DIVERSIFICATION OF SOCIAL SERVICES FOR PEOPLE WITH MENTAL DISORDERS IN POLAND. APPROACHES AND EXPERIENCE

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POLAND: a bit of demography…

2011:

Population: ▲38 538 447 (34th)

Area: 312 679 km^2 (69th)

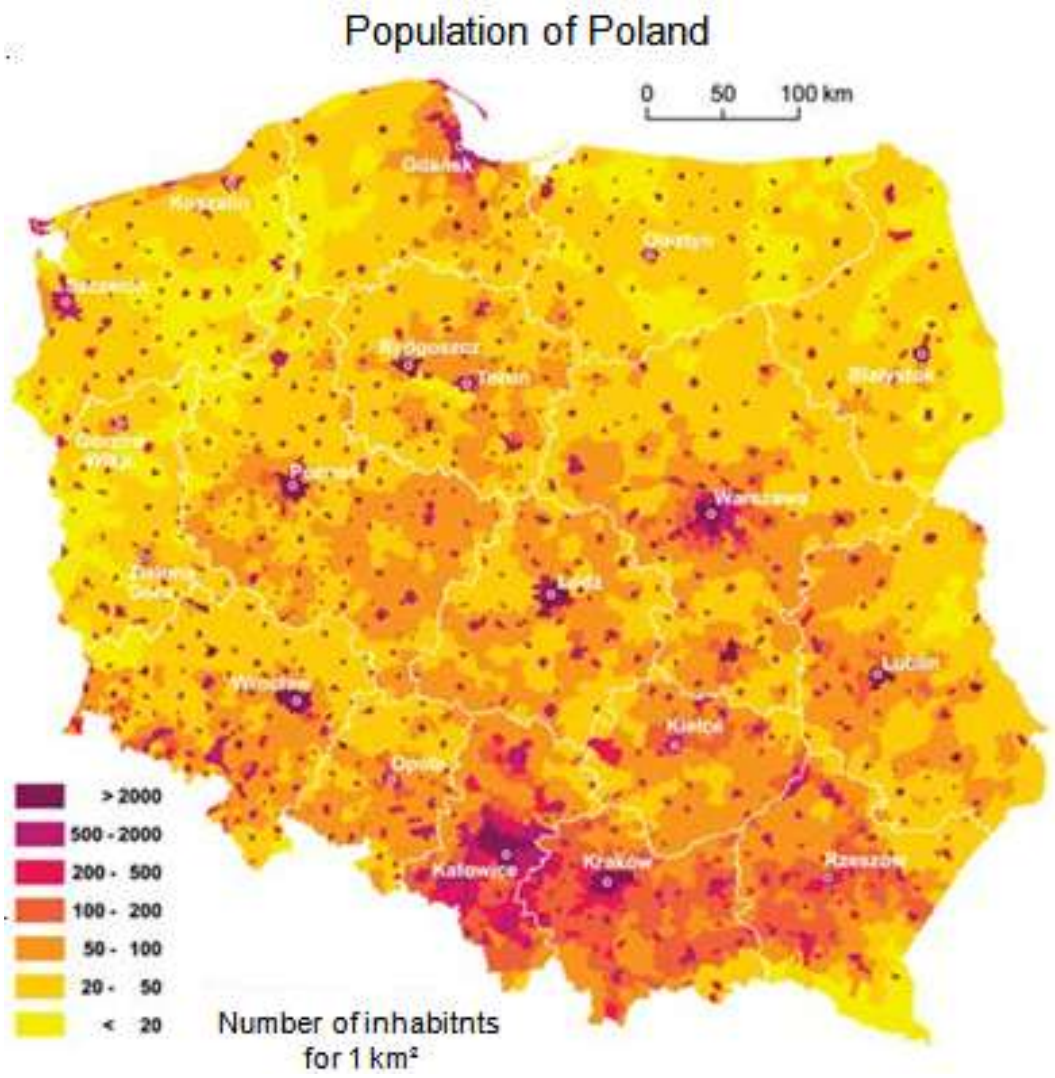
Density: 123,25/km^2 (83rd)

GDP (nominal): $513.821 billion

Per capita: $13,540

HDI: 0.813 (39th)

Expendture on mental health care (within total health care spending): 3,5%



Community-Based Care in numbers

- Community-based care in Poland is being developed since early ’70s (coordination, local coordination) in two, independent (financially and organisationally) patches: health care and social welfare – after 1989 – with significant involvement of NGOs.
- First Team for Communicy-Based Care (Zespół Opieki Środowiskowej) in Poland was established in Warsaw in 1984. First TCBC in Cracow was established within structures of Babiński Hospital (~900 stationary beds). In 2010 it served for 1510 patients, which resulted in shorter hospitalisation periods, avoiding so called ”revolving door of psychiatry”
- For this moment there is 40 TCBCs in Poland. In Malopolskie Voivodship there is 8 of them. According to guidelines from National Mental Health Prevention Programme (2008) there should be 87, including 65 for adults
- Due to financial reasons liquidation of 2 community-based teams in 2000

POLAND: a bit of epidemiology…

- Since early ’90s: gradual increase in mental health problems, considering psychotic (300%) and non-psychotic disorders (73%), drug abuse (800%), mental impairments (153%), alcohol abuse (82%)
- Additional causes: socio-economical transformation and “new” social problems: poverty, unemployment, lack of economical, social and health security
- In 2006 about 4% of population of Poland has been treated within mental health system (about 11% in EU)
- Not only in Poland the mental health services are less accessible but also there is less interest in such services – people in Poland perceive mental problems as shameful

… and social reception

- There were many social campaigns concerning attitude towards people with mental disabilities. It seems like they had little influence: according to research recently conducted by Public Opinion Research Center (CBOS) most of the people in Poland declare indifferent or adverse attitude towards this group
- People after psychological crisises are not given a right to full participation in social life even when their symptoms are inactive in a long period of time
- People in Poland declare objection against people with mental disorders performing social roles associated with responsibility for other people
- On the other hand, they declare acceptance for former patients of psychiatric hospitals as their neighbors, colleagues, co-workers. Which correlates with quite high acceptance for alternative treatment centres in the community

Constitution of the Republic of Poland (1997)

Article 68

1. Everyone shall have the right to have his health protected.
2. Equal access to health care services, financed from public funds, shall be ensured by public authorities to citizens, irrespective of their material situation. The conditions for, and scope of, the provision of services shall be established by statute.
3. Public authorities shall ensure special health care to children, pregnant women, handicapped people and persons of advanced age.
4. Public authorities shall combat epidemic illnesses and prevent the negative health consequences of degradation of the environment.
5. Public authorities shall support the development of physical culture, particularly amongst children and young persons.

The Polish Mental Health Act (1994)

According to the Mental Health Act: "Acknowledging that mental health is a fundamental human value and that the protection of rights of people with mental health disorders is an obligation of the State, this act proclaims the following:

- Article 1.1. Mental health protection shall be provided by the State administration, local government agencies, and appointed institutions.

1.2. Voluntary associations and other civic organisations, foundations, vocational councils, churches, and other denominational unions, and self-help groups consisting of patients and their families may participate in the provision of mental health protection.

- Article 2.In particular, mental health protection shall consist in:

1. Promoting mental health and preventing mental health disorders;

2. Providing the mentally ill with comprehensive and accessible health care, as well as other forms of care and assistance essential for them to live in the family and the community;

3. Developing appropriate social attitudes towards persons with mental health disorders, in particular, understanding, tolerance, and kindness, and counteracting discrimination." This seems to be one of the few legal acts to so clearly state the need for an anti-discrimination policy concerning the disabled

Alterations (2005, 2011)

- Starting from January 2006 rights of patients of psychiatric hospitals are being oficially represented by the ***Psychiatric Hospital Patient's Rights Ombudsman*** (all the cases concerning admission, treatment, conditions). This institution is supposed to perform at every psychiatric hospital in the country (Patient's Rights Movement)
- Mental Health Council (advisory body established by the Ministry of Health)
- Mental Health Promotin Council (advisory body established by the Ministry of Health)

Aministrative act and regional administrative acts

- In July, 2008, the **National Mental Health Prevention Programme (*No Health without Mental Health*)** for the years 2010-2014 was passed by the Polish Parliament as a part of The Polish Mental Health Act. From 2009 assignemnts mentioned in the Act are being implemeted throughout actions described in the Programme (strategy)

  Among tasks described by the Programme there is implementation of local support system, suicide and depression programmes at the national and regional level, funded by the State and Regional Authorities' Budgets

  - **Regional Mental Health Prevention Programmes** (eg. Malopolski Mental Health Prevention Programme for 2011-2015)

Aim of National Mental Health Prevention Programme

Providing people suffering from mental disorders with **multilateral, integrated and accessible** health care **along with other forms of support essential for living in social environment** (including family, occupational environment) through popularization of:

- community-based model of psychiatric mental care
- diversified forms of help and social support
- participation in professional life
- coordination of various forms of care and support

Stages of transformation of mental health care in Poland

Stage I – establishing network of Mental Health Centres (accessibility/continuity of treatment)

Stage II – increasing the number of day-care units, hostels and assisted living facilities, transportation management

Stage III – restructurisation of resources of mental health care (from isolated hospitals to units in general hospitals), establishing community-based services

+ Continuous social education

BACKGROUND for community-based services

- Establishing of a **network of Mental Health Centres** (1 for every 50 thousands of people) serving complex care for adults, children and adolescents of given region. These centres would be responsible for development and coordination of psychiatric care in the region. Centre consists at least of: ambulatory team, community-based team, day-care team, hospital unit
- **Transformation of big facilities** into smaller ones (up to 300 beds) as well as specialised (profiled, rehabilitation, foster, assisted living)
- Ensurance of **professional personnel** (especially: psychiatrists, child and adolescent psychiatrist, clinical psychologists, nurses, social workers, psychotherapists, community therapists [new profession], addiction therapists, coaches) **with various and quality competences** adequate to needs of the patients in community-based care
- Increase and adjustment of financing of mental health services to needs and requirements of community-based care model

SYSTEM for community-based services

- Enabling cooperation among open institutions (public and non-public) and community-based care and specialised psychiatric hospitals for guarantee of continuity and coordination of treatment
- Team for Community-Based/In-home Treatment does serve counselling: diagnostic, therapeutic, controlling, psychological visitations, sessions of individual/group/family psychotherapy, sessions of psychosocial support
- Team for Community-based Treatment consists of: psychiatrist (after or during specialisation), psychologist, nurse, social worker or other staff member with experience in community-based care
- While establishing regional centres – coordinators for the poviat level and district (in bigger cities) should be choosen
- Psychosocial interventions are directed also to the family of patient, home visitations are often in teams of two or more (also due to security reasons)
- Patients are being consulted during common meetings of the Team (on daily basis)

PROCEDURES for community-based services

- It is Mental Healts Centre or psychiatric unit who directs the patient to community-based services
- Psychiatric community-based care is provided mostly for patients with severe and persistent psychotic disorders
- In the headquarters, counselling by the phone takes place, by the duty staff member, for both patients and potential patients
- Patients attend headquarters according to appointments. They are being informed on possibility of maintaining contact and obtain help at any time in case of rapid aggravation
- Each patient has his therapist (psychologist, nurse or other person with expericnce in community-based care, rarely – psychiatrist). All medical procedures (diagnosis, pharmacotherapy) require consultancy from psychiatrist

Political background

Reform of mental health system towards community-based services was not implemented consistently due to accumulation of other reforms after 1989

- **Administrative reform (1999)** – relocation of responsibility for support strategy and location of financial resources from State authorities to local authorities (communities and poviats)
- **Reform of financing in health care (1999)** – implementation of Patients Funds, economisation/commercialisation of health care, independence of health care providers (corporate identity)

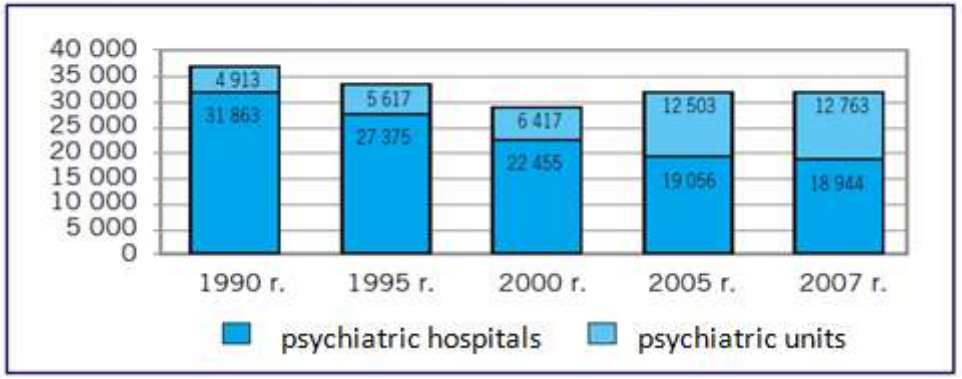
Polish ”standard” in community-based psychiatry

- 1-3 meetings/visitations per week
- over 50% meetings out of the headquarters (mostly: at the place of residence of the patient/his family)
- 60% of patients in treatment for over a year, the rest – up to 12 months
- all services paid in a model of fee-for-service

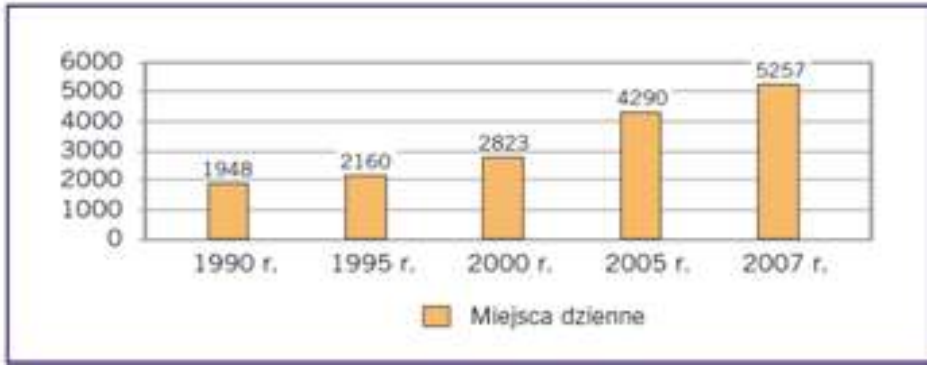
Changes in structure of mental health system I

- In last 25 years number of beds in psychiatric hospitals decreased by over 1/3
- In recent years the number of beds in psychiatric units in general hospitals multiplied.
- Also the number of patients on day-care units has increased, and community-based facilities providing social support to the people with mental disorders are being established within the welfare system

Stationary care – beds in psychiatric hospitals and psychiatric units



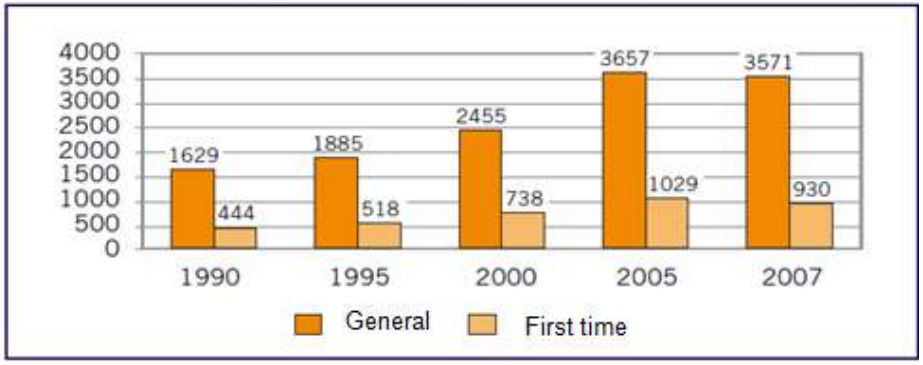
Day-care – number of patients



Changes in structure of mental health system II

- Lenght of hospitalisation on psychiatric unit in general hospital is 36 days while in specialised hospitals – 55
- In 2009 there were 52 specialized psychiatric hospitals with 18.507 beds. In 2011 there were 37 stationary psychiatric hospitals and 25 Care and Treatment Centres for patients with persistent mental disorders (mostly elderly and with associated somatic disorders)

Patients in mental health care system (indicator in 100 000 people)



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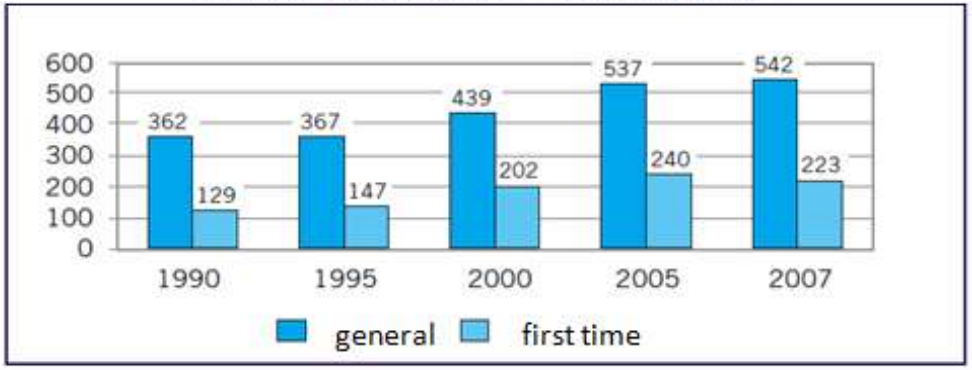


Criminalisation of mental disorders

The index of the total number of psychiatric beds has increased in the years 1999-2003, especially as regards long-term care, which may be a symptom of the so-called **trans-institutionalization** (rotation among welfare, mental health and justice institutions)

Wider: criminalisation of margin

Condition of Polish mental health care I

- Uneven location of hospital base
- “Blank” areas with no psychiatric beds at all (on county – poviat – level)
- Overconcentration of hospital beds in big, specialized psychiatric facilities
- Large distance between hospitals and places of residence of the patients (over a half have to drive over 80km)

Condition of Polish mental health care II

- Large percentage of patients with persistent disorders in psychiatric hospitals due to social indications (no room in Geriatric Assisted Living/Psychiatric Assisted Living/Nursing Homes)
- Uneven location of qualified personnel
- Diversified standards of diagnostics and treatment (dependent on number of professionals and availability of diagnostic tools/medical equipment)
- Community-based mental health care is very uneven located, mosty in biggest cities and its suburbs

Condition of Polish mental health care III

Report of Auditor General on condition of psychiatric care in Poland (released June 2012)

- Time before admission to psychiatric hospital: from 20 to 228 days
- Time before admission to addiction therapy: from 30 days to 659 days
- Time before admission to forensic psychiatry unit (basic security level): from 15 to 726 days
- Overdosing meds with no prescription from psychiatrist (proactive tratment)
- Overusing force (physical, psychological, medical)

- Low equipment standard (especially in big facilities)
- Underfunding of infrastructure (historical, listed buildings)
- In practice: no consistent social politics regarding mental health
- Irrational and discriminative way of financing mental health care
- Medication refund system threatening regular pharmacological treatment

Social Support System

HEALTH	SOCIAL SERVICES	WORK
BASIC HEALTH CARE	SOCIAL WELFARE CENTRE	OCCUPATIONAL THERAPY WORKSHOPS
MENTAL HEALTH CENTRE	SPECIALISED SERVICES	CENTRE FOR OCCUPATIONAL ACTIVITY
STATIONERY UNIT	COMMUNITY-BASED DAY CARE HOME/CLUB	CENTRE/CLUB FOR SOCIAL INTEGRATION
DAY CARE UNIT	STATIONARY COMMUNITY-BASED CARE HOME	SOCIAL ENTERPRISE
TEAM FOR COMMUNITY-BASED TREATMENT	NURSERY HOME	SUPPORTED EMPLOYMENT
HOME TREATMENT TEAM	SHELTERED ACCOMMODATION	
HOSPITAL-AT-HOME SERVICES	HOSTEL	
	FAMILY GROUP HOME	

Struggles...

- problem of information flow...
- and coordination of actions between particular services...
- slight integration of psychiatric care actions with basic health care and specialised health care services...
- slight integration of psychiatric care actions with NGOs...
- no case management

A bit of history…

First psychiatric hospital – Jan Boży Hospital – was established in Poland in **1630**, nearby Warsaw (destroyed during WW2).

The oldest still in service is one in Świecie (Pomorskie Voivodship), established in **1847**.

...due to their economical ineffectiveness

Case of supra-regional Babiński Hospital in Cracow:
Unique garden-city hospital, area of 60,49 ha, 60 facilities (25 000 m²), performing since 1918. Since 2012 is being managed by Industrial Parks of Malopolska (public corporation for industrial development of the region)

Srtike of staff due to:

1. Finanses
2. Organization (management)
3. Reform plans (rumors)

Against big facilities

State

- Big facilities are economically ineffective (performing as enterprises)
- Families often treat big facilities as ‘checkroom’
- In psychiatric hospitals less care is taken of somatic disorders
- Psychiatric hospitals are total institutions
- Patients are unproductive
- No prevention results

Patients

- Psychiatric hospitals are able for admission of a patient without/against his will (9%) and use enforcement (17%)
- Group treatment in hospitals does not match needs of those with severe mental disorders
- Attitude of staff is also group- not individual-oriented
- Safety issues (abuse)

Staff members

- Treatment in such institution stigmatise (language)
- Limited contanct with families, communities

Other comments

- Psychiatry serves the State for repression matters (antypsychiatry)

The other side

Staff members	Patients
➢Safety issues (!) ➢Pharmacological safety ➢Multidisciplinary teams ➢Chance to conduct clinical research ➢Chance to obtain specialisation ➢Supervision ➢Self-help ➢Coordinate regional system of mental health care	➢Safety issues ➢Isolation from situational causes ➢Provide workshops, occupational therapy ➢Therapeutic community ➢Less staff rotation

SWOT analysis (Babinski Hospital, by Marek Szepski)

Strengths	**Limitations**
Quality staff Potential of big facility Modernisation of many facilities Attractive area Divisions in most districts of the city and suburbs	Professional burnout Poor technical conditin of many facilities No development strategy (even vision) Permanent financial shortage
Opportunities	**Threats**
Increase in acceptance towards psychiatric treatment in the society Increase in psychiatric disorders Chance to perform as a legal person National Strategy (frame) Historical backround	Instable and discriminating system of refunding medical care Area attractive for developers Authorities lack of interest in psychiatry both on governmental and local level Technical issues may not qualify buildings for medical use

- Establishing financial managers for particular units, diversify sources of financing
- Conduct commercial activities such as: pharmacy, counselling centre, conference centre, other involving the area and infrastructure, establishing social enterprise
- Establishing scientific manager, educational actions, closer to the patient and community, support for psychiatric units in general hospitals, permanent development of staff
- Adjustment/diversification of medical services (psychosomatic, general, adolescents, combat distress units) and improvement of technical conditions of facilities

What is community-based mental health care?

H. Kaszynski: Community-based services are not revolutionary – it is simply living togetner. It is not WHAT but WHO it is. Deinstitutionalized psychiatry is politicians, economists, social groups, every each one of us. That is why this is **psychiatry of challenge**. Challenging our own powerlessness – as professionals. It is also patient as a teacher

It re-defines mental health care. In the manner of **medical social responsibility** (like corporate SR). Especially while health care proveiders act as corporations

Reduction of meds administration and
syndrome analysis. Development of
therapeutic relation in patient's habitat.
Interest in everyday life, structure of activity,
giving **hope** for education and labor,
practical help in basic difficulties
as a manifestation of **understanding**.

Is community-based psychiatry still psychiatry?

”Psychiatrists are necessary. Work and social space is not enough. Psychiatrists are necessary for patients. But not enough.

Have psychiatrists in Poland take responsibility for their patients, are they working with them in their community? It seems not. What is rather noticed is increase of involvment of local civic structures and NGOs who take initiative and only include psychiatrists.

Have mental health care system in Poland work out background for community-based psychiatry? Not to desirable extent. We are not together, NGOs, social welfare, representatives of patients and families – we are not cooperating with psychiatric system”

[representative of community-oriented association of families and friends of people with mental disorders]

Principles of healing (=effective) community-based treatment

- It is not a method → it is rather a **coordinated** way (modus) of thinking and performance
- Results are time-vulnerable, decline easily and fast → requires long-lasting treatment/relation and persistent core personnel
- Ethos of care-giving, it is not a patient who seeks for help → it is the care-giver who take the hardship
- Treatment does not depend on care-giver's special professional interests → solutions must match single individual patient
- It is not a system given once and for all → it requires regular evaluation of needs as well as adjustment abilities
- The treatment lasts as long as required → it requires flexibility and patience of care-givers

[community-oriented psychiatrists, therapists, social workers – mostly academics]

Limitations in implementing less-institutionalized services

- Politics – lack of charismatic leader to initiate changes
- Financial – relocation of resources from other health care problems, unstable financial situation of local governments (self-governments)
- Administrative-legislative – no procedures, no insight (eg. integrating psychiatric units in general hospitals does not equal integrating psychiatric patients with the society)
- Human – lack of qualified staff, divided gropus of interest (status differences), relation between patients and psychiatrists seen perceived as antagonist
- Feedback – no standards of evaluation
- Attitudes – psychiatrists often do not perceive community-based treatment as beneficial for the patient or are simply not interested in cooperation with welfare system, low instight of patients, low social trust

Threats of irresponsible deinstitutionalization

- Atomisation of the system – towards non-system system (instable), marginalisation, homelessness, criminalisation
- People do not change their habits/performance rapidly (not to mention people with severe mental disorders)
- Non-complience in pharmacological treatment (3x1/3), insight troubles, material /residentional/communicational security indangered
- Proactive performance, medicalisation – subiective considering regular status as pathological (eg. grief), following ‘trends’
- State’s intervention into family system
- Many patients left in basic psychiatric care – less chance to correct treatment
- Considering social attitudes towards non-standard behavior – pharmacological control or social conflict over neglecting safety issues
- Risk of dependency on the terapist
- Risk of fast professional burnout due to intensity and short-distant relation
- Marginalisation of the role of psychiatrist (self-treatment)

Developing choice opportunities

- No choice between institutionalization/deinstitutionalization actually needs to be done
- In Polish conditions – there is no choice in fact (except for lables)

Who does need deinstitutionalized services?

- peope with SMD
- drop-outs from hospitalization
- people with low social skills and low cooperation

estimated 20-40% of SMD

Who is ‘not proper’ for community-based services?

- people with addictions, personality disorders, anti-social behavior, psychoorganic disorders, people with SMD and urgent need for hospitalisation and 24h care

Myth of opposition

Deinstitutionalized psychiatric servies do not oppose psychiatric hospitals.

Both can point out community-based healing, empowerment, advocacy, involve families, voluntary workers.

Both should keep responsible in flexible world of no relationships.

All forms of help may risk abuse.

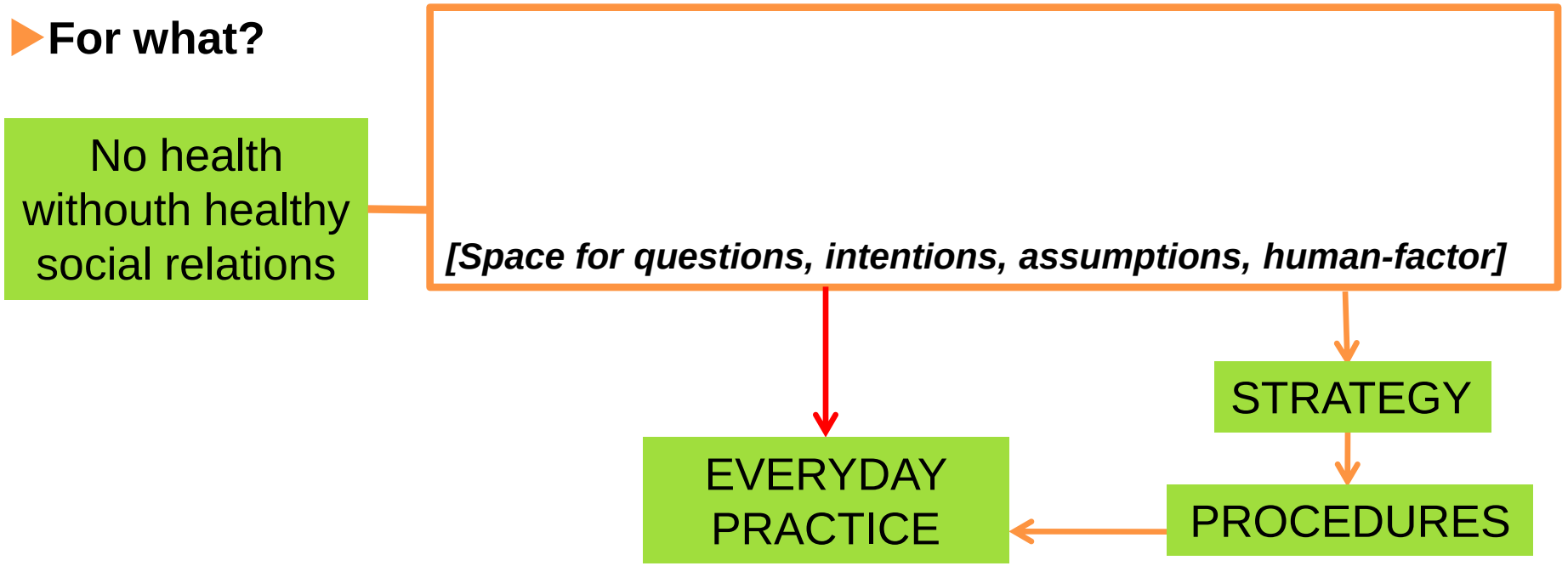
Criticque of pharmacotherapy does not mean its rejection or undermining its scientific rationallity. In fact – in Poland all the patients of community-based teams are on meds.

Conclusions on big facilities

- **It is possible and worth effort** to liquidate/reorgnise part of big, old-style facilities. Liquidate as psychiatric hospitals, not support facailities
- **It is not possible** to suspend admissions because it would cause catastrophy (homelessness, criminalization of mental disorders)
- Reform is possible **after the increase of mental health care resources in the region and preparing background**
- Reform's goal is to **provide patients with a choice**

Conclusions on deinstitutionalization

- **Deinstitutionalization is not a goal** (then it sounds like a threat to stable system and puts patients aside)
- **Deinstitutionalization and medicalization** (at the same time) **makes no sense**
- **Deinstitutionalization is a tool**
- **For what?**



Further information

Association in Aim of Development of Community-based Psychiatry and Care http://www.stowarzyszenie-rozwoju.eu/

Mr Cogito Pension and Hotel http://www.pcogito.pl/

Workshop for Community-based Psychiatry (Jagiellonian University, Collegium Medicum) http://pracowniapsychiatriisrodowiskowej.pl/

Fundacja Wspólnora Nadziei http://www.farma.org.pl

The MONAR Association http://www.monar.org/pl/

J.Babinski Specialized Hospital http://www.babinski.pl/

Atlas of Best Practices in Social Economy http://atlas.ekonomiaspoleczna.pl/x/671387

Polish Psychiatric Association, Division of Community-based Psychiatry and Rehabilitation http://www.psych.edu.pl/ptp/

WHO Europe, What are the arguments for community-based mental healts care http://www.euro.who.int/__data/assets/pdf_file/0019/74710/E82976.pdf

Deinstitutionalization – good practices
The Community of Hope Foundation – Farm of Life

Ďakujem za pozornosť