Country Profile Greece

Community-based Mental Healthcare Networks: Key Facts and National Priorities

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Introduction

The EU-Co-funded "Joint Action on Implementation of Best Practices in the area of Mental Health", short **JA ImpleMENTAL** has a duration of 3 years, lasting from October 2021 to September 2024. Detailed information can be found at the project's website JA ImpleMENTAL (ja-implemental.eu). It aims to promote and improve mental health structures, services, capacity and outcomes in participating countries in 2 specific areas:

- mental health reform (promoting community health services) and
- suicide prevention.

Two national best practices - mental health reform in Belgium and the Austrian suicide prevention programme SUPRA - serve as best practice examples. Selected components of these should be prioritised and implemented over the course of the JA in 14 i.e. 17 participating EU-countries. JA ImpleMENTAL comprises 6 Work Packages (WPs), 4 horizontal WPS and one for each best practice. WP5 on community-based mental healthcare aims to implement elements from Belgian Mental Health Reform, which is based on the principle of deinstitutionalization, i.e., the transition from care primarily provided in institutions to community-based care in order to improve mental health outcomes and quality of life and avoid unnecessary hospitalizations. In addition, the reform is based on the principles of rehabilitation and inclusion, decategorization, i.e., multisectoral cooperation, strengthening care in hospitals to make stays shorter, but with more intensive treatment, and the principle of consolidation, providing funds for pilot projects.

The present country profile is one of the major deliverables of the JA, presenting key facts of the national and local mental health system. It summarizes results of the recent situation analysis and needs assessment (SANA), lists lessons learned, recommendations, challenges and opportunities as well as outlining next steps necessary to scale-up, promote national/regional community-based mental health care services. The country profile forms a basis for strategy formulation, decision-making and commitment.

This country profile is based on a situation analysis conducted in two parts and subsequent needs assessment. For the situation analysis, two questionnaires have been developed by WP5, one for the analysis of the situation regarding the overall health system and community-based mental health care at national level, and another one for the analysis at implementational level. Following the data collection, a SWOT analysis was conducted by the countries to assess the needs in terms of community-based mental health care.

1 Situation Analysis (SA)

1.1 Country, Health and Social System at national level

Greece is a presidential parliamentary republic, administratively divided in 13 regions and located in southeastern Europe at the southern end of the Balkan peninsula. It has a population of 10 459 782 and its capital and largest city is Athens with 3 792 469 inhabitants. It borders to the northwest with Albania, to the north with North Macedonia and Bulgaria, to the northeast and east (by sea) with Turkey. Greece has a rich historical heritage, which is reflected in the 18 UNESCO World Heritage Sites

located on its territory. Although Greece faced a serious ten-year financial crisis (2009-2019) due to the global economic crisis, it is classified among high-income countries according GDP per capita (1).

Table 1. Population structure: 2022, expressed as number of persons, by age and sex (2)

	Sex		
Age group	Male	Female	**Total**
<18	901,076	847,644	1,748,720
18 - 64	3,162,242	3,175,667	6,337,909
65+	1,051,429	1,321,724	2,373,153
Total	**5,114,747**	**5,345,035**	**10,459,782**

Healthy life expectancy at birth is 76,1 (males: 73,8 / females: 78,5) and 16,1 at age 65 (males: 15,0 / females: 17,1) (3). A total of 26,3% of the population is at risk of poverty and social exclusion (4). Income inequality, expressed as the Gini coefficient, is 31,4 (5) and total healthcare expenditure relative to GDP is 9,51% (6). The proportion of numbers of YLD due to mental and substance abuse disorders to number of YLD due to all causes is 17,5% (7).

Overall, the Greek population enjoys good health, with a higher life expectancy than the European average. Extensive health system reforms have been ongoing since 2010, including the strengthening and expansion of public primary care services. There has also been reinvigorated focus on prevention and tackling risk factors through a new national public health plan. Challenges remain in ensuring accessibility and affordability of care, particularly in light of high out-of-pocket payments and the impact of the pandemic. Life expectancy in Greece in 2020 was about half a year higher than the EU average, although it fell temporarily by six months between 2019 and 2020 due to COVID-19 related deaths. The leading causes of death in 2018 were ischaemic heart disease, stroke and lung cancer. Prior to the pandemic, self-reported good health among the population was high, but Greek adults reported higher psychological distress than the EU average [8].

1.2 Mental Health System at national level

For most of the 20th century, psychiatric care in Greece was traditionally provided in big Psychiatric Hospitals. Nonetheless, in 1984, the reorganization and modernization of the mental care system began with the support of the European Economic Community; but it was not until the 1990s that these efforts were officialised and systemised so as to acquire the characteristics of an institutional reform.

In 1997, the European Union approved and financed the first National (Action) Plan for Mental Health (i.e. the first phase of "Psyhargos" program) which aimed to keep the pace and momentum of deinsitutionalisation with greater emphasis on psychosocial rehabilitation, social reintegration and vocational rehabilitation for people with mental health problems as well as on raising awareness about mental health issues in the general population.

In the years 2001 - 2009 the initial National Plan was revised, as it was deemed overambitious, leading to the formulation of the second National (Action) Plan for Mental Health (i.e. second phase of "Psychargos" program). This second phase of the psychiatric reform is characterised by further closure of psychiatric intsitutions across the country and the establishment of some community mental health services. It merits noting that throughout this period the legislation for social cooperatives of limited liability (KOISPE) was introduced in the country, an innovative -at the time- measure addressing both vocational rehabilitation of people with mental illness and economic sustainability. In the time period

2011-2020, the third National (Action) Plan for Mental Health was drawn up (third phase of "Psyhargos" Program) structured along three axes of action: a) development of services in the community, so as to cover all the needs of each Sector of Mental Health (ToPSY), organized by region on the basis of prefecture and sector, b) mental health promotion and prevention of ill mental health in the general population and c) organization of the mental health care system (sectorization, monitoring, evaluation), research and staff training [9].

As a corollary of all three phases of the „Psychargos programme", mental health care for adults is organised in 37 sectors nationwide and the configuration of the mental heath care system entails a diversity of services: community mental health centres (CMHs), day centres, days hospitals, outpatient services of general hospitals, outpatient services of psychiatric hospitals, psychiatric departments of general hospitals, psychiatric hospitals, mobile units, specialised services for specific patient population groups (e.g. for people with dementia, for people with personality disorders, for people with eating disorders) and residential facilities (including supported housing units) as well as social cooperatives of limited liability (KOISPE). Outpatient general/psychiatric hospital services provide primarily diagnosis, counselling and treatment services as well as administration and follow-up of pharmaceutical treatment, while in-patient facilities in general/psychiatric hospitals provide short-term (voluntary and involuntary) hospitalizations' for dealing with the acute crisis.

Complementary to the mental health care system is the public primary health care system in Greece. The Primary Mental Health Care includes all integrated services within the National Health System and aims to monitor, maintain and improve human health. Services are provided on an outpatient basis and include health promotion, disease prevention, diagnosis, treatment, comprehensive care and follow-up. The State has the responsibility for the provision of optimal quality primary health care services to the entire population, while respecting their rights and needs. Within the services of Primary Health Care, the delivery of primary mental health services and the interoperability with mental health and addiction treatment services, social care services, and public health services are carried out. Timely recognition and early identification of mental health problems in primary health care can contribute to filling the treatment gap between treated and untreated mental disorders/psychiatric morbidity in the community. It merits noting that mental health care for people with addictions lies on a different constellation of services, which is independent and runs in parallel with the existing care system for adults with mental disorders.

As regards community mental health teams, based on existing legislation, community mental health centres are at the heart of community-based care in the country, as their aim concerns the delivery of comprehensive psychiatric and psychosocial care to the residents of their sector. Specifically, this entails prevention and primary mental health care services, services that ensure contunuity of care and services that contribute to psychosocial rehabilitation through collboration with rehabilitation units.

In this frame, community mental health centres provide the following services: mental health promotion and primary prevention; diagnosis, counselling and treatment; adminsitration and follow-up of psychiatric medication; home treatment, when necesary; crisis interventions for preventing relapse or/and hospitalisation; raising awareness activities in the community; mental health professionals training; research activities; and establishing a network of services (mental health, health, welfare, and others) which ensure continuity of care and the delivery of a comprehensive care plan. It merits noting that community mental health centres address both common mental disorders

and severe mental illness. Mobile units provide services similar to those of the community mental health centers; however, they have been developed in areas where accessibility issues hinder help seeking (remote areas) and in regions where there is scarcity of mental health services.

In a similar vein to community mental health centres, day centres are also at the heart of community-based care in the country, congruent with existing legislation. They address people with severe and enduring mental illness and their aims include (i) treatment in the community, (ii) tackling social isolation and marginalization, (iii) improving his/her skills that facilitate social inegration and (iv) encouraging his/her negotiating potential and assertive behaviour for his/her equal participation in the community. To these ends, they provide the following services: needs assessment, formulation and application of an individualized care plan; social and individual skills training; therapeutic interventions in person or in groups; vocational skills; vocational rehabilitation and integration; meals preparation; entertaininment and cultural activities; social club operation; family support interventions, including the delivery of psychoeducation; mental health professionals training; raise awareness and anti-stigma efforts in the community; collaborations with other services (mental health, health, welfare, etc) and research. It merits noting that its difference to day hospitals lies on more intensive treatment being provided in the day hospitals.

Residential facilities run on a spectrum of different housing units in Greece depending on the degree of independence achieved as well as the duration of the stay. It encompasses both group homes as well as supported housing apartments; while the stay there is voluntary. Their aim is to help the person with severe mental illness to achieve independent functioning in the community and to this end, they provide the following services: formulation and application of an individualized care plan; administration and monitoring of the medication, including ensuring treatment adherence; social skills training; independent living skills training; psychosocial support of the family, including the delivery of psychoeducation; raise awareness and anti-sigma efforts in the community; mental health professionals training; collaborations with other services (mental health, health, welfare, etc) and research.

During 2023, early intervention for psychosis units have been developed aiming to detect and treat early symptoms/ episodes of psychosis as well as to engage these people with MHS early on, so as to prevent the disability caused by the long-term course of the illness in psychotic-spectrum disorders. They aim to reduce relapses, to improve functioning and to facilitate reintegration of these patients in their work, educational and social environment. To these ends, they provide the following services: needs assessment, formulation and application of an individualized care plan; social and individual skills training; therapeutic interventions in person or in groups; vocational skills; vocational rehabilitation and integration; entertaininment and cultural activities; family support interventions, including the delivery of psychoeducation; mental health professionals training; raise awareness and anti-stigma efforts in the community; collaborations with other services (mental health, health, welfare, etc) and research.

It deserves mentioning that in an effort to increase the scientific robustness of the MH care system (both hospital-based and community-based) and the intercollaborations among MHS, the Ministry of Health introduced the application of the ICD-10 classification system to all services for assigning diagnoses to the users of the service.

Throughout the last years, among the priorities in the mental health policy agenda has been the reduction of involuntary hospitalisations. Specifically, the proportion of involuntary admissions to

Mental Hospitals (4263) to number of total admissions (9803) is 0.43. Furthermore, the proportion of involuntary admissions to psychiatric wards of general hospitals (9861) to number of total admissions (25273) is 0.39. Although the proportion of involuntary admissions to total admissions is high, the rate of involuntary committed users to 100.000 of population is close to the average in EU [12].

Regarding follow-up care of people with mental health conditions discharged from hospital during the last year, 25% or less of them received a follow-up outpatient visit within one month. Moreover, the number of community-based/non-hospital mental health (MH) outpatient facilities is 57 while the number of MH outpatient facilities attached to a hospital is 68 and of other outpatient facilities (e.g. Mental health day care or treatment facility) 104. [12]

Table 2. Facilities, number of beds and hospital admissions related to mental health: 2020 [12]

Indicator at national level		Number	Rate per 100.000 adult/minor population
Mental health hospitals	Facilities	3	0,034
	Beds	*N/A	8,01
	Admissions	*N/A	66,81
Psychiatric wards/units of general hospitals	Wards/units	41	0,464
	Beds	*N/A	6,46
	Admissions	*N/A	237,06
Mental health community residential facilities	Facilities	457	4,36
	Beds	*N/A	*N/A
	Admissions	*N/A	*N/A
Mental health inpatient facilities specifically for children and adolescents	Facilities	12	0,653
	Beds	*N/A	3,48
	Admissions	*N/A	508,85
Mental health community residential facilities specifically for children and adolescents	Facilities	5	0,3
	Beds	*N/A	*N/A
	Admissions	*N/A	*N/A

*N/A = Not Available

Table 3. Mental health outpatient facilities/services for adults and children/adolescents: 2020 [12,13]

Adults						
	Hospital based		Community based		Other	
	Number	Rate per 100.000	Number	Rate per 100.000	Number	Rate per 100.000
Facilities/Services	96	1,09	57	0,64	104	1,18
Total visits in the last year by male	*N/A	*N/A	*N/A	*N/A	*N/A	*N/A
Total visits in the last year by female	*N/A	*N/A	*N/A	*N/A	*N/A	*N/A
Total visits in the last year	228.475 228,475	2584,07	132,628	1500,04	392,233	4436,19

Children/Adolescents						
	Hospital based		Community based		Other	
	Number	Rate per 100.000	Number	Rate per 100.000	Number	Rate per 100.000
Facilities/Services	34	1,85	27	1,47	0	0
Total visits in the last year	0	0	124,724	6,790	0	0

*N/A = Not Available

Table 4. Mental health workforce: 2020 [14]

	In MH service (all)		In child & adolescent MH services (totals of government and non-government services)	
	Total number	Rate	Total number	Rate
Psychiatrists	1607	15,0	---	---
Child psychiatrists	---	---	411	22,4
Mental health nurses	*N/A	12,75	*N/A	*N/A
Psychologists	*N/A	8.78	*N/A	*N/A
Social workers	*N/A	3.46	*N/A	*N/A
Speech therapists	*N/A	*N/A	*N/A	*N/A
Occupational therapists	*N/A	*N/A	*N/A	*N/A
Others	*N/A	37.02	*N/A	*N/A
Total	*N/A	*N/A	*N/A	*N/A

*N/A = Not Available

A major halter in the momentum of deinstitutionalisation in Greece had been the enduring financial crisis striking the country, lasting for roughly a decade. While the crisis resulted in growing and persistent mental health issues in the population, mental health services had dowsnized their operations and personnel leading some of them to full closure, in spite of efforts to be taken over by other organizations [9, 15]. Hence, in the early phases of the COVID pandemic in 2020 and due to its marked mental health impact being foreseen, mental health was prioritised. As a result of this, a special portfolio for Mental Health and Addictions was devised in the Ministry of Health. One of the first actions implemented was a rapid assessment of the country's MHS, in collaboration with WHO Europe, in an endeavour to identify the shortfalls in the MH care system and to illuminate the needs for creating new structures and services.

The Covid-19 pandemic highlighted the existing shortages and needs as well as the imperative need for equal access of all citizens to optimal quality CMHS. The impact of the pandemic has intensified the need for digital mental health services, as they facilitate accessibility to service. The total estimated cost of MHS for year 2020, as reflected in the Rapid Assessment of Mental Health Services in Greece, (Ministry of Health & WHO, 2020) was 470.366,600 € and represents 3.3 % of total health expenditure. A necessary and sufficient condition for the smooth and comprehensive implementation of the new national plan is the funding of all recommended interventions. The purpose of detailed estimated

budget within the new national Mental Health Plan, is on the one hand the smooth establishment and operation of the new structures; and on the other hand, the smooth implementation of actions and programs with an emphasis on prevention and promotion of mental health. The estimated budget for its establishment and 18 months of operation is 374.378,500 €, and for their subsequent annual operation 362.275,004 € [9].

More specifically, on the grounds of the needs assessment, the first priority actions implemented by the Ministry of Health includes an array of interventions pertaining to the further development of the community network, the integration of mental health services into primary health care and the use of new digital tools. As an example some of these interventions entail: i) the operation of a new nationwide 24/7 hotline for psychosocial support (10306), ii) recruitment of specialist staff in mental health (psychiatrists, child psychiatrists, mental health nurses), iii) increasing the budget by 62% for mental health and addictions to strengthen existing mental health structures and develop new ones across the country for all population groups, iv) development of remote psycho-education programs and support for family and caregivers of individuals with autism spectrum disorder, v) completion of the digital map of MHS in order to improve citizens' accessibility to them, vi) development of a tele-psychiatry network in the form of an integrated digital outpatient clinic in remote areas [9].Concomitantly , on the grounds of both the Rapid Risk Assessment and inputs from the new National Committee on Mental Health (established in 2021 and consisting of 35 members with vast experience in various areas of mental health), the fourth National (Action) Plan for Mental Health was formulated, covering the period 2021-2030.

The plan entailed the following 10 axes, aiming: i) to complete the process of abolishing institutional care; ii) to develop further and finalize the community network of MHS system reform, including the interoperability or integration of primary mental health services in primary health care; iii) to finalise the community network of MHS for children & adolescents; iv) to reform forensic psychiatric services; v) to expand the Network of Limited Liability Social Cooperatives; vi) to ensure the implementation of sectorization of MHS; vii) to curb involuntary hospitalizations to reach the EU average; viii) to facilitate the integration of people with mental health problems in labour market and to protect employees' mental health; ix) to protect the human rights of people with mental health issues and combat social stigma, x) to include mental health as an integral part of emergency planning for crisis intervention (pandemics, natural disasters, etc.) [(9)]

More specifically, with respect to the second axis on the finalisation of the community network of MHS system reform, the National (Action) Plan for Mental Health emphasises the definition of care pathways for (a) people who are at risk of developing mental health problems or who are at risk of relapse (i.e. primary and secondary prevention) , (ii) people with mild and moderate mental health problems, (iii) people with severe mental health problems and (iv) people from vulnerable population subgroups with mental health problems, such as children with mental health problems, children with autism, people with dementia, refugees, etc.

In a similar vein, emphasis is laid on MHS being digitally connected with primary healthcare services, secondary health care services (hospitals) and tertiary health care services (specialized and psychosocial support services) as well as with welfare services and with municipal support and care services. The interoperability of these services can be achieved through the development of citizen's electronic medical file, where all health issues will be recorded. The electronic medical record is the only coherent way for facilitating intercommunication among systems, structures and services,

tailored to needs of each citizen. The continuous recording of health outcomes by updating the data of the individual health file, constitutes a feasible and straightfoard recommendation for overcoming the obstacles posed by the fragmentation of the existing mental health services [9]. The applicaton of the ICD-10 diagnostic classification system to all MHS facilitates this process.

Moreover, upon discharge, the service user will be referred to a community unit or service located in the ToPSY to which he/she belongs and the first appointment will be determined. The design of local models of care on the sector level, aiming to esnure the provision of an entire chain of services covering the needs of the local population, has been stressed by the Rapid Risk Assessment as well. The second axis also incoprorates the development and implementation of a suicide prevention strategy or plan.

Concerning the sixth axis, a reorganisation of administrative and scientific coordination is proposed with a Network Coordinator body introduced in the level of the Health Region and re-organisaton of ToPSY. Finally, people with severe mental illness also receive social support (and benefits) by the state in the following forms: i) income support (disability > 67 %), ii) housing support (community residential services by NGOs and public hospitals), iii) employment support (employment quotas and subsidies in public & private sector and social cooperatives, iv) education support (special schools & special education in mainstream education) and v) legal support (free legal aid for low-income people) [10].It is noteworthy that, the share of people reporting unmet mental health care needs due to financial reasons in 2014 was 9.7 % (11).

1.3 Health and Social Structure Attica Region

Attica Region is the largest region in Greece with a population of 3,814,064 people. It is located on the eastern edge of Central Greece and encompasses the entire Athens metropolitan area, the core city of which is the country's capital and largest city, Athens [15].

The geographical territory of the Attica Region is divided into 11 Mental Health Sectors for adults and 4 Mental Health Sectors for childern and adolescents. Each Mental Health Sector includes: i) Primary Mental Health Units, ii) Hospital Units and iii) Psychosocial Rehabilitation Units [16].

The **pilot area** for the implementation of the Belgian Best Practice is the **5th Adult Mental Health Sector of Attica Region**, which is integrated (along with the sectors 4 and 6) into the 2nd Child and Adolescent Mental Health sector. The 5th Adult Mental Health Sector includes 8 municipalities (Acharnon, Kifissia, Lykovrysi-Pefki, Amarousion, Neo Heraklion, Marathon, Oropos, Dionysos) with a population of 439,887 people, according to the latest census (2021) [15,16].

Table 5. Population structure in 2011* of 5th Adult Mental Health Sector of Attica Region expressed as number of persons, by age and sex [17]

	Sex		
Age group	Male	Female	**Total**
<18	41,564	40,029	81,593
18 - 64	142,655	144,395	287,050
65+	32,142	37,930	70,072
Total	**216,361**	**222,354**	**438,715**

* Due to the lack of detailed data by sex and age from the last census (2021), the 2011 census data were used

The unemployment rate for the year 2022 in Attica Region (which includes the municipalities of the 5th Adult Mental Health Sector) is 10% (17). The life expectancy in Attica Region for the year 2021 is 82,6 years on average for women and 77 years for men (18).

A total of 21,8% of the population in Attica Region is at risk of poverty and social exclusion while the share of people reporting unmet mental health care needs due to financial reasons in 2022 was 7,5% [19,20]. Furthermore, 12,5% of citizens in Attica Region in 2022 stated that they faced severe material and social deprivation [21]. Finally, the educational attainment in the pilot area is quite high since 45,6% of people aged 25-64 had a tertiary level of education [22].

1.4 Community-based mental health care at pilot level

The 5th Adult Mental Health sector [23] provides a diversity of mental health services to the residents of 8 municipalities, covering thus the mental health needs of 439,887. Specifically, there is a psychiatric department in the general hospital of Sismanoglio (25 hospital beds); whereas 25 beds of the Psychiatric Hospital of Attica "Dafni" and 39 of the Psychiatric Hospital of Attica "Dromokaiteio" are assigned to this sector. It merits noting that the two psychiatric hospitals are not situated within the geographical borders of the adult mental health sector. Hence, in total there are 89 hospital beds in the sector, provided by two psychiatric hospitals and one general hospital. Moreover, there are also 5 outpatient services of general/ psychiatric hospitals allocated to the sector (Sismanoglio, Dafni, Dromokaiteio, Agioi Anargyroi, Multi-clinic of Olympic Village).

As regards community-based mental health services (non-hospital based services), there are two day centers, one day hospital and one community mental health centre in the sector. In terms of residential facilities, there are 21 housing units of varying length of stay and degree of independence required. There is also a Social Cooperative of Limited Liability (KOISPE) in the sector.

The sector also encompasses a specialized inpatient unit for people with eating disorders and a day centre for people with dementia. Moreover, quite recently (May 2023), an Early Psychosis Intervention Unit started its operation in the sector.

Apart from state-funded services, there **are 4 private** clinics in the region. It is noteworthy that in the sector, there is also a Families Association for Mental Health.

Furthermore, two helplines, one for psychosocial support (10306) and one for suicide risk (1018), operate 24/7 nationwide and as a result of this, they also cover the 5th sector. Similarly, one service of the sector (EPAPSY day centre) entails an Assertive Community Treatment programme.

Finally, there is also the provision of primary health care services in the region, delivered by 11 health centers spread across the municipalities that constitute the sector.

Table 6: Total number of MH workers in your pilot area (ref)

	In MH services (all)		In child & adolescent MH services	
	Total number	Rate per 100.000	Total number	Rate per 100.000
Psychiatrists	14	0,13	----	----
Child psychiatrists	---	---	13	0,71
Mental health nurses*	94	0,88	51	2,78
Psychologists	12	0,11	8	0,44
Social workers	3	0,03	4	0,22
Speech therapists	0	0	3	0,16
Occupational therapists	9	0,08	7	0,38
Others	4	0,04	23	1,25
Total	**136**	**1,27**	**109**	**1,02**

* All nursing staff is included regardless of their specialization

2 Needs Assessment (NA)

In order to perform a needs assessment, a SWOT analysis was conducted with regard to the pilot implementation area, i.e. the 5th sector of the 1st Health Authority of Attica. SWOT analysis was performed by the NPHO team in collboration with key stakeholders of the 5th sector as well as by drawing upon material from the recent rapid risk assessment of the psychiatric reform in the country by the Ministry of Health and the World Health Organization [9] as well as the „ex post“ evaluation of the implementation of the "National Action Plan Psychargos 2000–2009" of the psychiatric reforms by the Ministry of Health and the Institute of Psychiatry [24].

Table 7. SWOT Analysis

	Strengths	Weaknesses
INTERNAL	1. Great diversity of mental health services in the region 2. Great availability and diversity of interventions provided by these services (pharmacology, psychotherapy, mental health promotion, anti-stigma, Assertive community treatment, psychoeducation, rehabilitation services, etc.) 3. Modernization of mental health services (e.g. establishment of an early intervention for psychosis unit) 4. Local communities accepting towards people with mental illness. 5. People with severe mental illness are empowered. 6. Vocational rehabilitation active due to KOISPE 7. Families' Association in the area promotes patient and families' participation in decision making. 8. Anti-stigma initiatives in the region have reduced stigma surrounding mental disorders. 9. Institutional support for the implementation of the pilot 10. Experienced and eager staff 11. Political leadership 12. Rapid risk assessment of psychiatric reform by the Ministry of Health and WHO	1. Difficulties in coordination of care 2. Incomplete enforcement of sectorisation 3. Lack of standardisation of procedures regarding pathways of early diagnosis, care and referrals (primary health care, community mental health services, mobile units, inpatient hospitalisation, outpatient hospital services, day centers, community residential facilities (public and private) 4. Insufficient follow-up of referral and care pathways after inpatient admission hampering care and recovery approach 5. Insufficient intersectoral cooperation with health services, municipalities/regions and other sectors 6. Dearth of epidemiological studies about community mental health needs 7. Data collection about mental health services indicators (e.g. number of visits, socio-demographic characteristics of service users, ICD-10 diagnoses, etc) is heterogenous and non-systemised among services 8. Need of further training of staff in recovery approach 9. Lack of staff training on service evaluation, research and quality assurance philosophy and activities 10. Need of further training of stakeholder on community mental health care in recovery approach 11. Limited patient advocacy 12. Some delays in staff payments.
	Opportunities	**Threats**
EXTERNAL	1. Mental health among EU priorities 2. Mental Health in EU is considered an integral part of health and thus public health and Health should be considered in all policies. 3. JA ImpleMENTAL with knowledge and expertise transferring, especially in terms of providing training packages, building and sustaining intersectoral networks and rendering MHS patient-centred, quality assured and recovery oriented. 4. Deputy Minister of Health declaring completion of community mental health system reform a priority 5. New mental health plan 2022-2030 facilitating the transition to community-based care. 6. New mental health plan aiming at increasing resources (staff and services) is an opportunity for all sectors including the 5th sector.	1. Resistances to change, structural change and cultural change. 2. Staff burnout in the post COVID-19 era 3. Economic uncertainty 4. Administrative difficulties, especially in communication and networking among services and stakeholders 5. Difficulties in engaging stakeholders 6. Inadequate use of implementation science as a tool for transfer and implementation of best practices 7. Lack of sustained Leadership 8. Delays in staff payments and inconsistency in funding 9. Climate crisis creating new and pressing mental health needs

3 Reflection on SANA results

- Converging evidence from the "ex post" evaluation of the implementation of the "National Action Plan Psychargos 2000–2009" of the psychiatric reforms, which was commissioned in 2010 by the Greek Ministry of Health at the request of the European Union (Loukidou et al., 2013), the most recent rapid risk assessment of psychiatric reform by the Ministry of Health and WHO and personal interviews with key stakeholders, indicates that existing mental health services necessitate better coordination among them, including the establishment of mechanisms that ensure continuity of care. Clearly defined pathways for different population subgroups, ranging from mild forms of common mental disorders to people with severe and enduring mental illnesses, following a stepped care approach, are prioritized as well as standardization and harmonization of different processes, pertaining to inter-communication among services (within mental health as well as intersectoral), the delivery of individualized care plans (in line with the recovery model, which is adopted by a number of services in the country) and data collection for monitoring key indicators of quality of care.
- Our approach is focusing on adequate and effective prevention and early identification and diagnosis, access to high-quality, mental healthcare and treatment; and in the end ensuring reintegration into society after recovery. We aim to assess all steps that will help ensure through a well define implementation strategy the process for successful community mental health system reform in 1 out of the 37 sectors and monitoring and evaluating the process in order to provide adequate documentation on what are the enablers barriers, the procedure but also further resources and funding that will ensure quality of care and quality of services.
- As a result of this, the pilot implementation will address one implementation site, where the establishment, coordination, maintenance and sustainability of networks at different levels will be the top priority, congruent with the local needs as well as the needs of the Mental Health Care system nationwide. The establishment, maintenance, coordination and sustainability of these networks should occur at the following levels: within the mental health sector (especially better collaboration between community MHS and hospital-based ones) and across the mental health sector (with primary health care services, social welfare services, third sector and community institutions).
- To this end, the infrastructure should be established, that is protocols for ensuring optimal coordination and communication among services as well as appropriate training packages for all the involved parties addressing both the procedures as well as the community-based, recovery enshrined culture.
- At the same time, in line with patient-centred approach, promoting patient advocacy and their participation in all stages of decision-making is imperative for promoting health democracy in the implementation site as well as other regions of the country.
- Possible barrier is resistances to change (in general terms as well as with respect to structural and cultural change). By engaging stakeholder early in the plan, making them partners in the process and providing them with the suitable (in terms of their needs) training, we believe it will be circumvented. Moreover, continuous engagement of policy makers in the plan will facilitate the required changes (some of them in a top-down manner).

4 Priorities & Next steps

1st selected Strategic Area: Ensure (strong) governance structures/mechanisms

Sub-strategic area 1.1.: Governance conditions

- Establish continuous collaboration of NPHO team (JA ImpleMENTAL) with Member State Policy Committee member and Ministry of Health to keep the Ministry informed and to consult them on the implementation process and on the sustainability work. This will assist implementation process and the assessment of the policy relevance and value of JA achievements, and to explore integration of the JA results into national/regional policies. It will also support the adaptation of the best practice to national needs, while taking into account funding resources and policy priorities. October 2021- September 2024.

Sub-strategic area 1.2: Building (consolidating or extending) and sustaining networks based on intersectoral, multidisciplinary and recovery-oriented approach (at pilot site)

- Country Coordination of JA ImpleMENTAL and development of an expert JA ImpleMENTAL team by NPHO on the transfer, implementation and guidance of the BBP for the pilot in 5th Sector but also for future transfer of BBP in other sectors if needed. October 2021- September 2024.
- Draft guidelines on networking and care pathways for people with (at risk of) mental illness;
    a. people with (at risk of) mental illness or who are at risk of relapse (primary and secondary prevention);
    b. for people with mild and moderate mental health problems;
    c. people with severe mental health problems;

  following a stepped care approach (i.e. to stratify help seekers into different 'needs groups' along the continuum of at-risk, mild, moderate and severe illness categories, and to match intervention intensity with these needs; while rationalizing the use of resources).
  Emphasis will be stressed on early identification and diagnosis, standardization of referral processes linking hospital care to community care (with an emphasis on continuity of care after hospital discharge) as well as among structures of the community network (community mental health services, primary health care services, social welfare services, third sector and community institutions). September 2023 – September 2024.
- Identify sector Network Coordinator in the 5th sector, 1st Health Authority of Attica, perform SANA at pilot level + prioritized measures, structure the implementation process, pilot action plan and implementation team at sector level. June 2022 – November 2023.
- Mapping of the extant health services and intersectoral networks at sector level as well as on site visits to all of them (mental) health services, social welfare services, third sector and community institutions in the 5th sector of the 1st Health Authority of Attica so that the work together in a systematic way towards setting-up intersectoral and multidisciplinary network at pilot site. June 2022 – December 2023.
- Develop/consolidate/extend engagement of ALL relevant stakeholders across (health and non-health) sectors in the 5th sector, 1st Health Authority of Attica. November 2023 – September 2024.
- Establish/consolidate/extend participation of users/families (meso-level) - incl. involvement of peer workers in the 5th sector, 1st Health Authority of Attica. November 2023-September 2024.

2nd Strategic Area: Development or transformation of MH services and interventions (incl. multidisciplinary approach)

- Define care pathways for people at risk of mental illness as well as mild to severe mental disorders, including a standardized referral procedure to interconnect them in the 5th sector of the 1st Health Authority of Attica. This will take into consideration the draft guidelines of the 1st strategic area and will address separately the pathways for (i) people at risk of mental illness or relapse, (ii) the people with mild to moderate mental health issues and (iii) people with severe mental disorders, congruent with a stepped care model approach. Emphasis will be given on early identification, standardization of referral procedures, following up the users after hospital discharge and referring them in a standardized manner to community-based MHS, interconnecting primary health care services and CMHS and ensuring timely identification of the user from his/her point of entry into the system, facilitation of his/her first appointment with the most suitable for his/her needs services and monitoring of his/her course. November 2023-June 2024.
- Nomination of a "care referent" (or" case manager") as individual contact person of the user Community mental health services already employing case managers. Efforts will be made to map, extend and homogenize the practice among services in the 5th sector of the 1st Health Authority of Attica. November 2023-June 2024.
- Definition and use of "Individual Service Plans". The CMHS use individual service plans; however, with marked variability with respect to their definition, format and content. Efforts will be made to map, extend and homogenize the practice among services in the 5th sector of the 1st Health Authority of Attica. November 2023-June 2024.

3rd Strategic Area: Extensive global training programme of stakeholders (in support of the reform & cultural change in service provision)- Training will be based on training packages of BBP, JA ImpleMENTAL and other existing evidence-based tools and initiatives

- Organize and provide training on pathways of care, networking, referral processes, the recovery model (including individualized care plans), and quality assurance processes to staff of mental health service in 5th sector, 1st Health Authority of Attica and performing a survey to map local training needs. October 2023 – September 2024.
- Organize and provide training to health professionals, employees of social services, employees of third sector and community institutions in the 5th sector, 1st Health Authority of Attica on common and severe mental disorders, available treatments, pathways of care, networking and referral processes and performing a survey to map local training needs. October 2023 – September 2024.
- Organize and provide training to users and their families about pathways to care, available treatments, their rights, and advocacy in the 5th sector 1st Health Authority of Attica. October 2023 – September 2024

4th Strategic Area: Intensive continuous communication, information and awareness raising among/towards stakeholders and users – Information and raise awareness material will be based on the BBP, JA ImpleMENTAL and other existing evidence-based material

- Internal Communication Dissemination at sector level about the project, its developments and evaluation to the relevant stakeholders. November 2023-September 2024.
- Communication, information and awareness raising (i.e. among stakeholders/partners). Inform the Ministry of Health and relevant national stakeholders (e.g. Hellenic Psychiatric

Association, Hellenic Branch of WAPR, Other health prefectures) about the project and its developments at national level. November 2023 – September 2024.

- External communication, information and awareness raising (i.e. towards users and general public). Dissemination to the service users and general public about the project. November 2023 – September 2024.

5th Strategic Area: Data collection, monitoring & evaluation

- Monitoring & evaluation (M&E) of the implementation process. The progressive implementation of the best practice will be monitored and evaluated through the M &E system of the JA ImpleMENTAL. October 2021 – September 2024
- Increase of data collection and usage. Increase standardization of data collection among services to facilitate cooperation and coordination of the sector Mental Health Services care and referral processes and quality assurance. This will include data on linkage of patients to community mental health services after hospitalization in Sismanogleio hospital. A concept for a dashboard of (mental) health indicators at sector level should be developed and agreed in cooperation with JA ImpleMENTAL WP5 dashboard team. December 2023 – September 2024.

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