SOCIOCULTURAL AND ORGANIZATIONAL DIMENSIONS OF MENTAL HEALTH CARE NETWORKS FOR OLDER ADULTS TOWARDS NEW FORMATIONS

M. Tzakanis, M. Valasachi, M. Moraitou, G. Kelemen,
M. Gavrila-Ardelean,J. Deloyer, C. Hanon, N.Hustinx,
I. Tournier, S. Vasseur-Bacle, C. Maes, L. Fond-Harmant

Manolis TZANAKIS, Assistant Professor, PhD,
University of Crete, Department of Sociology, Greece
tzanakism@uoc.gr.
Maria VALASAKI, PhD student,
University of Crete, Department of Sociology, Greece
maryvalas@hotmail.com
Marguerita MORAITOU, kepsipi@yahoo.gr
Kepsipi, Korydallos, Greece,
Gabriela KELEMEN, professor, PhD,
Aurel Vlaicu University of Arad, Romania,
gabrielakelemenuav@gmail.com
Mihaela GAVRILA-ARDELEAN, professor, PhD, MD
Aurel Vlaicu University of Arad, Romania
miha.gavrila@yahoo.com
Jocelyn DELOYER,
Centre Neuropsychiatrique Saint-Martin, Dave, Belgium
jocelyn.deloyer@fracarita.org
Cecile HANON, MD
Regional Resource Center of old age Psychiatry,
Corentin-Celton Hospital, Academic Hospital West Paris,
Psychiatric Department, AP-HP, Paris, France.
Paris Descartes University, Sorbonne Paris, France,
cecile.hanon@aphp.fr
Nicolas HUSTINX,
Centre Neuropsychiatrique Saint-Martin, Dave, Belgium
nicolas.hustinx@fracarita.org
Isabelle TOURNIER, PhD,
University of Luxembourg, Luxembourg
isabelle.tournier@i-zd.lu
Simon VASSEUR-BACLE,
EPSM Lille Métropole / WHOCC, Lille, France
svasseurbacle@epsm-lille-metropole.fr
Cristine MAES,

Centre Neuropsychiatrique Saint-Martin, Dave, Belgique
christine.maes@fracarita.org
Laurence FOND-HARMANT, Researcher, PhD
Luxembourg Institute of Health, Luxembourg
fond.harmant@gmail.com

Abstract: In this paper, we attempt to analyzethe developments of welfare state in European countries in relation to social networks of professionalsaimed at caring for elderly people with mental health problems.We start with a typology of the welfare state in Europe which has dominated the current debate. We focus on (a) welfare reformation and the values that characterize these reorganization (emphasis on autonomy, problematization of dependency, desire to improve independent living, etc.), (b) certain social processes that determine this change, (c) forms of organization of the socio-economic domain -sanitary current (multiplication of local networks and projects, decentralization of services, criticism of bureaucracy, improvement of the flexibility of care services, etc.). Then we will analyze the organizational, ideological and therapeutic issues of networking. Finally, we will highlight the problems that arise, as a consequence of these issues.
The paper is based on data that has been drawn on the context of a European program Erasmus+ entitled ARPA ageing.
Key words: mental health, professional networks, welfare state.

Introduction

The last years, care in the domain of mental health of elderly people is increasingly formingin a networking way. This organizational reorientation is, as we argue, a result of a wider reorganization of medical and social services; a result of the change in the basic structures of the welfare state in most European countries (Aspalter, 2006).Given the fact that professional networks operate in broader social, organizational, cultural, and national contexts, we have noted the profound differences, but also the commonplaces that emerge (Allen &Ciambrone, 2003). The culture of networks tends to acquire common traits with the broader reorganization of medical and social services, developments

that raise common concerns: ideological, cultural, organizational, etc.(Adam &Papatheodorou, 2016).

The evolution of professionals' networks whose main aim is to take care the elderly people with mental problems, are organized and operate on the basis of these new organizational and ideological orientations. We focus on:

(a) The welfare state reformation and the values that characterize these reforms (emphasis on autonomy, problematization of dependency, desire to improve independent living, etc.) (Lawson, 2007; Milligan, 2005),

(b) Social processes that determine the specific change (individualization, liquidation of traditions, new forms of family, flexibility of work, endemic unemployment, etc.) (Williams, 2001),

(c) The forms of organization of the socio-economic domain (multiplication of interdisciplinary professional networks and local projects, decentralization of services, criticism of bureaucracy, improvement of the flexibility of the care services, etc.).The changes in health social care sector is the result of the emergence of new ways bywhich these networks are supposed to operate(Cousins, 2006;Ferrera&Jessoula, 2016; Ferlie et al., 1996; Hill, 2006).

Startingwith a typology of the welfare state in Europe which dominates the current debate and extends our discussion to the countries of Eastern Europe, emphasis is given on the following assumptions:

- Different types of welfare states have been historically organized;networks of professionals are characterized by a particular dynamic in each "regime".

- In recent years welfare states are in the process of reforming. To a large extent, this reformation has common characteristics: organizational, moral and ideological. It is based on common values and political orientation. Indeed, the relevant literature refers to a "post-welfare condition": a new regime, a special status of the functioning of the health social care sector tends to dominate (Bonoli& Natali, 2011; Clarke et al., 2000). This process is very important in terms of how networks of professionals are organized and the role they are expected to have.

About the typology of Welfare States in Europe

The typology of the welfare state systems as presented today is the result of historical studies (Titmuss, 1974;Ferrera, 1996). It is common to classically define the welfare state by contrasting two major models: the Bismarckian welfare state, founded in Germany by the laws of 1880, and the Beveridgian welfare state, which is based on the 1942 report of "Social insurance and allied services" (known as the "Beveridge Report"),that was born in the United Kingdom after Second World War.

However, according to the current bibliography the study of social protection systems in Europe is based on a categorization of four types of organization and funding of the welfare state (Petmesidou&Tsoulouvis, 1994;Petmesidou, 2001; Pierson, 2001), that leads to the abovementioned typologyand is based on four criteria as summarized below:

a) The form of insurance coverage (selective or universal),
b) The organization and legal form of the social protection system,
c) The quality of services, and
d) The type of financing (contributions or taxes).

Studies such as those ofTitmuss (1974) and Ferrera (1996) categorize and attempt to clarify the characteristics of social protection systems. Based on this classification, we can distinguish five types: the social-democrat, the conservative-corporatist, the liberal, that of southern Europe, and that of the "East". However, big question for all kinds of typologies still remains the nature of the welfare state in Eastern European member-states of the EU.

Social-Democratic welfare state

This type of regime aims at reinforcing the possibility of individual independence whose most striking specificity is perhaps its fusion between social protection and work. The ideal aim is to strengthen family's independence but also the possibility of individual independence (a particular fusion of liberalism and socialism) (Arts &Gelissen, 2002; Petmesidou&Tsoulouvis, 1994).

A condition for financing such a high performance model is to ensure full employment. This model has the following basic features:

- General benefits of a universal nature;guarantee universal social rights for the entire population.
- The main reference point is the individual. Public sector intervention is strong, based on the principle of decentralization and monitoring citizens throughout their lives, each time covering different needs in the different phases of each person's life.
- The subsystems of care are part of the same project and refer to the whole broad redistributive intervention, based on a high level of taxation.
- Promote a gender equality policy. This point is directly related to the main topic of our study, since the functioning of professional caregivers' networks is based on (a) social representations of the particular capacities of women and men and (b) the sharing of "roles" and "care work" between men and women.

Conservative-corporatistwelfare state

This type of scheme is based on the Bismarckian model, for which quality of social protection depends on occupation and income. This regime is modeled by the state and also by the churchand its main concern is thedefense of traditional family values. The establishment of social rights is understood throughthe desire to maintain social hierarchies (Petmesidou&Tsoulouvis, 1994). The countries that are characterized by this model are mainly Austria, Germany, Italy(partly), Belgium and France. Its principal features are:

- Broad coverage of the population and generous benefits.
- Social transfers are important but also differentiated in relation to the subdivision of the population. It is based on the assumption that professional and social divisions exist and must be maintained.
- Linkage between the benefits and the socio-professional position and career of the person. *The care of the elderly is not the same for all but depends on the previous professional career,* an important dimension because the quality of life of the elderly and the risk of psycho-emotional difficulties are related to social resources.
- Often the reference point is the family. There is a major interest in this point becauseunder the new circumstances, the development of professional networks extends to the intermediate domainin which various formal and informal care networks as a family organization, ONG etc.,participate. (Allen et al., 2003;Amoss et al., 1981).

The liberal welfare state

This kind of state is a residual welfare state. It supports the market, either passively by providing a minimum level of protection, or actively by subsidizing private social assistance programs. There is an immense interest in this ideological orientation as it tends to affect all the reforms of the welfare state in terms of values. In a liberal regime the state intervenes only as a last resort and forces individuals to return as fast as they can to the labor market (the main role is played by market mechanisms) (Petmesidou&Tsoulouvis, 1994). The archetypal model countries are Canada, the United States, Australia, and in the European area can classify the United Kingdom and Ireland. This model has the following basic features:

- It is an individualistic social policy system based on property rights and the proper functioning of market mechanisms. It provides limited state intervention and aims at encouraging people to participate in the labor market.

- The state takes up responsibility for promoting prosperity only when family and market fail.
- There is a stigmatization of beneficiaries (see the tradition of charity in these countries and link the need for care with impotence and disability).
- In this system, the employees' earnings are only partially maintainedinthe case of accident, unemployment, *illness or when the retirement age comes*.

The Mediterranean-South European welfare state

According to Ferrera (1996) this model also includes elements of the corporate model (in the field of social security and social protection) and that of Beveridge Health Model (mostly private health sector). We find it mainly in the Mediterranean countries of the EU and it is considered to berudimentary if compared to other forms (it is also characterized as traditional or "elementary") (Gough, 1999;Katrougalos, 1996;Katrougalos&Lazaridi, 2002;Petmesidou, 1996; Rhodes, 1997). Other features are the follows:

- Limited importance of the principle of universality.
- *High degree of fragmentation and polarization of the social security system.* This point is very interesting as it often leads to the establishment of a specific type of professionals' networks with wide variations by sector of care.
- *Large gaps and strong inequalities have been observed in the field of social protection.*
- Family has a decisive rolein a poorly developed health social care sector. Much of the care is taken over by the family. In countries like Spain, Greece and Italy, there is a lot of coherence and solidarity within families; proximity,cohabitation,frequency of contact and communication, transfer of time and money, are used as indicators of positive evaluation.

EasternEuropean EU member states

This discussion and the relative categorization do not include Eastern European countries. In these countries, the control of the economy and the possession of the means of production by the state were factors that made social protection an obvious obligation for central government vis-à-vis citizens. However, rapid change in economic and political structures is bringing into question the management of social and medical servicesonly by the state (Gavrilă-Ardelean, 2015; Kaprio, 1991).

Reorientation of welfare states ends the professional networks

New values

These welfare state models are based on quite different values, ideologies and institutional traditions. The Anglo-Saxon model comes from the tradition of charity, the continental models are based on Bismarck's selective provision, while the Scandinavian tradition is based on the claim of social rights.All these welfare organizational versionswere created in the specific context ofa historical development;it was the result of coherent arrangements, which have determined the organization of social and medical services.

However, after 1980,we haveobserved the transformation of all these arrangements in a particular direction, which highlights the importance of professional networks. (Hill, 2006).The position on which we are based on, is that *(a) although many and different models of organization of social and medical services are historically observed, (b) today there is a structural transformation characterized by common values and specific organizational orientations, such as the development of professional networks, a combination that leads to a particular regime which could be named as "post-welfare condition" (c) that allows, if not imposes, the emergence and multiplication of hybrid forms of organization of social structures and health services, care actions and networks.*

If we assume that welfare state reformation has specific directions that lead to a post-welfare condition, then we need to ask about its characteristics and how the professionals'network, especially thementa l health networks, operate in this new regime (Mol, 2008). Certainly, we can point out that there is a trend towards a new balance of rights and obligations, with a focus on individual responsibility (Engster, 2005; Fine &Glendinnig, 2005).Therefore, given these transformations,professionals' networks of health and social care can only be organizational hybrids, as they are based on differentiated social realities and on an ideology that calls for invention, innovation, design, strengthening of locality and relevant cultural specificity. The basic characteristics of these transformations, in relation to the issues that concern us, are:

- The professionals are pushed to "self-motivation" and performance, and no longer to "play a role". The emphasis on formal definitions of professional and social roles is gradually limited to normativity that emphasizes on individual responsibility for collective issues.
- This process ultimately contributed to the creation of targeted services and institutions to renegotiate the relationship between medical and social services and their "clients", "users", etc.

- The concept of the *project* is the key word for understanding the mechanisms of formation of the "locals' " systems of mental health and social protection services concerning the elderly. The central lines are partly replaced by local action programs where cultural specificities and local social resources have to be interpreted as exploitable sources (Ion, 1990; Ion &Tricart, 1992).

The concept of "responsibility" and that of autonomy are fundamental elements of this ideological reorientation of medical and social services.

In this new environment of social policy management health professionals are often invited to participate as a subject that is capable of active cooperation. Thus, personal resources, experience, knowledge and individual skills "must" be used as collective resources in the functioning of care networks. On the one hand, this approach makes the individual co-responsible for the successful achievement of collective goals, while at the same time there is a tendency to underestimate the structural dimensions in the field of mental health, such as the unequal distribution of personal resources of all actors.

The privatization of care sectors and its "location" creates "local care service markets" where the patient or senior becomes a client (Arapoglou&Gounis, 2017; Milligan, 2003). Professionals'networks, and the information systems that support them, *must be friendly* to the "customer". The evaluation of these networks is often based on the principle of *what works*, always in relation to specific target groups (see elderly people with mental problems).

Responsibility perspectives

The gradual transition to a post-welfare condition forces us to think in terms of hybrids. Increasingly, hybrid forms of social protection and medical care are being developed. Therefore, professionals' networks can only be organizational hybrids as they are based on differentiated and contradictory social realities and an ideology that calls for invention, innovation, project design, emphasizing on locality and cultural specificity, focusing on intermediate target groups such as the elderly with mental health problems (McLean &Trakas, 2010). Hybridization raises new challenges;social and health services are being reorganized so that several responsibilities are entrusted to local organizations, regional government structures and the "private" or non-governmental sector. This reorientation aims at supporting existing social intervention networks and at creating new at local level. These networks are mobilized by individual and collective stakeholders, through the promotion of individual responsibility (Gavrilă-Ardelean, 2016).

Consequently, the abandonment or weakening of the responsibility for the implementation of major social policy programs has been reinforced by the transfer of responsibilities to larger networks; this tends to replace the traditional intervention structures of the State. At local level, there are opportunities for systematic registration of citizens'needsto enable better re-organization or co-operation of social services and the improvement of formal and informal care networks of older people. Particularly with regard to social protection networks for the elderly, a crucial issue is that of "effective" intercommunal cooperation and development of innovative programs as a mean to explore new forms of support (Bengtson et al., 2005; Bengtson et al., 2009; Hudson & Moore, 2009).

These social developments have a decisive impact on the way elder people live, receive care, psychological support and psychiatric treatment. On the other hand, in risk societies, under Beck's terms, the individual is formed by various institutions the goal of which is the development of self-esteem (Beck, 1996). The therapeutic discourse is disseminated to the general public through social mechanisms such as social work, individual counseling, and a certain perception of a "good life"(Rose, 1990, 2007). These institutional changes contribute not only to the development of a multitude of biopolitical technologies that regulate the body and the well-being of populations, but also to the development of technologies whichforce individuals toact on their selves and to self-governing subjects (Featherstone &Wernick, 1995).

However, how can we ensure an independent life and how can we achieve self-management, in the case of elder people with mental problems? These are questions that make sense in a world where people live their lives according to an individually conformed plan, that takes beyond their physical or mental weaknesses.

Professionals'Networks and discontinuations' management of care and treatment

The main concern is that, in a fluid institutional environment that is being shaped, a satisfactory group of carers cannot be clearly identified as happens with the case of elderly with mental health problems. In the context of a post-welfare condition, there is the possibility of creating significant gaps between the different areas of social health care sector, at local, regional or national level. In our case, improving intersectoral networks of professionals has as a result the liquidation of care and treatment. Care and support for the elderly is provided by several social institutions: the state, family, formal and informal social networks. Cultural rules and local traditions, which usually define what constitutes a "good" practice of care for the elderly, are often contradictory and ambiguous (Risseeuw, 2001; van der Geest 2002a, 2002b).

Given these local characteristics and by developing an effective networking policy in the area of care of older people with mental health problems the following two questions could be answered:

(a) How do these parameters determine the character of caring for a region, leading to local healing and healing cultures and ways of working together with citizens and services?

(b) Who and how will care for the mentally ill and the elderly, in the face of institutional changes as described above and the corresponding value orientations?

The new "value code" for the functioning of social services and more broadly formal and informal structures of health, care and psychosocial support do not disassociate the public and private sectors, while underlining the dimension of "choice".

Decentralization, deconstruction of hierarchical models of decision-making and governance, and the tendency to demand-based diversification are the organizing principles of thispluralistic model (Silverstein & Roseann, 2010). Non-governmental organizations and informal care networks have a major influence on this reorganization of social services. Informal care networks are often traditional family networks.In many Mediterranean countries this process is based on the established feminization of care for the elderly, especially in the immediate family environment, reproducing the traditional division of work into a new framework, based on self-development and the ideological project of autonomy. Elderly people who cannot serve themselves, are often supported by people living in the close family environment (Bettio&Veraschcagina, 2010; Prince, 2000), fact that creates a gap between the new code of values, which reorganizes care of the elderly, and the therapeutic reality that is rarely characterized by organizational discontinuities.

A basic organizational discontinuity, which professionals' networks are called to face in a fluid institutional environment, is the breach between medical and social care. Thus, as is often the case, in societies where the welfare state has never been sufficiently developed and much care was taken by traditional networks, especially the family, the "problems" related to the "needs" of the old age are classified as "pure" social problems: they are considered as organically linked to family dysfunctions, mainly by the inability of some families to take charge of the "natural" event of the old age without external help and government intervention.

However, even if services are available for the care of the elderly with psychiatric problems, another gap often occurs: this is between biologically oriented health services and social services. This is undoubtedly a problem of redistribution of responsibilities, for which the development of professionals in

the intermediate field between medical institutions, mental health services and social care services have much to offer.

Often,services designed to respond to medical problems, such as hospitals, are defined by the law as responsible for elderly's care, unlike structures that can deal with social problems, thusas a result, older persons are transferred from one state agency to another, from one specialist to another(Kostakiotis,2010). The representation of old age in our contemporary world is complex. On the one hand, we seek to obtain a label of "aging well", and on the other hand, there is a practical gap for the daily life of old people who accumulate handicaps and deficits, and the therapeutic efforts are often vain and expensive.Drop-out areas appear as a field with evident consequences for the elderly who are exiled there;marginalized spaces are created by the combination of moral perceptions, legal regulations, lack of resources and social mechanisms. "From social services without handsto medical services without eyes"according to Kostakiotis(2010), referring to the one-dimensional look of medical services and the weakness of social services in the case of Greece, the elderlyare moving into a no-man's land, in the abandonment zones. There, without care, the weak old people are actually punished for their inability to act on the two dominant projects of the Greek society: on the one hand, the creation and maintenance of a circle of affectionate relatives according to the dominant model family life; and on the other hand, their failure at the financial level.

Developing professionals' networks signifies that we are trying to overcome these *gaps* in the field of care, in a fragmented and liquid care landscape of the post-welfare regime.

Increasingly, hybrid forms of social protection and medical care are being developed. It is for this reason that we observe at European level, a reconfiguration of public policies in the field of mental health and care of the elderly, towards decentralization and establishment of an intersectional local or regional welfare state, both situated and open-flexible. To sum it all up, at local or regional level there are opportunities for systematic recording of citizens' needs, in order to allow a better re-organization and cooperation of social and medical services with mental health institutions in terms of community, and improvement of formal and informal care networks for older people (Velpry, 2008). Particularly with regard to social protection networks for the elderly, a crucial issue is the effectiveness of inter-municipal cooperation and the development of innovative programs as a means to explore new forms of support.

References

Adam S., Papatheodorou C. (2016). Dismantling the feeble social protection system of Greece: Consequences of the crisis and austerity measures. In J. Kuhlmann, K. Shcubert & P. Villota (Eds.), *Challenges to European welfare systems* (pp. 271–300). Cham: Springer.

Allen S.M., Ciambrone D. (2003). Community care for people with disability: Blurring boundaries between formal and informal caregivers. *Qualitative Health Research* 13(2): 207-226.

Arapoglou V., Gounis K. (2017). *Contested Landscapes of Poverty and Homelessness In Southern Europe. Reflections from Athens*. Palgrave: Macmillan.

Arts W., Gelissen J. (2002). Three worlds of welfare capitalism or more: a state of the art report, *Journal of European Social Policy*, 12(2): 137-158

Aspalter Ch. (2006). New developments in the theory of comparative social policy. *Journal of Comparative Social Welfare*, 22(1): 3-22.

Beck U. (1996).*The Risk Society.* London: Routledge,

Bengston V.L. Coleman P.G., Kinkwood T.B.L. (2005). *Age and Aging.* New York: Cambridge University Press.

Bengtson V.L., Gans D., Putney N.M., Silverstein M. (2009). *Handbook of theories of aging*. New York: Springer.

Bettio F., Veraschchagina A. (2012). *Long- Term Care for the Elderly- Provisions and Providers in 33 European countries*. Luxemburg: European Union.

Bonoli G., Natali D. (2011).The Politics of the New Welfare States in Western Europe, *EUI Working Papers*, RSCAS 2011/17.

Clarke J., Gewirtz Sh., McLaughlin E. (2000) (eds.), *New Managerialism, New Welfar*e? London:Sage Publications.

Cousins M. (2006). Typologies of Welfare. in Cousins M. (Eds) *European Welfare States: Comparative perspectives*(pp. 107-123).London:Sage publications.

Engster D. (2005). Rethinking Care Theory: The Practice of Caring and the Obligation to Care. *Hypatia* 20(3): 50–74.

Featherstone M., Wernick A. (Eds.) (1995). *Images of Aging.* London: Routledge.

Ferlie E., Pettigrew A., Ashburner L., Fitzgerald L. (1996). *The New Public Management in Action*. Oxford:Oxford University Press.

Ferrera M. (1996). The 'Southern Model' of welfare in Social Europe. *Journal of European Social Policy*, 6: 17-37.

Ferrera M., Jessoula M. (2016). Poverty and social inclusion as emerging policy arenas in the EU. In R. Halvorsen & B. Hvinden (Eds.), *Combating*

*poverty in Europe: Active inclusion in a multi-level and multi-actor contex*t (pp. 62–84).Edward Elgar Publishing.
Fine M., Glendinnig C. (2005). Dependence, Independence or Inter-dependence? Revisiting the concepts of care and dependency. *Ageing & Society*, 25: 601- 621.
Gavrilă-Ardelean M. (2015). Comparative Analysis of the Evolution of Mental Illness in Romania And Eu Countries,.*JournalPlus Education*, 12(1):150-159.
Gavrilă-Ardelean M. (2016). Reducing the Stigma of People with Mental Handicap, *Agora Psycho-Pragmatica*, 10(2):39-45.
Gough I. (1999). Welfare Regimes: Onadapting the framework to developing countries. *SPDC Paper no.1*, University of Bath.
Hill M. (2006). Comparative theory. In M. Hill (2006) *Social Policy in the Modern World: A Comparative Text*(pp. 19-42). Oxford:Blackwell.
Hudson A., Moore C. (2009). *Caring for older people in the community*. United Kingdom:Wiley- Blackwell.
Ion J., Tricart J.P. (1992). *Les Travailleurs Sociaux.* Paris: Découverte.
Ion J. (1990). *Le Travail Social à l'épreuve du Territoire*. Toulouse: Privat.
Kaprio L.A. (1991). *Forty Years of WHO in Europe: The Development of a Common Health Policy*. World Health Organization: Regional Office for Europe.
Katrougalos G. (1996). The South European welfare model: The Greek welfare state, in search of an Identity. *Journal of European Social Policy*, 6: 39-60.
Katrougalos G., Lazaridis G. (2002). *Southern European Welfare States: Problems, Challenges and Prospects*. New York: Palgrave Macmillan.
Kostakiotis G. (2010). "Why should I eat shit?" Negotiating the "dirty work" of taking care of elders on an Aegean island. *Medische Anthropologie* 22(1):77-92.
Lawson V. (2007). Presidential Address: Geographies of Care and Responsibility. *Annals of the Association of American Geographers* 97 (1): 1–11.
McLean A., Trakas D. (2010). Beyond impediments to caring: Toward a morality of late-life care. *Medische Anthropologie* 22 (1): 13-30.
Milligan C. (2003). Location or dis-location? Towards a conceptualization of people and place in the care-giving experience.*Social and Cultural Geography* 4(4): 455- 470.
Milligan C. (2005). From home to "home": situating emotions within the caregiving experience. *Environment and Planning* 37 (A): 2105-2120.
Mol A. (2008). *The Logic of Care: Health and the Problem of Patient Choice*. London, New York: Routledge.

Petmesidou M., Tsoulouvis L. (1994). Aspects of the changing political economy of Europe: welfare state, class segmentation and planning in the postmodern era. *Sociology*, 28(2): 499-519.

Petmesidou M., (1996). Social protection in Greece: a brief glimpse of a welfare state. *Social Policy and Administration,* 30(4): 324-347.

Petmesidou M. (2001). Employment and labor market policies in South Europe. In: M. Kohli and M. Novak, eds *Will Europe work*(pp. 73-91). London: Routledge.

Pierson P. (2001). Post-industrial pressures on the mature welfare states. In P. Pierson (Ed.) *The New Politics of the Welfare State* (pp. 80-104). Oxford: Oxford University Press.

Prince M. (2000). Dementia in developing countries: A consensus statement from the 10/66 Dementia Research Group. *International Journal of Geriatric Psychiatry*, 15, 14- 20.

Rhodes M. (Ed.) (1997). *South-European welfare state. Between crisis and reform.* London: Frank Cass.

Risseeuw C. (2001). Policy Issues of Inclusion and Exclusion in Relation to Gender and Ageing in the South. *The European Journal of Development Research,*13(2): 26-48.

Rose N. (2007). *The Politics of Life Itself. Biomedicine, Power, and Subjectivity in the Twenty-first Century*. Princeton: Princeton University Press.

Rose N. (1990). *Governing the Soul. The Shaping of the Private Self*. London: Routledge.

Silverstein M. & Roseann G. (2010). Aging and Family Life: A Decade Review. *Journal of Marriage and Family* 72(5): 1039–1058.

Titmus R. (1974). *Social Policy: An Introduction*. New York: Pantheon Press.

van der Geest S. (2002a). "I want to go!" How elderly people in Ghana look forward to death. *Ageing & Society*, 22(1): 7-28

van der Geest S. (2002b). From wisdom to witchcraft: Ambiguity of old age in rural Ghana .*Africa*, 72(3): 437-463.

Velpry L. (2008). *Le quotidien de la psychiatrie. Sociologie de la maladie mentale*. Paris, Armand Colin.

Williams F. (2001). In and beyond New Labor: towards a political ethics of care. *Critical Social Policy* 21(4): 467-493.