from 22 to 30 years old. After that period, I went to Saint Olga and to Dafni, and there they gave me Zyprexa [Olanzapine] and Lamictal [Lamotrigine], and a vitamin for the neurological problems… And one injection of Interferon every week [for the multiple sclerosis he is suffering from]... It helped me [the drug treatment], but that was not the only help I had; the most important thing was that I had my parents and they were supporting me. It was the support from the environment. That was what saved me, because at that time my mind was over my head. If I didn't have my parents, I was finished.

Equally aware about the pharmaceutical treatment he was receiving while in the institution was Mr. Barbarigos [43 y/o], a resident of the psychogeriatric boarding house, who felt that the drug treatment was helpful:

> **R:** At the beginning in Dromokaition they were administering to me Aloperidin [Haloperidol] in injections, when I first went there… after a while they started administering me pills... I think they were also giving me Akineton [Biperiden]… for the quiver of my hands, for the quiver.

As a result, residents in this group seem to be fully aware of the drugs they were receiving while in hospital. What is impressive though is that again – as it happened with residents in the previous group – most did not know *why* they were receiving those drugs as far as SMI is concerned, and they could not influence the changes that were happening to their treatment or the prescription process in any way. The comments of Mr. Kalos [54 y/o], a resident of the psychogeriatric boarding house, were very characteristic; he mentioned not having any say to the changes that were happening to his drug treatment, although in general he found those changes beneficial for the course of his treatment:

> **I:** Did you request to have your drug therapy changed?
> **R:** No, they changed my drugs by themselves. After a while they changed Largactil [Chloropromazine] and they gave me Aloperidin [Haloperidol]… Aloperidin helped me to feel I have more strength. I found myself. It was a good change.

Similar was the case of Mrs. Zachou [63 y/o], a resident of the protected apartment in Aigina: although no one explained to her *why* she was receiving the particular pharmaceutical

treatment, or *why* certain changes had to take place in her drug therapy, she however felt that the treatment helped her to overcome the serious anorexia nervosa she was suffering from.

In conclusion, these residents seem to know which drugs they were receiving while in institution. This however is not due to a different therapeutic approach by the part of hospital's staff, because as it became clear no one ever devoted the necessary time to explain to them the reasons behind why they were getting administered the particular drug therapy. Most probably, the residents' knowing the drugs they were receiving was simply due to a better level of awareness.

However, the opinion of residents themselves seems to be entirely absent from decisions about drug therapy. What staff members of mental health institutions seem to neglect – or don't fully recognise yet – is that in the clinical encounter there are two experts present: the clinicians having technical knowledge, and the people with SMI, having expertise by experience. There is a great and equal value of both professional and personal knowledge, and the more *both* sides are taken into serious consideration the closer psychiatric practice will come to a more balanced and evidence-based approach to treatment (11). What is encouraging though is that more and more patients are seeking information and education concerning their treatment, along with greater involvement in the decision making process. That, in conjunction with patients' organisations and family members' organisations, can push practice towards the direction of a more patient-centered approach. Mrs. Koubaraki, one of the Dromokaition Hospital's psychologists, stated on the matter:

> **R:** There are some [patients] who know names of the drugs and who are much more active as far as their drug treatment is concerned, and they talk about it, and they *require* to have the necessary information – most of them – but most of the time they do not get that information, and it is not their fault… Most of them have *huge* experience concerning what particular effect each drug has on their body, and I think that someone should listen very carefully on what they have to say on the matter…

c) Side effects residents experienced because of the drug treatment while in mental health institutions

Residents in both groups – those who knew and those who did not know the drugs they were receiving – felt rather disempowered from the prescription process, which did not address their own opinions or concerns. Because of the lack of monitoring, along with the authoritative approach of practicing psychiatry, certain residents experienced serious side effects from the drugs they were receiving, but it seems that no one ever took their complains into serious consideration. Mrs Ioannou [62 y/o], a resident of Afaia, stated about the side effects of the drugs she was receiving while in the institution:

> **R:** They were giving me heavy drugs... My head was feeling like lead. I was like lead. I did not know where I was stepping and where I was going.

In many cases, drugs given for SMI may treat disease symptoms, but at the same time produce side-effects that can impact upon physical health (12). Confusion and drowsiness due to sedation in the central nervous system by most neuroleptic drugs are very common side effects among patients with schizophrenia, who are under drug treatment (13). In cases like this, patients – on an international scale – complain that doctors in charge do not take their complaints seriously (14,5). This mainly stems from poor relationships between psychiatric staff and patients, which are often referred to as a poor therapeutic alliance (15). The only way to resolve this and make things easier for patients is by taking the time to listen to patients, treating them with respect, explaining things to them and involving them in treatment decisions insofar as this is feasible (16).

One should also not neglect the fact that it is often an unfortunate but common practice for patients in long–stay institutions to be given high doses of medication (17), which aim not only to decrease the psychotic symptoms, but also to make it easier for staff to cope [rather than the individual].

According to Dr. Starlis – psychiatrist at Dromokaition – the most common side effects that patients complain about in the institution are: drowsiness, reduction of vigor and of feeling energetic, along with extrapyramidal symptoms – basically trembling. Patients also complain about xerostomia (dry mouth), excess salivation, and akathisia. One resident in this group also mentioned that he was adversely affected by the polypharmacy, and this resulted in him deteriorating while in the hospital and under drug treatment, instead of showing improvement. Mr. Poulakis [47 y/o], a resident of the hostel stated:

> **R:** [In the mental health hospital] they changed my drugs many times, and in fact during the period I was receiving too many drugs I was deteriorating, because I was experiencing the complete opposite comparing to the period I was getting few drugs… in fact, I reached a point in the mental health institution where I lost 25 pounds because of the drugs, that's how badly they affected me. When I got out [from the hospital] I had the impression that I might not have been able to continue my job as an EKAB [ambulance] driver and that I would lose my job, that's why I had to take for one month Seroquel [Quetiapine] of 75 mg, and for one month Ladose [Fluoxetine].

In cases like this though, an individual suffering from SMI may experience feelings such as being involved in a futile situation: on the one hand, he/she takes the drugs to reduce the emergence of psychotic episodes, and on the other hand, the side effects of these drugs lead the individual to a reduced ability to function efficiently on a daily basis, something that acts as a constant reminder of the fact that the individual is suffering from schizophrenia (14). This issue however makes it even more urgent for the voice of patients with SMI to be taken seriously into consideration, until the most effective

treatment is found for each particular patient. Clearly, there is no single pharmaceutical scheme that "fits" all patients. Apparently, there is a great need for more personalised treatment plans that would best serve the particular needs of each individual. In order to achieve this, there needs to be greater collaboration between doctors and patients, placing emphasis on each individual patient's best interests (16).

1.2. Residents who had experienced electroconvulsive therapy while in mental health institution

Three residents in this research study had undergone electroconvulsive therapy while in the mental health hospital, and two of them mentioned it as an extremely traumatic experience. Mrs. Chatzichristou [84 y/o], a resident of the psychogeriatric boarding house, stated: "In the hospital they gave me shock, shock, shock [electroctreshock/electroconvulsive therapy]. Thanasis the doctor gave me shock". Staff members in the community care units of Klimaka have noticed that those residents who have had the negative experience of going through electroconvulsive treatment in the hospital, when they first got transferred to the CCU were even afraid to blow-dry their hair, because they had associated in their minds electricity with electroconvulsive therapy. Mrs. Aristaki, head nurse of the psychogeriatric boarding house mentions on the matter:

> **R:** In here we have older people, and when we first brought them here we started helping them to take their bath, wash their hair, and then to blow-dry their hair with the blow-dryer… We have an older lady who as soon as they tried to help her blow-dry her hair with the blow-drier she started shouting and screaming that they were trying to harm her. She has memories from electroshock treatments.

Another resident in the hostel also mentions electroshock in a very negative way to staff members. The nurses at the hostel stated that every time he remembers having electroshock in the hospital he gets very upset. Mrs. Boukala, a nurse at the hostel, stated: "when he [the resident] mentions it, he starts losing himself and becomes a totally different person". This clearly shows that although these residents had undergone ECT years ago, the effects of this type of treatment are lasting.

It is true that electroconvulsive therapy – particularly in older years, when it was performed without first giving anesthesia to patients, was an extremely traumatic experience for people with SMI (3). Of course there are several psychiatrists and neuroscientists who believe that electroconvulsive therapy – without a known mechanism – in some cases helps the brain to restore the balance between the levels of neurotransmitters, and as a result some patients may see an improvement with electroshock treatments along with the drug therapy (18). In fact, ECT has been shown to be an effective form of treatment for severe depression, and for schizophrenia accompanied by catatonia, extreme depression, mania or other effective components (18). What has progressed with ECT in recent years – to make it a less traumatic experience – is that patients are given first anesthesia: they are put to sleep with a very short-acting barbiturate, and then the drug succinycholine is administered to temporarily paralyse the muscles so that they do not contract during the treatment, because that is something that can cause fractures (18,19). When waking up patients, usually they do not remember anything from the treatment (19), although they may experience some side effects such as a brief period of confusion, headache, muscle stiffness, short memory loss, and some heart rhythm disturbances (18).

What is impressive in this research study is that one participant, Mr. Poulakis [47 y/o], resident at the hostel, believes that the electroconvulsive treatment he had while in the mental health institution was much more beneficial to him than the pharmaceutical treatment, because while he experiences serious side effects from the drugs, he experienced no side effects after each ECT, and he has no lasting negative experiences from the sessions. In fact, he believes that the 11 electroshock treatments he had within a period of 20 days, helped him so much, so that he was quickly able to return to work (he has working as an EKAB [ambulance] driver).

In fact, Mr. Poulakis, has already told his psychiatrist (that treats him in the CCU) that if he ever relapses again, he would definitely prefer to be sent to a mental health hospital in order to have electroshock treatments. He stated:

> **R:** Even now I say to my doctor that in case I relapse… because I have a very bad experience from drugs, they bring me many side effects…. So, I've told him: "now that I am sane, in full consciousness and able to talk, in case I have a relapse and start hearing voices again – because I was hearing voices during the whole period back then – then It would be better to give me electroshock instead of "crushing" me with so many drugs".
> **I:** So you prefer electroshock treatment than drugs?
> **R:** Yes. It depends on what suits each particular person. I was helped more by electroconvulsive therapy, because it caused less side effects. They put you to sleep first, and then they perform the ECT, so you don't feel anything while it lasts.

Although Mr Poulakis' case is unique in this study, however the case of patients feeling that ECT is beneficial as a form of treatment has been reported before (3). In the Greek context though, cases like Mr. Poulakis, - who think ECT is very beneficial – are rare (5).

1.3. Limited to non-existent participation of residents in psychotherapy while in mental health institutions

A fact which is exceptionally impressive within this sample of thirty residents is that more than three fourths of the participants while in the psychiatric hospital did not receive any kind of psychotherapy whatsoever. Mr Kerkyraios [42 y/o], a

resident of the psychogeriatric boarding house was a typical example of this group:

R: No, I didn't receive any kind of therapy from a psychologist…I only took my medicine.

Therefore, the majority of participants in this research appear not to have taken part in any organised psychotherapy while in the psychiatric hospital. This shows how the biomedical model of treatment prevails, based mainly on pharmaceutical treatment, instead of an implementation of the bio-psycho-social model, which is based not only on drug treatment, but also on psychotherapy and social skills learning. The main reason behind this is the lack of trained staff. According to Dr. Kastrinakis, psychiatrist and head of Klimaka, the maximum number of psychologists in every psychiatric hospital is 4 to 5 who cannot cope with the workload. Further, few of the psychologists working in mental health institutions have received the necessary training in order to practice psychotherapy. In Greece unfortunately, training in psychotherapy is in deficit and most of the professionals – psychiatrists and psychologists - never receive a proper and systematic training on the specific subject. Dr. Starlis, psychiatrist at Dromokaition Mental Health Hospital commented on that:

R: No psychotherapy takes place. There are no trained psychiatrists in psychotherapy and if any they are few. Because during their training, psychotherapy is not included and if it is, it is in a form of theoretical lessons. To practice psychotherapy is to go through psychotherapy yourself and this must be done in private sectors and/or institutions. It is a long-term process and an experiential one.... In the psychiatric hospital, let's say here in our place there might only be two or three that really know the subject... And there are many psychiatrists who do not believe in it [in psychotherapy], they don't.

Clearly, therefore, many psychiatrists [in Greek mental health institutions] enforce the practice of the biomedical model at the expense of the bio-psycho-social model and this is done in an authoritative manner. This reinforces the model of strong paternalism. One of the great advantages of the psychotherapeutic process is that it creates a dialogue between the doctor and the patient and establishes certain conditions for a more patient-centered approach. However, it seems that this is far from reaching reality in Greek mental health institutions.

Finally another serious reason – according to hospital's staff members - why most residents did not participate in psychotherapy programmes while in the psychiatric hospital is because of the pathogenic environment of the psychiatric hospital itself: through the procedure of incarceration, hope for the future is removed from the patient's life. This automatically removes any kind of mood for psychotherapy from the patient's part. Consequently, no objectives can be set out let alone be materialised through a psychotherapeutic process. Mrs Koubaraki, psychologist of Dromokaition referred to this:

R: If perspective is taken away from people, then any psychotherapy or any type of intervention is automatically rendered as useless. And this is only natural. If someone said to us "You are sentenced to 100 years imprisonment", then what? Psychotherapy? Well…it's over… You associate certain things with your life. If you do not have any kind of perspective, or goals? The sense of perspective is something that one cannot find alone unless the mental health system provides it somehow.

Therefore, for all these reasons, the majority of the residents of this sample had never participated in psychotherapy sessions while in the psychiatric hospital. A small minority, however, the one fourth of it – appeared to have participated in psychotherapy programs while in the psychiatric hospital. They even claimed that this had particularly helped them.

Mr Dimoulas [53 y/o], a resident of Afaia, mentioned that while in the psychiatric hospital he participated in a psychotherapy group once a month and felt that he was helped:

R: [It helped] a lot. Because the things I had, hidden in my soul, would give them to someone like you, and this pleased me.

Mrs Maragkaki [58 y/o], a resident of Afaia, felt that she was helped too by the psychotherapy sessions:

I: While in the psychiatric hospital, did you participate in psychotherapy with a psychologist?
R: Yes.
I: Did that help you, talking with a psychologist?
R: Yes, we talked, chatted….it helped me.

There is not enough evidence in order to draw conclusions about why these particular residents participated in psychotherapy, whereas the majority did not. Those residents however who underwent psychotherapy were greatly helped through the sessions.

What should also be considered in the Greek context however is to follow other approaches as well, such as the Cognitive Behavioral Therapy (CBT). CBT has emerged as one of the most effective evidence-based adjunctive treatment for psychiatric disorders (20). Evidence for the efficacy of CBT for schizophrenia is increasing: Studies (21) suggest that there are beneficial effects on relapse and rehospitalisation following brief CBT delivered by mental health nurses in patients with schizophrenia, which are maintained at 24-month follow-up. In the UK nowadays, CBT is taught in short courses to all kinds of medical professionals, particularly nurses. This is an approach that should also be considered by the Greek Ministry of Health as well.

In conclusion, the residents of Klimaka's CCUs, while in the public psychiatric hospitals developed relationships with the staff that were usually good or neutral, and in few occasions bad. This was mainly due to difficult working conditions for staff members. About two thirds of the thirty residents who

participated in this study did not know what kind of treatment they were receiving in hospital, although in many cases they recognised the drugs morphologically. Most believed that the treatment was helpful and had faith in the prescribing process. Only one third of the residents knew which drugs they were getting while in institution, however most did not know *why* they were receiving those drugs and had no say in the changes that were happening to their drug treatment. It also appears that the majority of residents did not receive any psychotherapy while in institutions, but those who underwent psychotherapy felt that they were greatly helped through the sessions.

2. Issues of pharmaceutical treatment and psychotherapy while in the CCUs

2.1. Residents' increased awareness of pharmaceutical treatment

The issue of pharmaceutical treatment and psychotherapy appeared to have several differences – but also improvements – in relation to what the residents received in the psychiatric hospital. Almost all residents of the units believed that the pharmaceutical treatment helped them. Moreover, more residents knew the kind of pharmaceutical treatment they received and in fact this number increased as we moved on to more independent living conditions.

In the psychogeriatric boarding house, five residents who had already known what drugs they used to take in the psychiatric hospital, knew in the CCU too. Mr. Papadopoulos [49 y/o], a resident of the psychogeriatric boarding house stated about his drug treatment:

> **R:** I know what drugs I take. The same I used to take in Dafni. Nothing has changed, because the treatment was good but ...I still take Zyprexa, Lamictal, and B1, B6 and B12 vitamins. Something like Neurobion. I am also given an Interferon injection once a week, for my nervous system, the multiple sclerosis... It is good [the treatment], it stabilises me. But not only that, the entire supportive system too [is helpful]. That is why I have told you: the doctor gives the treatment but who is going to support you after that? It is the supportive system mainly. And the help from the nurses, the psychologists of course, more or less from everybody.

Two more residents of the psychogeriatric boarding house did not know what drugs they were taking but they recognised their shape. Mrs. Iraklidou [70 y/o], for example, knew that she was taking "1 red and 3 in small pieces [pills]", which she thought helped her. The rest of the residents of the psychogeriatric boarding house who were very old, did not know what they were taking, but they trusted the doctor and were co-operative when it came to treatment. Because of the residents' old age and their serious health problems there was close monitoring from the staff to ensure that they were indeed taking their drugs. Mrs. Krinou, general duties staff member of the psychogeriatric boarding house, stated:

> **R:** I think that [the treatment] helps most of them and they show it. Many times when I give them the drugs I tell them: "Open your mouth to see if you have taken them" and some of them usually say: "Ok, I take them, here you are" and open their mouth. They say: "The drugs help me, that is why the doctor prescribes these to me. That is why we feel well, that is why we feel the way we feel". They take them and are positive.

In the boarding house Afaia, four out of seven residents did not know what drugs they were taking, but they believed that drugs helped a lot. Mr. Dimoulas [53 y/o], a resident of Afaia, stated:

> **R:** I don't know them [the drugs] but they help me a lot. I trust the treatment that the doctor has given me and I trust the nurses too.

Out of the seven residents of the boarding house Afaia who took part in the research, three knew what drugs they were taking: two of them knew what drugs they used to take while in the psychiatric hospital, and why they had to take them, while the third one, who knew in the CCU what drugs he was taking, had not known what drugs he was taking while in the psychiatric hospital. The fact that he knew in the CCU the medication he was receiving is a clear improvement in relation to his previous life at the psychiatric hospital. He believed that the treatment helped him a lot. Mr. Louloudis stated:

> **R:** Yes, of course [I know the drugs]: Akineton, Largactil, these are the drugs I take... So as to act normally, not to do anything stupid like I used to do: I guess this treatment helps me a lot.

Consequently, three out of the seven residents of the boarding house Afaia knew what pharmaceutical treatment they were receiving.

In the hostel the percentage of residents who knew what drugs they were receiving was even higher. Out of the five residents of the hostel who participated in the research, four residing in the hostel and one living independently under the supervision of the hostel, only one – Mrs. Bebekou [36 y/o] - did not know what drugs she was taking, but believed that the treatment was helping her a lot. The other 4 residents of the hostel knew what drugs they were taking. Two of them - Mrs Aggelopoulou and Mr Poulakis – also had known the treatment they used to receive while in the psychiatric hospital. Interestingly Mr. Poulakis authorised his doctor to give him an electroshock whenever he relapsed, since he believed that this was a better option for him than drugs.

Finally, out of the four residents of the hostel who knew what drugs they were taking, two of them knew unlike the past when they had not in the psychiatric hospital. Mrs. Marouli [62 y/o] who lived independently under the hostel's supervision stated:

R: Yes, of course [I know what drugs I take] They are called Leponex... 3 pills per day. This is what I take... Only Leponex ... [It helps] I am telling you. I feel a bit sleepy.

Finally, in the protected flat of Aigina, 100% of the residents knew what drugs they were taking every day. Two residents – Mrs. Zachou and Mrs. Vasilikou – had known this since the psychiatric hospital. Mrs. Vasilikou [53 y/o], a resident of the protected flat stated:

R: I still take one of the drugs I used to take while in the psychiatric hospital and Dr. Kastrinakis has added more... Risperdal, Aloperidin, Milibrat... I do not remember now, but there is another one... Yes [the drugs help me]: I hear voices, and when I take the drugs I feel better, I hear fewer voices.

A third resident of the protected flat, Mr Monachos [53 y/o], had not known what drugs he was taking while in the psychiatric hospital but in the CCU he knew in detail:

R: [I take] Stilnox 10mgr, Zyprexa 5mgr, 2 pills Ribex, Zantac, and Disipal 50mgr. And Neurobion, the vitamin complex. It helps me [the treatment]. I sleep better, more quietly.

Another thing that was different for the residents of the protected flat was the way they received treatment and its monitoring. Unlike in the psychogeriatric boarding house, where the residents were very old and had many pathological problems and the nurses were the ones who administered the drugs and checked if the residents had swallowed them, in the protected flat the residents were taking their drugs on their own under the psychologist's supervision. Mrs. Zachou, [63 y/o] stated about the way the drugs were administered: "The psychologist tells us: 'What drugs do you take?' And we take our drugs on our own".

Overall, in Klimaka's CCUs, four residents (Mr. Louloudis, Mrs. Marouli, Mrs. Olympiou and Mr. Monachos) out of the whole population of the residents with SMI had not known what drugs they were taking while in the psychiatric hospital, but knew in the CCU. Furthermore, three more residents (Mrs. Pappas, Mrs. Iraklidou and Mrs. Ioannou) had not known what kind of treatment they received while in the psychiatric hospital but they knew what kind of drugs they were taking in the CCU, recognising them by their shape. It is apparent, therefore that there was a considerable improvement in understanding about treatment among residents, in relation to the psychiatric hospital. There is still room for improvement so that the percentage could rise. For this to happen, however, certain obstacles must be overcome.

There are two factors that inhibited this percentage of residents with insight about the treatment they received from increasing. The first, according to staff members, was the old age of some residents. Due to this – especially in the psychiatric boarding house – and to the many years they had spent at the psychiatric hospital, communication on this issue was very difficult. According to Mrs Aristaki, head nurse, this justified why the staff strictly controlled the administration of drugs to ensure that the residents took them. However, the younger the residents the easier the communication. That increased the insight in relation to drugs.

The second factor that inhibited the increase of insight of the residents was the denial of some of them that they suffered from SMI. Mrs. Olympiou [38 y/o], a resident of the hostel, is an interesting case because she had spent many years in Theotokos Institution, a place for children with special needs. At some point, she was diagnosed with SMI and had to be transferred to the community care units of Klimaka. At first, she had difficulty accepting the fact that she had to receive treatment for SMI but after a series of extensive discussions with the psychiatrist she came to an understanding:

R: Yes, I know what drugs I take, but at first I was upset and cried [and used to say]: 'why do I take drugs?' Then I got used to it, I talked with the psychologist, the doctor and they explained the reasons and I finally got over it.

Mrs. Olympiou's case demonstrates how important it is to educate residents on the issues related to SMI's nature, the recognition of the symptoms along with treatment of the disease with drugs and psychotherapy (16). Educating the resident plays a central role in the increase of insight and enables residents to reach a point where they can take their drugs on their own. This principle governs the way Klimaka's community care units operate. Dr. Kastrinakis, head of Klimaka, stated:

R: A very large number of patients [residents] understand the importance of drugs. This understanding has been facilitated due to our own intervention with a number of educational activities, concerning SMI: what is this disease, what is the role of this drug, the role of the external conditions. We offer it [this information] continuously, or we have given it so many times that they understand... The approach was the following: you take this drug so that you will have fewer ideas, fewer audio illusions, so that you can realise all these faster and come and talk to us so that we can modify the treatment... There is great cooperation with the patients [the residents] here.

This comprehension and realisation along with the insight about the pharmaceutical treatment is very important in order for residents to experience "enhanced autonomy" (8). This in turn can facilitate them to make a successful transition to more independent living conditions either in the protected flat or living alone outside the unit.

2.2. Increased monitoring of treatment and increased participation of residents in psychotherapy while in CCUs

Another positive feature of Klimaka's way of operation, according to staff members, was the significant monitoring of the residents from the staff [both doctors and nurses] and the cooperation between the staff and the residents. The result of this was that the physician could understand better what the resident experiences. Mr. Lyritzis, psychologist, explained:

> **R:** Many times when they do not feel well, the residents themselves will come and talk to us about their drugs and this helps us modify the pharmaceutical treatment. Then we can immediately intervene. We are not the type of boarding house that the psychiatrist visits once a week... We have psychiatrists here from 9.00 o clock in the morning to 12.00 o'clock at night every day. So there is immediate access to a psychiatrist, truly immediate.

This close monitoring of the residents facilitated immediate treatment of possible relapses, which could happen to the residents. This was something that the residents themselves realised, so they would inform the psychiatrist or the psychologist in order for immediate modification in pharmaceutical treatment to take place. Mr. Leonidopoulos [64 y/o], a resident of the psychiatric boarding house, is a characteristic example. He relapsed from time to time when he remembered an old incident during which he blamed himself:

> **R:** Look: There is a possibility of relapsing... when we relapse, we reach a point where we say enough is enough, I cannot take it anymore, I utter these words to the psychologist. Then the psychologist alerts the psychiatrist and he comes down with the head nurse and changes the medication. This helps, this helps a lot.

Furthermore, each member of Klimaka's staff functioned as a "reference person" for 1 or 2 residents. He/she was responsible for recording their progress within the CCUs and whether he/she had achieved the specific goals set by the therapeutic team. Mrs. Vlicha, general duties staff member of the psychogeriatric boarding house explained:

> **R:** There are 'reference persons' who are responsible for certain people [residents]. I am responsible for two women [residents]. I am responsible for the programme assigned for them: it is called the upgrading programme. It sets goals and every time we set a new goal which improves their functionality. Every six months a meeting takes place and we talk about these specific people [residents].

Finally, another parameter that helped the residents greatly and was an integral part in their treatment was psychotherapy. As mentioned in section 1, for the elderly residents there had been no psychotherapeutic approach while in the psychiatric hospital. On the other hand – according to one of Klimaka's psychologists, with many years of experience in working at public psychiatric institutions - the younger residents, while in hospital, went through a lot of discomfort due to the great number of "psychotherapists" who had neither the knowledge nor the specialisation to use psychotherapy per se. The environment of the hospital also played a negative role in the sense that it deprived the residents of any notion of perspective. In the CCUs, however, the framework was such that the residents knew that they could visit a psychologist at any given moment and discuss anything that bothered them, when they needed it, without feeling that they were obliged to do so. Mr. Lyritzis, psychologist of the psychogeriatric boarding house stated:

> **R:** When they [the residents] are in a state of intense stress, you can see that they ask for it. You know, I do not believe that someone who has been a patient for 50 or 30 years does him/her any good to undergo psychotherapy for the 68th time, let's say with a different therapist, because he/she has seen so many, right? Ultimately, it cannot be therapeutic; on the contrary, it can prove very traumatic to such a point that it resurfaces traumatic experiences. What I am interested in is for the residents to be able to have an emotional and immediate relationship with us, so we can discuss anything at any given moment... on a human level, outside the formal role of the therapist and the patient [the resident].

Consequently, psychotherapy in the CCUs was taking place on a more relaxed basis, where residents who were preoccupied with something could talk about it. Mr. Poulakis, a 47-year-old resident of the hostel stated: "I will see the psychologist here when I have a problem. I will ask to see her. The system is more autonomous here. I am more autonomous".

What was also interesting was that the main goal of psychotherapy in the CCUs was to help and educate residents on how to deal with daily issues rather than setting long-term goals. The daily issues were vitally important for the residents who needed to adjust to the new circumstances within the community. Mr. Dimoulas [53 y/o], a resident of the boarding house Afaia, stated:

> **R:** It helps us [the psychotherapy] to deal with the things the way they are. She tells us [the psychologist] what we need to do, how to be careful in the streets when we walk, stuff like that. How to be careful in general and how to adjust in the community and the society. Psychotherapy helps a lot.

This type of psychotherapeutic approach had a counseling nature and aimed to help the residents with daily issues instead of long-term ones. Mrs. Dimitraki, nurse of the hostel, explained:

R: Psychotherapy...they [the residents] do not do psychotherapy the way I or you do...in the sense that we ask for it and we would go to a psychologist or a psychotherapist. It is part of the unit. Mainly it takes the form of a discussion about daily issues. This is the framework... We offer counseling here and supportive psychotherapy. In other words, when they [the residents] do not feel well, or are afraid of something we discuss it [and ask:] 'why do you feel like this?' something like that. It is more of a supportive process..

In conclusion, it is apparent from the results that issues concerning pharmaceutical treatment and psychotherapy were clearly improved for residents while in CCUs, in relation to the psychiatric hospital. The residents' insight and understanding of the systematic administration of pharmaceutical treatment and participation in psychotherapy were increased in most cases.

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