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***What shapes the pathway of  
becoming an elderly care worker?  
Young workers' perspective***

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## ***Abstract***

Elderly care is becoming a much more recognised job in an ageing society. The aim of this article is to reveal how young workers in elderly care describe and interpret the process of entering the field of elderly care and provide insights into how this knowledge could support the development of strategies for youth involvement in the sector. The study, based on a qualitative research strategy, developed the concept of the pathway leading young workers (both men and women) to elderly care work. The concept consisted of three sections in the pathway: points of departure, societal filters that either push or hinder entering elderly care work and preconditions/factors that are important in the process of choosing the work. A gender gap exists in each section of the pathway to this career choice. The results of the study not only reveal the variety of factors influencing job choice in a comprehensive manner but also emphasise the importance of analysing these factors within the context of personal identity and professional fulfilment searches.

**Keywords:** young workers, carer choice, elderly care work, self-identity, pathway

## ***Introduction***

The growth of the older population indicates that the long-term care sector will be one of the major job creators in the future (ILO, OECD, 2019). The sector is already identified as an important source of employment, accounting for 130.2 million workplaces worldwide, which constitutes 3.9% of the global employment (OECD, 2020). However, the extent of the ageing population is higher than the growth of labour in the long-term care sector, which raises the problem of how to provide the sector with sufficient labour resources (OECD, 2020). Social workers and care workers are becoming increasingly recognised and needed professionals in long-term care services. There is a scarcity of research documenting the perspective of social workers who are engaging in work with older adults in long-term care services (Weng & Valenzuela, 2022). Additionally, there are limited studies in the area of understanding the unique experiences of care worker assistants choosing employment in these services.

In addition, the largest portion of the workforce in this sector is comprised of middle-aged and older women. For example, in 2019, more than half of those employed in the sector in Lithuania were aged 50+, which is almost 14% above the EU average (Eurostat, 2020a). The attraction of both the young people in general and young unemployed individuals, in particular, to the sector, has been extensively discussed in different countries for a certain period of time (see: Montgomery et al., 2017). The statistics on youth unemployment show that young people (15–29 years old) who are not in education, employment, or training constituted an average 13.6% in the EU. In Lithuania, this percentage was 13% in 2020 (Eurostat, 2020b). Studies show that the main limiting factors for young people's involvement in elderly care are low wages, insecure employment opportunities offered by the sector, limited training, and development opportunities (Hjelte et al., 2018; Hussein & Manthorpe, 2010;

Montgomery et al., 2017; Cameron et al., 2019). Nowadays, young people are less likely to stay in the elderly care sector compared to older generation (Hodgkin et al., 2017).

The current research aims to increase understanding of young people's perception of elderly care work and contribute to knowledge about the factors influencing their decision to pursue this career. While there is extensive research on why young people are not drawn to work in elderly care, there is limited research on the motivation of those who are already working in the field. Qualitative research examining the circumstances surrounding young people's entry into the elderly care sector within a specific country context is relatively uncommon. This study also holds practical significance as it offers insights into social policy on how to attract young people to this sector.

The aim of this article is to reveal how young workers in elderly care describe and interpret the process entering the field of elderly care, and give insights on how this knowledge could support youth involvement in the sector. In order to reveal this, interviews were conducted with young employees who directly provide long-term care services to the elderly. These services are provided in Lithuania by individuals with higher education, such as social workers, nurses, and physiotherapists, as well as by personal care workers, nursing assistants who do not have higher education requirements (Ministry of Social Security and Labour, 2014). The research aimed to explore the reasons why young people choose to work in the aged care sector. Therefore, the selection criteria for the research participants were based on their jobs and positions in elderly care facilities, as mandated by national regulations. Although their specific roles in service delivery may vary, all groups are workers in the sector, which is not attractive for young labour force in general.

The main research question addressed in this study were as follows: what are the circumstances and factors that influence the decision of young individuals to pursue a career in the elderly care sector?

## ***1. Theoretical framework***

Occupational choice has a significant impact on our entire life. Studies explain why and how people choose one occupation or another by presenting a variety of theories. For example, some studies emphasise the importance of work adjustment, while others focus on vocational personalities in the work environment, social cognitive factors, self or social identity, rational choice, or development of career patterns. Roe (1990) takes the position that an individual's career and work decisions are influenced by a multitude of factors that interact or even reinforce each other, forming a pathway of choice. The current study explains the choice of work in elderly care by relying on the concept of socially-structured pathways in career decision-making, which is emphasised in sociological literature. It embraces a plethora of factors and circumstances determining work choices (Nelson, 2004). Social identity ideas are also important in explaining career decisions, as they are often closely tied to one's sense of self and identity (Berger, 1963). Additionally, there are strong links between career choice and self/identity, as evidenced by studies conducted by Gagne (2014), Kanter Moss (1977), Maree (2019), Ryan and Deci (2018), and Luken (2020). Furthermore, the concept of



public services motivation is relevant in the explanation of career choice, as it emphasises the significance of intrinsic rewards (such as a sense of accomplishment and self-worth in choosing helping professions (Bozeman & Su, 2015; Houston, 2000; Perry & Hondeghem, 2008)).

## *2. Research methodology and sampling peculiarities*

The empirical data for this research was collected by implementing the project “Youth labour force participation in elderly care sector addressing population ageing” (funded by the Research Council of Lithuania, S-GEV-20-35 ) and analysed using the qualitative research strategy and the qualitative descriptive method. This approach allowed us to examine the research object within a broader context, which is particularly beneficial in practice-related disciplines (Creswell, 2009; Sandelowski, 2000). Additionally, advantage of qualitative research in this case is ability to explore experiences of young workers by relying on their own explanation and argumentation, not specific questions suggested by the researcher. The research employed a semi-structured interview approach, following a pre-prepared question guide.

The selection of informants was based on a combination of targeted and convenient sampling methods. This approach was necessary due to the absence of a comprehensive registers in Lithuania which includes social service organisations, social workers, or care workers. The first stage of the selection aimed to represent three different types of elderly care service organisations: home help services, day care centres for elderly, and elderly homes. The second stage of the selection aimed to find young workers in these organisations. The researchers faced a challenge in selecting research participants, especially men. As a result, the initial decision to limit the age range of the selected young workers to 35 years old or younger was changed, and the age range was widened for the male group to 37 years. To reach various social services providers, 40 out of 60 Lithuanian municipalities administration were contacted by phone to inquire about the presence social services providers with young workers. In most cases, it was reported that only young female workers were available, and that young men did not provide services in elderly care organisations directly. Instead, they tended to work as administrators/organisers, take up technical jobs (e.g., drivers providing special transport services), or perform maintenance and other similar tasks. So, they do not meet criteria to be direct care worker. Private elderly care organisations were contacted separately, not through the municipality administration. No research participants matching the criteria were suggested of the contacted private elderly care organisations. To be eligible for the interview, the respondents had to meet three specific selection criteria: 1) be 35 years old or younger; 2) be directly providing services to elderly individuals<sup>2</sup>; 3) have at least two or more years of work experience in this position.

According to Lithuanian legislation, social workers are employed in care institutions for the elderly to provide services such as counselling and assessment of client needs.

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<sup>2</sup> According to Lithuanian legislation, these employees work in positions such as personal care worker, nursing assistant, social worker, or nurse, directly providing services for elderly individuals. However, administrative staff and support staff (e.g., accountants, drivers, cleaners, etc.) are not included in this category.

Individual care workers also assist with household chores, food preparation and consumption, dressing, and personal hygiene. Employment specialists organise employment opportunities, artistic self-expression, and socio-cultural activities (Ministry of Social Security and Labour, 2014). Additionally, nursing homes employ assistants who work with the elderly (Ministry of Health and Ministry of Social Security and Labour, 2007). Staff positions for social workers, nurses and physiotherapists are only available to individuals with a higher education degree, while individual care workers and nursing assistants only require short-term training programmes in Lithuania. Thus, the situation in Lithuania is very similar to information in other studies (e.g., Rubery et al., 2011), which describe activities performed by staff in aged care facilities. These activities which are typically mentioned include lifting, bathing, feeding, meeting medical needs, and performing functions that require interpersonal or social skills, as well as the preservation and enhancement of social functioning, and administrative and document management functions.

**Table 1.** Characteristics of the research participants

Characteristics of research participants		Number
Age of respondents: mean 31.1		19
Gender	Female (26–35 years old, mean: 31.6)	11
	Male (24–37 years old, mean: 30.6)	8
Institution type	Home help services	6
	Elderly homes	10
	Day centres	3
Position	Social worker	8
	Personal care worker	6
	Nursing assistant	2
	Occupational therapist	2
	Physiotherapist	1
Education	Professional education/training	8
	Higher education in social work/social pedagogy	11
Place of residence	In three biggest cities	5
	Outside the biggest cities	14
Length of employment in the elderly care sector: 2–12 years, mean: 5.5 years		

A total of 19 interviews were conducted with young workers who directly provide services for elderly individuals. These interviews took place either by phone or using teleconferencing platforms such as Zoom, MS Teams, Messenger between June and September 2021. The sample consisted of 11 respondents with a higher education degree and 8 individuals who had completed short-term training. It is worth mentioning that one respondent with a higher education degree worked in the position of an individual care worker, which is also the case in this sector in Lithuania.



The research utilised a qualitative content analysis as the data analysis method. All interviews with the respondents were recorded and subsequently transcribed. The content analysis of the data was then conducted based on these transcriptions, according to Mayring (2014) basic procedures. The transcriptions were coded using MaxQDA 2020 software for qualitative research, resulting in the creation of a list of emerging categories. In the final stage of the analysis, researchers reviewed the coded segments once again and, in parallel, reformulated initial sub-categories transforming them into a unified system of categories that were further utilised in the analysis. Later, the Code Matrix Browser allowed us to observe the spread of the research categories across separate interviews, as well as track the gender dimension. In other words, to assess the distribution of categories in terms of gender, the categories obtained using the code matrix browser tool were reviewed again, and further divided based on the gender of the interviewee (see Table 2 in the section 3.3 of the article).

### **3. Results**

The qualitative content analysis of the research data focused on respondents' explanations of how/why they entered the workplace in the elderly care sector. Two big themes emerged from the interviews: firstly, the origins of individuals in the elderly care sector, and secondly, the factors that influenced their decision to work in this sector. Under the first theme, the following five categories were identified: entry into the elderly care after participating in the employment services system, choosing to work in elderly care after graduating from university; entry to the elderly care work directly from other fields of practice, entry after completing training courses for individual care worker based upon personal initiative, and entry elderly care through internship.

The second theme consisted of seven categories: parental influence and family values, informal care experiences, self-discovery of identity, random choice, finding a job after a long search for professional identity, seeking a more peaceful job, and public attitude towards work in elderly care.

#### **3.1. Departure points to enter care work with the elderly**

Research participants explain how they entered elderly care work in a variety of ways. Some referred to the employment service system, where they applied in search of a job, others reported changing jobs from other fields, or mentioned entering the sector after studying (and graduating in) social work or social pedagogy at universities. It should be noted that the fact of studying social work itself was not an incentive for some graduates to choose a job in the elderly care sector.

##### **Choice to work in elderly care after graduation in social work or social pedagogy at universities**

No wonder, that after social work studies, some of the research participants specifically aim to work in elderly care organisations:

*When I graduated, I already knew what group I wanted to work with. Although social work is quite a broad field, one can choose working with different groups but I wanted to work with seniors (I3-F)<sup>3</sup>.*

Another respondent who graduated from social work studies, agreed to work as an assistant because there were no vacancies for the position of a social worker then:

*[...] since I got on very well with elderly people from as early as I was a young child, I somehow imagined that I'd be working in that field and I was looking for something along those lines, so I even agreed to take a job as an assistant in order to give it a go (I10-F).*

Some respondents noted that they were looking for a job, asking around, and just happened to enter the field of elderly care after their social pedagogy studies:

*I graduated from social pedagogy studies and was planning to work with children. But after my studies, the situation was that I needed to find a job as soon as possible, and I got an offer to work with the elderly... (I9-F).*

### **Entry to elderly care through internship**

The fact of studying social work in general was not an incentive for some participants of our research to choose a job in the elderly care sector (see the quote above). Rather, on the contrary, as other studies suggest (see: Genece, 2021; Wang & Chonod, 2013) social work with elderly people is not among the priorities of social work graduates. Our research revealed that some students were attracted to this sector as a place of work only after having the opportunity to engage in practical experience:

*When I started doing practice in the third year, which involved more interaction with elderly individuals, I really enjoyed it. It suited me well and I stuck to it (I12-F).*

This experience of engaging in practical work with elderly individuals was important for both female and male respondents. The importance of internships in terms of decisions regarding choosing a job in elderly care sector was indicated and by respondents who participated in employment service programmes. During those internships they discovered that working with the elderly was appealing to them:

*There was a youth training course at the Job Centre [...] and we had a three-week internship in elderly homes (I14-M).*

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<sup>3</sup> Throughout the text, each informant is assigned a unique code, where "I" stands for informant, "3" and other numbers represent the informant's number, "F" indicates a female informant, and "M" is a male informant.

### **Entry to elderly care through employment service system**

Through participation in various activities and programmes offered by employment services, the respondents found that they enjoyed communicating with and assisting elderly individuals:

*The Job Centre had a programme for young people under 30 called 'Discover yourself'. It was there that I stood out from the whole group in terms of organisation and communication [...] After that programme, I was sent to train as a visiting care worker, I passed the exam, and the next day, I started working as a social worker's assistant. And that's what I've been doing ever since (18-F).*

Another respondent indicated that he chose to participate in home helper training courses because that programme seemed to be simpler and more familiar:

*[...] at the Job Centre where we had three training options in construction, architecture, and working as social workers' assistants. So my friend and I chose the one we were familiar with [...] (14-M).*

### **Completed training course (personal care worker/assistant social worker) not through employment services**

Some research participants indicated that they independently completed courses and obtained certificates that qualify them to work as assistant care workers. This information is significant as it provides additional insight into the motivation of the research participants to engage in elderly care. In other words, the study highlights that some young individuals take the initiative to pursue a career in care work, not solely relying on the more common path through the employment services system. The story of one research participant reveals that her tendency to help the elderly dates back to her early youth. From her interview emerges a memory of a visit to an old people's home during a high school voluntary event, which made a lasting impression on her.

*My first encounter with elderly individuals was when I was young. I found myself captivated by these persons who often go unheard. They have so much to share and yet are often overlooked (17-F).*

After several years, during which the research participant dedicated herself to her family and raising children, she found herself drawn back to the experience and decided to pursue a course for individual care workers to find a job in an elderly care facility.

### **Entry to elderly care work from other fields of practices**

For some respondents, their entry into the field of elderly care employment is linked to their previous work experience in sectors other than social services. These respondents had worked in industries that eventually closed or went bankrupt. During their job search, they randomly inquired at an elderly care institution that happened to have a vacancy at the time.

Additionally, several respondents had previous jobs in administration and realised they did not enjoy those roles:

*[...] I worked with projects in one institution, where I mainly had to do paperwork. So, I thought that it might be more interesting to work with people. And this is how I got into this sector (I18-M).*

One research participant was in the past social work managers in the elderly care but he quit his job when a position of personal care worker became available (I18-M). He described his previous position as control work, which he did not like. However, after transferring to work as a personal care worker, he found the job much more satisfying:

*And this position is different, and people's attitude towards it is different, they want your help and expect it from you (I17-M).*

### **3.2. What circumstances influenced respondents' choice/decision to entry elderly care work**

While recalling their choice to work in elderly care, research participants mentioned a variety of circumstances that either encouraged or were important for their decision.

#### **Parental influence/family values**

The respondents noted the influence of their parents and family in their choice of job. One of them reflected, *I think that there is a lot of parental input into my choice of the job (I3-F)*. Another respondent stated that his relatives also worked in the elderly care sector and set a good example for him to choose the same pathway (I14-M). A young woman also attributes her choice of this work to family traditions and values:

*My grandmother, my grandmother's father and my great-grandfather always helped people. [...] we always helped those who were in need of food, money or other things. We were always helping others, and I was always there, I was contributing as well [...] So, that's how it started in my childhood. When I finished the 12<sup>th</sup> grade at school, I already knew where I wanted to go to work. It was either nursing or social work (I11-F).*

#### **Informal care experience**

The experience of informal caregiving was important factor that encouraged the choice to work in the elderly care sector:

*[...] I had to look after my husband's father, which was a good experience [...] I got him back on his feet [...] when I had already gained experience in nursing, it was when I had the idea that maybe I should look at this and dedicate myself to this work and choose it as my job. [...] I chose the nursing assistant's programme at the Job Centre, and then with my own money, I got the certificate of a social worker's assistant so I could work in the service centre (I6-F).*

### **Discovering self-identity**

While reflecting on their entry into this sector, research participants highlighted they enjoyed helping people, listening, and communicating with them. They also preferred a quieter environment and a slower pace of life when working with elderly clients. The alignment between the respondents' identity and the nature of care work is typical for this group of informants. Female informants reflected on their work choice:

*I found this profession suitable for self-fulfilment because I can express myself and help someone else (I3-F).*

*[...] you talk to someone and you just see that you can help them in some way [...] and I'm simply happy to be here (I2-F).*

*I have more fun with others, I like people, I like communicating, I like finding out things, I like listening to stories and learning how things were in the past and how they are now, I like comparing things (I7-F).*

However, the male informants expressed a similar view; they perhaps spoke even more emotionally and vividly about how this work helped them find themselves:

*So I think that it is the place where you can fulfil yourself. And you don't have to be so stressed, you don't have to pretend, and I don't know, but you can be here in a simple way and you will be accepted. So, this simplicity and lightness are is the biggest rewards (I18-M).*

*And all this awareness that they are old and the world has become harder and less conceivable for them, and that I, as a young person, can still help them, help them integrate into society and start socialising. I want to help them clarify all their doubts and help them just live the rest of their lives with diligence. For me it's the old people, as we say, who are wounded [...] I myself am so much calmer when I talk to them [...] I just love communicating with them [...] they are so much slower and I do not try to speed them up in any way (I16-M).*

### **Random chance. Fate must have arranged it...**

A recurring theme in the respondents' statements was the random entry into this workplace:

*[...] now that I think about it, it's probably how fate must have arranged it. Because I was actually thinking about something else all the time [...] (I16-M).*

*I have actually never planned to work with the elderly because, first of all, I studied social pedagogy and was planning to work with children (I9-F).*

*So, I have never planned this pathway [...] this job found me not vice versa (I5-F).*

### **Finding a job after diligent searches for a professional identity/vocation**

The prominent theme in the informant's explanations was searching for professional identity before they realised that working with older people is the job for them:

*I really didn't think about helping old people. I thought it was nonsense. I didn't even like my own grandfather. Old people mumble, they speak nonsense, then they forget it and repeat the same thing all over again [...] After finishing 12 grades at school, I was going to study directing. But then I changed my mind [...] and all 12 years of learning at school were in for nothing [...] I had to take up physically dirty jobs. And then I thought, 'No, I have to do something. I have to change something [...]'. So, I went to the Job Centre [...] This programme referred me to the Visiting Care Workers Programme [...] And that's where I found myself. But it took me a very long time to get it (I8-F).*

*I was never able to find my place anywhere, I always felt like I was missing something. And now I am doing very well (I1-F).*

The respondents who had planned to work with children while studying social work or social pedagogy and then did so for a while realised that they did not like it. It was only when they tried working with the elderly that they discovered their vocation:

*[...] I had to work with children with disabilities for a while [...] I became convinced that I can work with children, I can do the job, I really can, but there's no inner joy anymore [...] I don't find this work as exciting as working with seniors [...] And that's how I found myself and my calling, simply by doing this (I9-F).*

*I never planned to work with the elderly in my life. During my studies and internship, I worked with children at a school [...] but I quit this job [...] When I went to the labour exchange, they offered me a job at a retirement home. I thought that I never planned to work in a retirement home but I accepted the offer [...] when I went there, I realised that this was my field, and I felt like a kid in a candy store [...] here with the elderly [...] (I5-F).*

The possibility to try working in elderly care was a very important factor for research participants to find work that met their needs:

*You won't know it without trying it [work] out. That's the golden rule [...]. You have to try it because you don't know what you might like. We will only know it by trying. If you don't have any big dreams and don't know where to start, you can start your career by working with the elderly. It can be is a very good place to start (I16-M).*

The salary of care workers in the field is low, still having found their place in elderly care, the male respondent tended to justify to the relatively low salary in the sector:

*[...] when you want to work, you somehow solve your problems and everything seems to be fine (I17-M).*

### **Different societal support for men's and women's choice to work in elderly care**

Male respondents have to withstand certain pressures from their families and society when choosing elderly care as a career pathway. For example, one of them said



that when he decided to work as a personal care worker in a retirement home, his parents discouraged him and did not approve of his choice. However, after a year, they came to terms with it as soon as they saw that he was happy with his work (I4-M).

In the narratives of the informants, we can find signs of dissatisfaction with low salary, especially for male workers:

*You cannot afford much for such a salary, especially if you have a family... So, for now, I'm here but only until I find something better (I13-M).*

But another male worker enjoys the work and liked being unique in the field:

*Most people say I'm good at this job, and I like it myself. I feel I'm contributing to society because women mostly do this work. People are asking why I do this job [...] It is because I like it and I think it is good (I14-M).*

Even the female respondents support the stereotype that care work is a job only for women:

*I think that it's anyway feminine work because it requires a lot of understanding, a lot of sincerity and lots of other things. Well, not all men have a lot of such qualities, or if they have them, they don't show them. Women are born to take care of others, to sympathise, to help, to wipe tears, and men are very different [...] (I11-F).*

### **Finding a more peaceful working environment**

The respondents indicated a calmer and less stressful environment as one of the advantages of working in the elderly care sector. They described the attractiveness of this working environment as a factor that led them to leave their previous job or choose to work with the elderly:

*The desire to feel less stress and rush in the workplace (I10-F).*

*Because I'm a bit of a calmer person myself [...] they [the elderly in care centres] are maybe a bit slower and I do not try to speed them up in any way [...] (I16-M).*

*Because somehow I always imagined that working with older people was somehow a bit easier [...] There's no rush, the schedule is not very busy, and you can relax a little bit. As I was already emotionally very exhausted, I decided to give it a try (I10-F).*

### **3.3. Does gender gap exist in the pathway to the elderly care work?**

When discussing the starting points of entering the field of elderly care, some female research participants mentioned that they personally chose to complete individual care worker courses to pursue this profession. This was particularly true for those who had previous experience in caring for the elderly either within their own families or in institutional settings. Meanwhile, the men did not mention similar

circumstances. They opted for the mentioned courses only when they were registered at the labour exchange, as it was a new field of activity for them which they had not explored previously, including providing care for family members.

Both male and female respondents have mentioned majority of the same preconditions for choosing work, as mentioned above. However, certain differences can also be observed. The importance of informal care experience as a precondition for choosing care work was mentioned only in the accounts of women respondents. Table 2 presents the categories mentioned in women's (red) and men's (black) interviews.

**Table 2.** Visualisation of the categories mentioned in women's and men's interviews using MAXQDA's Code Matrix Browse

	Categories	Number of interviews (women in red and men in black)	SUM of Interviews
Departure points to enter care work with the elderly	Entry to the elderly care through employment service system	●●●●	4
	Completed training course (assistant social worker) not through PES	●●●	3
	Choice to work in the elderly care after graduation in social work/social pedagogy	●●●●●●●●	10
	Entry to elderly care through internship	●●●●●	6
	Entry to elderly care work from other fields of practices	●●●●	4
What circumstances influenced respondents' choice/ decision to start working in elderly care	Parental influence/family values	●●●	3
	Informal care experience	●●	2
	Discovering self-identity	●●●●●●●●●●	11
	Random chance	●●●●●●●	8
	Finding a job after diligent searches for a professional identity/vocation	●●●●●●●●	9
	Different societal support for men's and women's choice to work in elderly care	●●●●	4
	Finding a more peaceful working environment	●●●	3

\* Total number of the interviews conducted: 19

It is not surprising, considering that in Lithuania, the culture of care work as a job for women is still dominant (Mažeikienė & Dorelaitienė, 2011). This finding aligns with research insights obtained by scientists from other countries (see: Scrinzi, 2010; Näre, 2010; Kubiciel-Lodzińska, 2021) which show that women dominate the field of

elderly care. Women make up almost 70% of the global health and social workforce (World Health Organization, 2021).

It should be noted that male and female research participants use different language to describe their personal motivations for becoming care worker. While young women highlight the importance of their empathy and compassion in this line of work, male research participants are more likely to emphasise their communication and listening skills, willingness to assist vulnerable members of society. The latter circumstance is significant while considering which competencies should be publicly emphasised to make the elderly care sector attractive to men as well. It is possible that empathy and compassion, which are often highlighted as major competencies in this field, may not be of interest to or may discourage men from pursuing this line of work.

4. Conceptualisation and discussion

Working further with the categories that originated from the analysis of the interviews and were provided above, the authors developed a concept called *the young workers’ pathway to the elderly care work*. The concept included three parts which reflect the circumstances and factors influencing a young person’s decision to pursue a career in the elderly care service sector. These three sections of the pathway are: points of departure, societal filters that either encourage or hinder the transition into elderly care work, and preconditions/factors that are important in the process of choosing the profession (see: Figure 1).

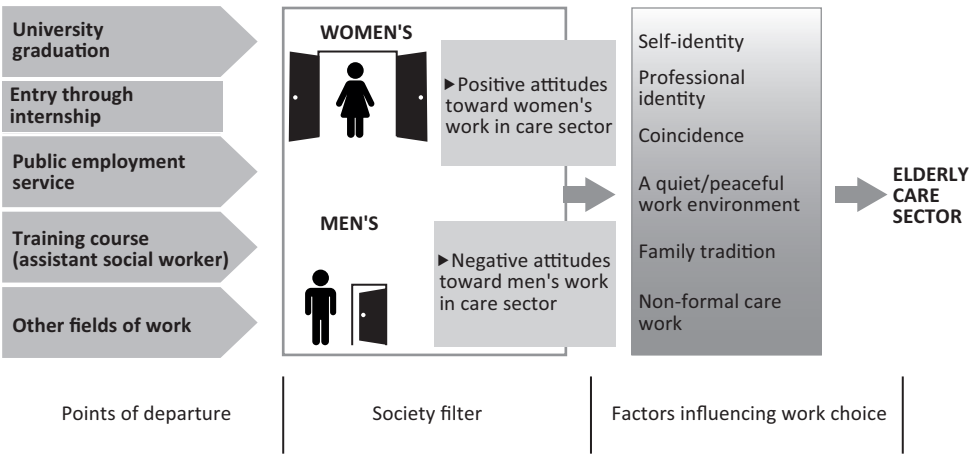


Figure 1. “The young workers’ pathway to the elderly care work” concept

The *starting positions* to the elderly care work was very different: some research participants recalled periods of unemployment, while others mentioned their job search after graduating from studies in higher education; some even referred to dissatisfaction with their previous job, which pushed them to explore the opportunities

in elderly care. Study of Sutcliffe and Dhakal (2018) noted interdependence of working experience in elderly care and choice of similar types of studies. The results of our research indicate that social work studies as such do not directly lead respondents to choose work in elderly care. After graduation, they initially chose to work with other social groups and only later realized their attraction to working with the elderly. Therefore, it is important to emphasise that the starting point for entering the field of elderly care is not limited to institutions such as employment services or social work study programmes in higher education institutions. Practical experience in providing social help to the elderly, outside of institutional settings, also plays a significant role.

The *second part of the pathway* reflects the importance of public attitudes in the decision-making process for selecting a career in elderly care. The results of the survey suggest that both men and women had to navigate societal attitudes that acted as a filter when considering a career in the elderly care sector. This attitude tended to open the door for women, and keep them hardly closed for men. It is also evident in studies of other researchers, e.g., England, Folbre and Leana (2012) argue that women's preference towards care-oriented careers and men's preference towards non-care-oriented careers are reinforced by gender essentialism, i.e., a stereotypical belief that women are better suited for care work. Interestingly, our results also reinforced this stereotype, as even female respondents emphasised that women were more suitable for elderly care work due to perceived qualities that men lacked. Women are still seen as "society's primary caregivers" (Tong, 2009, p. 18). Russell (2007) concludes that, despite the growing proportion of men in the care sector, care work performed by men continues to be viewed as unusual. In our study, male participants who opted for care work often surprised their family members and others, leading to numerous inquiries. However, none of the male respondents mentioned feeling intimidated because of their choice in care work, which does not align with the findings highlighted by England et al. (2012).

Regarding the *third part of the pathway towards elderly care*, young people's accounts indicated a range of preconditions that can be categorised into *extrinsic* and *intrinsic* motivational factors influencing their job choices. The respondents' statements conveyed a clear message that elderly care work helped them to discover their own identities, pursue their personal inclinations and fulfil their individual needs. Other studies also suggest that intrinsic motivation encourages individuals to choose caregiving based on personal reasons such as finding meaning and fulfilment, rather than being driven solely by external rewards (Clamor, 2020; England et al., 2012; Hu & Hirsh, 2017). The importance of intrinsic values for engagement and work in the elderly care is also noted by England et al. (2012) who argue that intrinsic preferences for care stem from biology, early socialisation, or ongoing involvement in care work. The connection between having an emotionally close relationship with grandparents or other elderly persons and the preference for choosing work in elderly care was also observed by Robert and Mosher-Ashley (2000) in their study of college students' perspectives.

Our findings also point to the conclusion drawn by Vandenabeele and Schott (2020) who found that care work is unique and that job satisfaction arises from intrinsic motivations. As a result, employees are willing to accept lower financial rewards for

the job. The concept of *public service motivation*, explored in studies by Hassan, Ansari and Rehman (2021), Kim, Kang and Lee (2021), as well as Perry and Vandenabeele (2015), among others, supports the explanation that the meaningfulness of the work compensates for salary disadvantages, and that congruence between the public sector and individuals' prosocial motivation do exist (Kjeldsen & Jacobsen, 2013).

The enjoyment derived from helping others, as shown in our study, can also be associated with public service motivation (Breagh et al., 2018).

The importance of relationships and interaction in elderly care is also prominent in our results, as well as in the studies conducted by other researchers (see: Schott et al., 2019). Sutcliffe and Dhakal (2018) reported that participants in their study continue working in the elderly care because it provided opportunities for listening, talking, sharing stories, and engaging in face-to-face interactions. Clamor's (2021) study showed that emotional attachment helps caregivers in attaining self-fulfilment (Carlo & Randall, 2001).

Other researchers also noted the importance of informal care experience in the choice to work in elderly care (Howe et al., 2012; Robinson et al., 2008; Sutcliffe et al., 2018). For instance, Sutcliffe (2018) found that millennials' interest in entering the elderly care industry can be accredited to their past experiences of caring for grandparents or having close relationships with elderly relatives or friends.

Overall, the research not only confirms the presence of various factors and circumstances that influence the choice of care work among young workers, as discussed in caregiver development theories but also highlights the significant role of self-identity exploration in this process. The conducted research supports the notion that there are strong connections between career choice and one's sense of self and identity (see: Luken, 2020). In terms of self-identity, our study participants exhibited a typical motivation towards public service, as they associated their choice of care work with intrinsic rewards such as a sense of accomplishment, self-worth, and satisfaction derived from helping others. The search for a professional identity can be linked to individuals' prosocial motivation, where the capital of prosocial motivation acts as a guiding force that shapes their behaviour accordingly (Kroll & Vogel, 2018).

## Conclusions

Despite the unattractive public discourse of elderly care work, especially among young people, the results of the study provide encouraging insights that some young people find this line of work suitable for their needs and personal identity. The decision to enter this sector is influenced by both external factors (such as family values, public attitude, a calmer working environment) and internal factors (such as the search for personal identity and professional fulfilment).

The concept of *the pathway to elderly care work*, developed based on research data, addresses the main question of the study: how and under what circumstances does one enter the elderly care sector and make the choice to pursue this line of work? This concept not only validates the multifaceted nature of factors influencing job choices but also emphasises the importance of analysing these factors within the

context of self-identity exploration. Furthermore, it highlights the significance of having the opportunity to try out this job in advance as a means of self-discovery. In addition, this concept allows for distinguishing the work choice process into two main stages: a) the departure points for entering elderly care work, and b) the circumstances which influenced respondents' choice or decision to enter elderly care work. The research results revealed the importance of public attitudes in the decision-making process for selecting a career in elderly care. While societal attitudes may pose barriers for young men considering this profession, they can overcome these obstacles upon realising that working with the elderly aligns with their identity. In contrast, societal attitudes tend to encourage women to work in this sector, and even female research participants themselves reinforce the perception of care work as inherently feminine. Furthermore, the "departure points" stage in the work choice process provides insights into the origins that lead young people to decide on elderly care work. This, in turn, guides future research that can verify and provide further details on circumstances which guide carer choice. For example, whether the circumstances that determine the choice of care work are the same for young workers who enter elderly care through employment services as for people entering from other fields of practice. The latter aspect is interesting not only because it reflects the respondents' active search for self-identity but also because it underscores the significance of occupational mobility opportunities in the decision to pursue a career in care work.

The new circumstances revealed by this work choice research indicate that it is important to have an opportunity to try this job without any prior motivation or even with negative prejudices, particularly, due to societal attitudes towards this profession.

In terms of further research, the suggested concept of "the pathway to elderly care job" offers a comprehensive examination of the circumstances and factors influencing career choices in caregiving. Additionally, it enables the control of the diversity of these factors and provides a more comprehensive understanding, particularly, when describing and comparing career paths across various professional fields.

### **Practical implications of the research**

To increase the appeal of employment in the elderly care sector, it is necessary to present this job in a comprehensive and engaging way by highlighting its unique features and advantages to both school children and young unemployed individuals.

Given that personal experience (such as trying out this job) and intrinsic factors strongly influence the employability in the elderly care sector, it would be beneficial to create more opportunities for young people to familiarise with this sector in general education schools (e.g., by organising specialised summer schools or volunteer groups).

At the level of education, vocational training, and particular vocational guidance, more attention should be paid to debunking the myth of the feminisation of work in the elderly care sector.

In employment services and career guidance centres, it would be useful to profile the unemployed individuals and offer them jobs in the elderly care sector if they possess sociability, a higher level of empathy, and a preference for a slower pace of lifestyle.



**Research limitations**

The selection criteria for the research participants were based on the staff positions in elderly care facilities, as mandated by national regulations, but not on their specific roles in service delivery. Therefore, research data allow as to explain, how and why young people decide to work in elderly care in general. However, the scope of this research does not enable us to assert that all the departure points to elderly care identified in the study also determine the significance of the same set of factors for choosing elderly care work.

**Research ethics**

The permission to conduct interviews with staff members was granted by the administration of each elderly care organisation. Prior to an interview, informed verbal consent was obtained from all workers, who agreed to participate in the study. Each respondent was informed about the anonymity of their personal data in the research publication, using a code to conceal their identity.

**Conflict of interests**

There are no conflicts of interest.

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## ***Elderly care and its contexts. Example of Poland and Albania***

### ***Abstract***

The article presents a comparative development and current state of care for the elderly in Poland and Albania, as well as some of its determinants. These countries were selected for analysis both because of their post-socialist welfare state tradition and similarly strong familisation of care. The text discusses both the health and

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socio-economic situation of the elderly population and demographic trends affecting care (based on Eurostat, WHO, and national statistics) as well as the panorama of the current care system created by the state and/or the private and non-governmental sector. Based on the analyses, several conclusions were presented. The high level of internal and international migration (especially in Albania) disrupts the model of family care for seniors, especially in some regions of these countries. The countries studied vary in the types of chronic diseases older people suffer from, which should influence the type of care provided. The scale of social services in both countries is far from sufficient, however, based on numerical data it can be concluded that in Poland support, both institutional and environmental, is much more widely available. In Albania, the main provider of formal services is the private sector, and in Poland, there is a move towards a multi-sector model, increasingly entrusting the running of institutions, daycare centres and care services to non-public entities and the civic sector (volunteering, neighbours). The directions of care policy in both countries are similar, consistent with those set by the EU, and aim at deinstitutionalisation and multi-sectoralisation.

**Keywords:** deinstitutionalisation, long term care, ageing of the population, elderly, social policy

## *Introduction*

In Polish literature, there are more and more studies on the support of dependent elderly people, as well as studies comparing the care systems of European countries (Golinowska & Sowa, 2013; Błędowski & Maciejarz, 2013; Łuczak, 2016; Bakalarczyk & Jurek, 2021). Meanwhile, there is no literature on the support of the elderly in Albania, despite the fact that there are articles on problems with financing healthcare (Druga, 2021, 2022), the development of social work (Ymeraj, 2018; Dhembo et al., 2020), or general direction of social policy. The current literature shows that the reforms of social policy developed in Albania, after the transformation from the totalitarian system to the current one, shape a marginal model of social policy in which social services, especially for children, the elderly, and the disabled, are significantly underfunded. The role of a woman in this system is that of the main caregiver, which hinders professional activity. Social services have a poor range and involve, without financial support from the state, civil society (volunteering in the broad sense) as well as private entities and non-governmental organisations (Poni, 2022). Meanwhile, the study of Albanian social policy seems interesting, not only for purely theoretical reasons but also because Albania has had the status of an EU candidate since 2014, and this fact seems to influence the country's current social policy. It is a kind of similarity to the social policy that is implemented in Poland, which, being a member of the EU since 2004, also conducts a coordinated state and EU policy. Belonging to supranational political structures entails obligations to provide similar responses to civilisational challenges, such as the need for taking care of a growing group of dependent elderly people. The European Union sets out the directions of care policy for seniors,



such as deinstitutionalisation or multisectorality, which are largely related to the need for reducing the cost of care (*Common European Guidelines...*, 2012). Common directions are also set by other global organisations, the World Bank, ILO and UN. For example, the United Nations recognises such principles of elderly long-term care as: (i) independence in terms of food, water, shelter, and access to income-generating opportunities; (ii) participation in terms of integration into the society; (iii) care like access to health care for physical, emotional wellbeing; (iv) self-fulfilment; (v) dignity (United Nations, 1999).

Deinstitutionalisation and multi-sectorality are among the most important concepts defining the contemporary shape of care for seniors (in addition to the influence of the directions of care policy, they also include the concepts of activation, social investments, innovations in economisation and managerisation, the use of the informal sector, goods, and public choice) (Grewiński, 2021). These directions aim to develop social services. These concepts are associated with the term service society, based on an economy in which services prevail over goods, and there are more and more service professions in the employment structure. Daniel Bell wrote that this type of transformation takes place in post-industrial societies.

The first of the mentioned concepts – deinstitutionalisation – is defined in the literature on the subject and in programme documents, especially the EU. It is presented synthetically by Krzyszkowski (2018), as an element of senior policy. Firstly, he sees it as a contemporary tendency in formal care for dependent people. Secondly, he understands it as activities undertaken to create various forms of services (including health services) in the community, aimed at ensuring proper care and extending the period of psychophysical fitness and the ability to perform social and professional roles. The development of community services is also aimed at limiting the scale of support provided in 24-hour institutions such as social welfare homes. The two leading reasons for accelerating this process are economic (considering institutional care to be more expensive) and social (customer preferences). Attention is drawn to the fact that the European Commission guidelines have intensified this process, especially in the last decade. Already in 2012, *European guidelines on the transition from institutional care to care provided at the level of local communities* were developed.

In turn, the concept of multi-sectoral refers to the implementation of local social services and involves institutional diversity in the implementation of social services (welfare pluralism). The essence of multi-sectoralism is the distribution of responsibility for the implementation of social tasks and services among a larger number of entities operating within equal sectors (governmental, non-governmental, and commercial). It involves various stakeholder groups in the provision of social services, as well as citizens who co-create more or less formal social services. This contributes to the development of the governance approach. Services are provided by the public sector (usually local government, less frequently by the state), and services are produced and implemented by non-governmental or religious organisations, market entities, and public institutions. The informal sector (family, friends, neighbors, community, local environment) also co-produces services (Grewiński, 2021).

This article aims to present in a comparative perspective selected elements of the system of care for the elderly in both countries, as well as to illustrate some of its

conditions. The authors of the article assume that when writing about care for the elderly, one should take into account not only the characteristics of the system itself but also its demographic, socio-economic, and health context, because it shapes the approach to the organisation of this system. However, due to the limited size of the article, we will focus only on demographic factors – the process of ageing of societies and factors related to health. The following research questions were formulated encompassing two spheres. The first, concerning the conditions of care: what are the similarities and differences between Poland and Albania in terms of demographic and health conditions of the system of care for the elderly<sup>3</sup>? And the second, regarding selected features of the care system: (i) how is care for the elderly (long-term) understood in Poland and Albania? (ii) What is the specificity of the organisation of institutional and community care in the surveyed countries? (iii) What are the main directions of development of care for the elderly specified in programme and strategic documents?

When answering research questions, the authors refer to statistical data and Eurostat, UN, and WHO – whenever it is possible to obtain data for both countries, as data on Albania are often presented to a very limited extent. In turn, the description of the care system was developed on the basis of national (Polish and Albanian) strategic documents, programmes, departmental reports, and research reports on care for the elderly. It is worth noting that comparative comparisons are difficult to make, because long-term care systems are very diverse.

The studied countries differ in many aspects, but they also have similar features. They are diverse in terms of population, based on Eurostat data from 2021, 37,747,124 people lived in Poland, while in Albania the population was 2,811,667 (Eurostat, 2023a). However, they have a similar rate of urbanisation, around 60% (United Nations, 2023), much lower than the EU average<sup>4</sup>, which is worth noting in the context of the topic in question. This indicator is important because rural and urban lifestyles are different, as is the structure of households in rural and urban areas, or access to social services for the elderly. On the other hand, it is predicted that in 2050, almost 80% of the population will live in the city in Albania, and about 70% in Poland (United Nations, 2023a). In both countries, there are high emigration rates, which also affects the situation of caring for the elderly, because mainly people of working age, i.e., those who can take care of the elderly, emigrate. The surveyed countries, in turn, are differentiated by another factor important from the point of view of the possibility of

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<sup>3</sup> Long-term care is defined as a range of services provided to people with limited physical, mental or cognitive ability to function, as a result of which they become dependent on assistance in basic activities of daily living for an extended period of time. This care can be treated as a set of medical and social activities consisting in the provision of long-term nursing care, rehabilitation, therapeutic services and nursing and care services as well as the continuation of pharmacological and dietary treatment for chronically ill and dependent people who do not require hospitalisation in a hospital ward. This care may be provided by formal carers (medical staff and social assistance workers) or informal carers (family, relatives, volunteers). WHO and OECD definitions (Ministry of Labour and Social Policy, 2022).

<sup>4</sup> For comparison, 100% of citizens live in cities in Belgium, 85% in Finland, 74% in the Czech Republic, 72% in Hungary, 80% in Greece, 78% in Belarus, 75% in Bulgaria, 54% in Romania, 65% in Portugal, and in Great Britain 83%.

care, namely, independent living of the elderly. In Poland, 13.5% of all households are composed of the one adult of 65 years of age or above type, and in Albania only 4.3%, while the percentage of two adults, at least one aged 65 years old or above type of households is similar – in Poland 10% and in Albania 12 % (Eurostat, 2023b).

There are differences in wealth between the countries surveyed. In Poland, the nominal GDP per capita in 2021 was USD 17,815 and in Albania USD 6,375 (IMF, 2022). However, the Gini coefficient measuring income inequalities does not show large differences in the income level amounted to 32 in Albania and 30 in Poland. Albania seems to be on a different stage of demographic development than Poland, although both countries exceeded what is called the advanced ageing scale<sup>5</sup>. Poland has been experiencing this process for several decades now and the percentage of people over 65 is much higher here than in Albania, so social policy towards seniors also seems to be more advanced. Albania is just beginning to see the problems in the pension and healthcare systems caused by an ageing population. Public authorities are concerned that more and more elderly people live alone, while their economic situation is worse than the rest of society. The Director of the Institute of Public Health confirms that Albania is late in taking measurements for the amortisation of the problem. He suggests measurements in promoting fertility, increasing bonuses, and subsidising families with many children but also a private scheme of retirement could be a solution, along with increasing the age of retirement (*Monitor Magazine*, 2017).

It should be noted, however, that in both analysed countries the advancement of the population ageing process is definitely lower than in the countries of the old European Union, however, at the same time, preparing for the provision of services for dependent elderly people is definitely less developed, e.g., the scale of providing care services for seniors significantly differs from the scale of rich European countries. In Poland, in accordance with EU recommendations, there are heading towards deinstitutionalisation, while we have not yet reached the point where institutional services would have been sufficiently developed. An example is the institutional support for the elderly, which can be determined based on the Long-Term Care Resources and Utilisation index: beds in residential long-term care facilities per 1,000 population aged 65 years old and over. The value of this indicator shows that Poland belongs to the EU countries where this number is the smallest, and in the years 2010–2020 it systematically decreased from 12.4 to 10.7 (OECD, 2023a). Currently, a similar level is in Turkey, which bases the care system almost exclusively on the family. There, the value of this indicator in 2020 was equal to 9.6. In Poland this index is even lower than such Central European countries as Latvia, and definitely lower than Slovakia, where this index is 46.9, or Hungary 43.6, and Sweden, which has the highest index, 64.8 (OECD, 2023a). Unfortunately, OECD databases do not provide any data regarding the number of beds for Albania. However, based on other sources of and own calculations, it can be estimated that this indicator was 1.65 in 2020 (ILO, 2023)<sup>6</sup>.

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<sup>5</sup> The share of the population aged 65 and above exceeded 7% (Rosset, 1967, p. 75).

<sup>6</sup> There are in total 697 beds where 344 beds are offered by public institutions and 72 are offered by private institutions (ILO, 2023).

It is also worth noting that the countries surveyed have different crude divorce rates. In Albania it is 1.1., which is much lower than in Poland – 1.6 and, in Albania, there is also a much higher percentage of households with 2 or more children (Eurostat, 2023 c). However, the surveyed countries share the family model of senior care and the attitude to the family as a value, as well as the declared great respect for the elderly (Halman et al., 2022). In Albania, the percentage of people who are concerned about the elderly is higher – 80–89%, while in Poland it is 60–69%, the results are similar in relation to the sick. In Albania, this concern is among the highest in Europe, perhaps due to culture but also because of the limited availability of public support (Halman et al., 2022)<sup>7</sup>.

### *Advancement of the ageing process in Poland and Albania*

The advancement of the ageing process is related to the increase in the number of the oldest age groups and is an important variable determining care needs. The older the age group, the higher the percentage of people using care. As the Polish report *Mapa Potrzeb Zdrowotnych* shows, long-term care patients aged 65 and more constitute the vast majority of all long-term care users – people aged 65–79 make up 30.3%, and people aged 80 and more make up more than 50% of the patients (55.2%) (BAZiW, 2023).

The world is extremely diverse in terms of population ageing, the advancement of this process is the greatest in Europe, more than in North America. It can be said that the reason for this is that we are dealing with different phases of demographic development simultaneously (Van De Kaa, 1987) and the accompanying phases of epidemiological transition (Wróblewska, 2009). While in Europe it is predicted that the percentage of people aged 65 and above will be around 23% in 2030, and almost 30% in 2050, demographic processes in Africa are of a completely different nature. The population is the youngest there, in 2019 people over 65 accounted for about 4%, and forecasts for 2050 predict a maximum of 5% older than 65 (United Nations, 2019). In the context of preparing the world for a better life for the dependent elderly people, the news about the increase in the subpopulation of the elderly is also important. It turns out that in 2015 people over 80 accounted for about 4% in Europe, 3% in North America, and less than 1% in Africa. The percentage of octogenarians is projected to increase to 10% in 2050 in Europe (United Nations, 2019). Another common phenomenon is the feminisation of the old age, i.e., the number of women exceeding the number of men, which is related to the higher average life expectancy of the former. Feminisation is accompanied by singularisation, i.e., women living in one-person households.

One of the fundamental regularities related to the process of population ageing is that in countries with low and medium income per capita, the phenomenon of ageing

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<sup>7</sup> The inhabitants of Poland and Albanians also have an attitude towards religious values, although they are followers of different religions, representatives of both countries declare that religion is very important in their lives (notably, religion is equally important for Italians). In Albania, faith in God is declared by over 90% of the inhabitants, and in Poland by about 70% (Halman et al., 2022, p. 19).

is more intense than in high-income countries. Currently, two out of three older people live in low- and middle-income countries, and this proportion is projected to increase to four out of five older people by 2050 (Tessier et al., 2022).

The problem is that ageing in these poorer countries co-occur with the economic and institutional development, which is usually much more difficult than when high-income countries such as France and Sweden begin to age. There are significant differences in the progression of this process within Europe. In Poland and Albania, although they are younger societies than the countries of Western or Northern Europe, the increase in the percentage of seniors is much faster, the negative consequences of which are felt more strongly (at the level of the entire society and households). Let us add that mass emigration in both countries strongly affects the ageing of societies, as well as limits the possibilities of caring for the elderly, which is definitely higher in Albania than in Poland<sup>8</sup>.

One of the population ageing indicators is the median age. In the analysed countries, it is different, in 2022 it amounted to 40.3 years in Poland and 37.6 in Albania, forecasts say that this difference will remain unchanged and in 2030 the indicator will reach 40.3 in Albania and 44.1 in Poland, which is conditioned, among others, by higher fertility rates in Albania (United Nations, 2023 b). At the same time, the percentage of elderly people in Poland and Albania is also dissimilar. According to National Statistics of Albania (Instituti i Statistikave, INSTAT) on January 1, 2019, 12% of the total population in Albania is aged 65 and above. In turn, Poland was at this stage several decades ago and today the ageing process of the society is much more advanced, in 2019, from among 38,382,576 inhabitants, 18% were people over 65 (in 2021 already 19%) (GUS, 2023). The ageing process, however, is intense in both countries studied. From 2009 through 2019, the number of people in the post-working age category (women above 60 and men above 65) increased by 2,096,328 (33.2%), and the share of these people in the total population increased by 5.4 % (from 16.5% to 21.9%). The population projection until 2050 predicts the continuation of the existing trend (GUS, 2014). In the same period, the number of people aged over 80 increased from 1,257,221 to 1,691,736 (by 34.6%), while their share in the total population raised from 3.3% to 4.4%. The forecast until 2050 indicates a continuation of the above trend. At the end of this period, the number of octogenarians is to amount to 3,537,498, i.e., 109.1% more than in 2019, and their share in the general population is estimated to amount to 10.4% (GUS 2014)<sup>9</sup>. In Albania, the increase in the percentage of older people is even faster. From 1990 through 2020, the population of people over 65 increased from 5.5% to 14.8%, and forecasts for 2050 predict an increase to 26.4%. On the other hand, people above 80 accounted for 2.9% of the population in 2020, forecasts for 2050 assume an increase to 9.1% (ILO, 2022, p. 2). The government of Albania notes the population is ageing, because of the combination of three factors: the increase in the percentage of elderly people, 65 years old and

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<sup>8</sup> Over the last 30 years, 1.6 million Albanians have left the country, almost half of the country's population (Halman et al., 2022).

<sup>9</sup> According to current population projections (for 2023–2060), there will be 3 million people above the age of 80 in Poland in 2050 (GUS, 2023).

older, the decrease in the percentage of children and young people as well as emigration growth. Currently in Albania, about 46% of elderly people (65+) live in rural areas, isolated and alone (INSTAT, 2023).

*Health condition of the elderly as a care influencing factor*

In terms of elderly care, it is worth presenting data showing the relationship between age and the health and functional capacity of the elderly. The ageing of the population leads to an increase in chronic diseases and disabilities, which in turn is associated with greater needs in the field of care for the elderly, often intensive and continuous. The analysis of data on the health situation of the elderly in Poland and Albania leads to two conclusions. Firstly, in both countries, the scale of the incidence of diseases increases significantly with age and the group of people unable to live independently (which is a common phenomenon). Secondly, there are significant differences between the countries in question regarding the types of diseases, which prevail in this group. Probably these differences result from many economic and social differences affecting the lifestyle, the state of the environment, and healthcare. In the 1970s, Marc Lalond, researcher and Canada’s Ministers of Health, wrote about the profound impact of lifestyle on health (Wysocki & Miller, 2003). This aspect was also noted by Giddens (2008) when he discussed habits protecting health or exposing a person to its loss, which are diet, physical activity, coping with old age, sexual behaviour or the use of stimulants.

When it comes to the differences in healthy life expectancy in Albania and Poland, it should be noted that these differences are not as significant as, e.g., those between Poland and some Western European countries (the average healthy life expectancy in Sweden is about 10 years longer than in Poland). As shown in Table 1, the health condition of men in Albania is better than in Poland, which is also evidenced by the data showing the frequency of particular types of chronic diseases in elderly men. The situation for women, however, is different. In Poland, they are healthy longer than in Albania.

**Table 1.** Health status in Poland and Albania in 2021

Country	Healthy life years by sex/ Male	Healthy life years by sex/ Female	Healthy life years by sex/ Male/60 years	Healthy life years by sex/ Female/60 years
Poland	71.6	79.6	17.2	22.3
Albania	73.6	77.7	17.7	20.2
UE 27	77.2	82.9	21.0	25.1

Source: Eurostat (2023d)

The PolSenior 2 research shows that over 40% of people over 60, i.e., about 3.7 million Poles, suffer from what is called great geriatric problems (falls, urinary incontinence, mobility problems, depressive and cognitive disorders, multimorbidity). Almost 70% of the elderly in their youngest age groups and over 90% in the oldest age



groups experience multiple diseases. The most common diseases include cardiovascular diseases and endocrine and metabolic diseases (Kujawska-Danecka et al., 2021; GUS, 2021). In turn, the assessment of the life independence of the elderly shows (GUS, 2016, pp. 18–19) also that after the age of 70, there is a significant increase in the percentage of people for whom independent functioning is challenging, defined both in the ADL scale (problems relate mainly to lying down and getting up out of bed or sitting down and getting up from a chair, taking a bath or showering) as well as on the IADL scale (the most frequently mentioned problems are performing easy and difficult housework and shopping). It is estimated that in Poland, constant assistance in basic everyday activities is required by 30% of people over 60 and as many as 60% of people over 80 (Dziechciaż et al., 2012). The estimated number of elderly people requiring assistance in everyday functioning in 2030 will amount to 4 million (Wilmowska-Pietruszyńska & Putz, 2009).

In Albania, according to research conducted there, the health condition of the elderly is the most important problem. Several studies carried out by the Association of Gerontology showed that about 60% of the elderly throughout the country suffer from chronic diseases. On the other hand, 21.6% of persons aged 65 or above living in private households have limitations in performing daily activities because of health problems. These results are confirmed by other studies, e.g., the Institute of Public Health in 2016 found more than two-thirds of the elderly over 650,000 are ill or suffer from a chronic disease, while one-third of them report suffering from more than one disease or health problem (*Monitor Magazine*, 2017). According to the Institute of Public Health out of 530,000 elderly people registered with the family doctor, about 405,000 use the services financed by the health insurance scheme. About 160 thousand are regular beneficiaries of the scheme, and on average they reach the value of 252 M ALL (2.3 M Euro) per month (*Monitor Magazine*, 2017). Currently, out of 90,900 people in need of care, 51,700 are women and 31,900 are men, but only 1.6% are benefitting from social care services. At least 90,900 (21.6%) aged persons above 65 years of age are estimated to be in need of long-term care, and in 2031 their number is estimated to increase to 130,000, while in 2050, there will be about 161,000 such persons (ILO, 2021). It seems, therefore, that the analysis of health condition of the oldest inhabitants of Poland and Albania indicates a greater need for care in Poland.

Due to the different income situation of Polish and Albanian populations, the possibility of providing care in the event of disability and illness may differ in both countries. In Poland, the rate of persons at risk of poverty or social exclusion at the age of 60 and above in 2020 was 19.9%, and in Albania as much as 49.2% (in the EU 20.8%) (Eurostat, 2023e).

A higher income gives a greater opportunity to pay for social services, and to reach a doctor in a situation of a long distance. The report on the reasons for the inability to meet health needs seems to confirm this relation. It is presented in Table 2. It shows that there are differences in access to health care between the countries surveyed. In addition, it is worth noting that people living in rural areas, apart from more difficult access to health care, have much lower pensions. In both countries, pensions in rural areas account for about 30% of the average salary, and about 60% from the non-agricultural system.

**Table 2.** Self-reported unmet needs for medical examination by sex, age, main reason declared and educational attainment level – 65 and above in 2020 year

Country	Too expensive	Too far to travel	Waiting list	No time
Poland	0.4	0.3	2.2	0.1
Albania	15.2	0.8	1.9	2.0
UE 27	1.6	0.2	0.9	0.1

Source: Eurostat (2023f)

As has already been pointed out, not only the scale of dependence but also the specificity of the diseases they experience, especially chronic ones, is of great importance for determining the nature of care for the elderly. The types of diseases and their frequency should not only be an indicator of the size of the need for assistance but also for a specific type of medical, psychological, and social care, and for a specific type of medical and social care professionals. The differences between Poland and Albania regarding the types of chronic diseases experienced by the elderly are significant, and the explanation of these differences may be an interesting research topic.

According to the Causes of DALY, for both sexes aged 60 and above daily per 100,000 index (WHO, 2023), in both countries the most common diseases are ischemic heart disease and stroke. However, in almost every age group, stroke occurs much more often (in some age groups even thrice) in Albania than in Poland, both in the case of women and men. However, interestingly, in Albania women experience it more often than men, and in Poland it is the opposite. In the case of ischemic heart disease, the relationship is also interesting, in Albania more women than men suffer from it in each age group, and in Poland, it is the opposite (except for the oldest age group – 80 years and older). It is worth noting that much more Polish men are affected by this disease than Albanians. In addition, it can be seen that:

- differences between countries are also evident in the incidence of Alzheimer disease and other types of dementia. Among Albanian women, the scale of this disease is already significant in the age group of 70–74, and among the cluster of 75–89 year olds it is visible in both sexes. In Poland, on the other hand, this disease is visible on a larger scale only among women over 75, and among men over 80. However, among Albanians of both sexes over 80 years of age and older, this disease is much more common than in Poland (twice for men, thrice for women). Statistics show that Parkinson disease affects people of both sexes above 80 in Albania (causes of DALY for both sexes aged 60– 100,000), however, this disease does not appear on a large scale in Poland;
- a significant difference between Albania and Poland is observed on the example of Diabetes mellitus. In Poland, this disease is diagnosed twice as often, and in some age categories (70–74) almost thrice as in Albania. In Poland, in the case of both sexes, it is also much more common than in Albania. As is the case with colon and rectum cancers, where the causes of DALY for both sexes aged 60+ DALY per 100,000 do not show cases of this disease in any age group.

- Poles (both women and men) suffer from chronic obstructive pulmonary disease almost twice as often in each age group of the elderly. Similarly, other types of hearing loss are more common in Poland than in Albania but in both countries it is more common in men than in women (WHO, 2023).

### *Caring for the elderly. The case of Albania*

In Albania, long-term care is defined in Law 121/2016 on the Services of Social Care in the Republic of Albania. The law is designed for all the six categories in need, and one of these is the elderly group. The law prevents five types of services, however, in the case of the elderly it provides: *residential care services* for those with permanent health problems who cannot have their basic needs met; *home services* which are provided in a form of home-like meals and medicines supply, personal hygiene, etc.; and *daycare services* at the community centres offered by the local government (ILO, 2023, p. 10). On the other hand, social care services are organised in public social care provided by the state and non-public social services. Regarding the health care system, the respective law For the health care in the Republic of Albania does not mention the elderly (ILO, 2023, p. 10). Moreover, no profession for old age care exists in Albania. The only school existing for this profile is developed as an international project initiative from the German Agency for International Cooperation (GIZ). Even the nurses are not specialised in medical services for the elderly or other categories (Federich Ebert Foundation, 2014).

The law on the services of social care provides also the principles of the care such as: (i) universality; (ii) social justice; (iii) subsidiarity; (iv) social support; (v) deinstitutionalisation; (vi) partnership; (vii) respect for human rights and the integrity of the beneficiary; (viii) non-discrimination; (ix) confidentiality and protection of personal data (Law 121/2016, Article 4). On the other hand, the National and Action Plan for Elderly defines other principles such as empowerment at personal and community level; attention to the neediest or vulnerable groups, gender equality, intersectoral measures, financial sustainability, and cost-effectiveness (Ministria e Shëndetësisë dhe Mbrojtjes Sociale, 2019).

In Albania social care services are provided by public or non-public legal entities which can offer such services in accordance with the conditions defined in this law (Law 121/2016, Article 27). The institutions responsible for the administration of the system of social care services are the Ministry for Social Issues and its dependent institutions, the district and the municipality (Law 121/2016, Article 27, 30). Concretely, the ministry is responsible for policy preparation, such as designing and update of standards, determining criteria, and conditions, undertaking campaigns for volunteer work, etc. (Law 121/2016, Article 30). On the other hand, the Institute of Social Service, and the Services Inspectorate of Social Care, are under the supervision of the ministry. The first one is responsible for drafting standard documentation for beneficiaries of social services, assessing the performance and the needs of social care services (Law 121/2016, Article 32), while the Inspectorate of Social Care is responsible

for controlling the implementation of the criteria and conditions of public and private entities and can impose fines in case of violations of the provisions of the law (Law 121/2016, Article 34, 35).

At the local level, based on Law 139/2015 On local self-government, the municipalities are responsible for the creation and administration of community social services at the local level, construction, and administration of centers. Nevertheless, despite the decentralisation of powers the possibilities of the municipalities for the establishment, administration, and operation of social services for the elderly are limited because of the lack of financial resources. The study “Observation on local budgets spent on social care services in some municipalities of the country”, supported by UNDP in 2018, showed that social care services in the municipality are almost completely financed by conditional funds (government funds). Financing from “unconditional funds” or “income of the municipality itself” is almost negligible, about 2–3%, with the exception of Tirana, where “income of the municipality itself” covers 8% of the needs (Ministër e Shëndetësisë dhe Mbrojtjes Sociale, 2020, p. 25).

From the structural point of view, all 61 municipalities have appointed one social worker for 6–10 thousand inhabitants. In the case of municipalities with a smaller population, the services are offered by the regional officers of the State Social Service (Law 121/2016, Article 36). The duty of social workers is crucial as they verify the social and economic situation of individuals and families who need social care, help with the preparation of the documents, collect information and statistics for potential and real beneficiaries of the social system, etc. On the other hand, the role of the district is just to gather the needs, the statistics, and the plans of the municipalities as well as to present them to the responsible ministry (Law 121/2016, Article 36, 37).

In Albania, in total, there are 50 types of social care services for the elderly provided by 43 institutions, where 19 (42%) are public institutions and 24 are private institutions. Regarding public institutions, 43% are financed by the municipalities and 39% by the state. On the other hand, regarding private institutions 35% are financed by NGOs and 31% by international organisations, and 34% are financed in a mixed way (ILO, 2023). In terms of types of service, 32% are community services and 26% are residential services, followed by emergency services (16%) and family services (14%). Other types of services like specialised services, consultations, alternative care, and pre-social services constitute 12% in total (ILO, 2023).

The service for the elderly in the residential centres is guaranteed, qualitative, and based on the service standards approved by the Albanian government. In the service of the elderly, there are staff with specialised employees for this type of service, multidisciplinary teams that carry out a personalised assessment of the requirements of each elderly person, who have also drawn up, at the same time, an individual intervention plan to meet the identified needs. The right to appeal for any case of dissatisfaction or dispute about the quality of food, hygiene, employee behaviour, etc. is guaranteed. However, social service centres for the elderly are insufficient, while their capacity is also limited to meet service needs (Ministër e Shëndetësisë dhe Mbrojtjes Sociale, 2019, p. 11).

In Albania there are 91,000 persons over 65 years old, or 21% of people over 65, who needs long term care but only 2% of them (or 18,200) receive long-term care other than

in hospitals. On the other hand, in Albania in 2021, the number of elderly receiving social services is 1,682 persons or 1.6% of population over 65 years old (ILO, 2022).

The first national plan for the elderly was developed in 2000, and it includes also the action plan of the government in terms of elderly care until 2024. It aims:

*(i) to ensure the construction of an appropriate environment that supports and helps older women and men to be integrated into society, preserving human dignity, regardless of health status or autonomy their functional; (ii) to ensure the construction and strengthening of the social and health care system in all municipalities of the country, based on the principles of healthy ageing, guaranteeing the use of quality services for it all elderly people who need care; (iii) to enable a life as long as possible, healthy and active for all Albanians, through the awareness of society on good health, prevention of diseases as well as reducing inequalities in the treatment of the needs of the third age (Ministre e Shëndetësisë dhe Mbrojtjes Sociale, 2019, p. 18).*

Other laws and regulations affecting long-term care are Law 121/2016 For the services of social care (the most important law regulating the state help for the subjects in need); Law 57/2019 For the social assistance, Law 10107/2009 For the health care in the Republic of Albania, and Law 139/2015 on self-governance in the Republic of Albania. Furthermore, Council of Ministers Decisions also regulate specific areas of long-term care like Decision 822/2006 on Standards for social care services for elderly people in residential centres and Decision 518/2018 on community and residential social care services: procedures for their benefit and the measure of personal expenses for beneficiaries of organised services (Conkova et al., 2019; Jorgoni, 2020).

In Albania, there is a serious lack of care services and territorial differences in this aspect: 36 municipalities (out of 61) or 56% do not provide any kind of services for elderly. At the national level, social services for the elderly, granted by social care centres of all types, constitute only 15%. Therefore, from 259 centres all over Albania, 39 centres are for the elderly. From 39 centers for the elderly, 14 centers are located in Tirana, while other 25 offer services respectively in Korça (6 centres), Shkodër (5 centres), Berat (3 centres), Durrës, Vlorë, and Elbasan (from 2 centres) as well as Lezhë, Dibër, Gjirokastrë, Fier, and Kukës (from 1 centre) (Ministre e Shëndetësisë dhe Mbrojtjes Sociale, 2019).

### *Caring for the elderly. The case of Poland*

In Poland, long-term care, although it is associated mainly with medical care (MRIPS, 2022, p. 44), is divided into two sectors – health care and social assistance. Therefore, care is coordinated by two separate ministries – the Ministry of Health and the Ministry of Family and Social Policy. Long-term care services are provided in the stationary and community (de-institutional) form in both of these sectors.

In the health care sector, this service is mainly regulated by such legal acts as: (1) The Act on healthcare services financed from public funds (The Act of August

27..., 2004, item 965 )); (2) Directive of Minister of Health on guaranteed services from the scope of care and welfare under long-term care (2022, Item 965)); (3) Directive of the Minister of Health on referral to care and treatment and nursing care facilities (2023, item 893).

On the other hand, in the field of social assistance, the most important legal acts regulating care issues are as follows: (i) Act on Social Assistance (The Act of March 12..., 2004, item 593); (ii) Directive of the Minister of Labour and Social Policy on Nursing Home (2017, item 734); (iii) from 2019 also the Act on the Implementation of Social Services by the Social Services Centre (2019, item 1818) as well as other acts listed later in the article. At the local government level, the coordination of care services, both in the institution and in the community, is carried out by social assistance centres (municipalities), and stationary institutions, such as social assistance homes, are also run by poviats.

In the area of health care, long-term care is defined as professional, continuous and long-term care and rehabilitation along with the continuation of pharmacological and dietary treatment, provided in an inpatient or home form for people with significant limitations in self-care but not eligible for hospital treatment. Inpatient long-term care services are provided in the form of a 24-hour stay and care provided by health care centres (Pol. *zakłady opiekuńczo-lecznicze*, ZOL) and welfare and nursing homes (Pol. *zakłady pielęgnacyjno-opiekuńcze*, ZPO) and are offered to people whose functional efficiency is determined at the level of 0–40 points on the basis of ratings according to the 100-point Barthel scale Directive of Minister of Health on guaranteed services from the scope of care and welfare under long-term care (2022, item 965). Patients can stay in these facilities after prior referral by a doctor after the end of hospital treatment. Health services provided in the centres are financed by the National Health Fund, while the person staying in the centre covers the costs of accommodation and meals (Furmańska-Maruszak & Wójtewicz, 2016; Kilian et al., 2018).

In turn, long-term home care (in other words, community, deinstitutional) is provided formally by state institutions in the form of nursing home care and by a long-term home care team for mechanically ventilated adults, children, and adolescents (Ministerstwo Zdrowia, 2018). A doctor's referral is required to receive this type of care, similar to inpatient care. Patients whose functional efficiency does not exceed 40 points on the Barthel scale are entitled to this form of care. Its main objectives are both to provide nursing and care services in the home environment, as well as to educate and prepare the patient and her or his family for self-care. These services are provided by both long-term home care teams and long-term nursing care at home. Nurse visits usually take place several times a week, and in justified cases also on Saturdays and holidays. The services are aimed at people with respiratory failure who require respiratory therapy, carried out continuously or periodically but do not require to stay in intensive care units. The services include medical, nursing and physiotherapy visits, as well as a full range of diagnostic and imaging tests. The person under care is equipped with the necessary medical and auxiliary equipment (Ziębicka & Marcinowicz, 2015; Kilian et al., 2018). The map of Poland's health needs shows that in 2021 the total number of centres providing long-term care (in the area of health care) was 1,925,



of which 461 were stationary centres and 1,544 were community (de-institutional) centres. There are constantly and significantly more people using this type of care. The number of patients per 1,000 population in 2021 amounted to 297.27 (home benefits 182.41 and stationary 118.64) and increased compared to 2016, because then it amounted to 273.40 (home 169.95 and stationary 107.35) (BAZiW, 2023).

Care services are also provided under the social assistance system and include residential and community care. Assistance in the stationary form is mainly a stay in nursing homes, and relatively recently also in a new type of institutions – care and residential centres (MRiPS, 2021). The cost of staying in a nursing home is partly covered by the person being cared for, and partly by the family or the commune in the event of a difficult financial situation of an elderly person (Act on Social Assistance (2004, item 593), Directive of the Minister of Labour and Social Policy on Nursing Home (2017, item 734).

Among the many types of nursing homes, the elderly are most often directed to geriatric homes, although for various reasons they can also live in other facilities, e.g., homes for somatically ill or physically disabled people. Between 2016 and 2020, the total number of communal, municipal, and regional nursing homes increased slightly from 816 to 826, which means that mainly community services are being developed in Poland. On the other hand, the number of inhabitants, among the 11 types of houses distinguished by the legislator, is decreasing, e.g., in terms of houses for the elderly their number was systematically reduced from 7,104 in 2016 to 5,719 in 2021, and in houses for the elderly and physically disabled 1,569 to 1,453. According to the data at the end of 2020, 1,478 elderly people were waiting to be placed in social welfare homes (i.e., in an institutional form) (at the end of 2010, there were 1,901 of them). In 2020, the number of residents of nursing homes decreased (this was due to, among others, the epidemic caused by the spread of the COVID-19 in 2020 and a significant increase in the prices of stay) (Strategy for the Development of Social Services, Public Policy to 2030 (with an Outlook to 2035). (Resolution 2022, No 165 Polish Official Gazette, p. 28).

Various forms of community support and the programmes of the Ministry of Family and Social Policy developing them seem to support multi-sectoralism and deinstitutionalisation as well as accelerate their implementation. Analysing the current legal and organisational solutions proposed in the social assistance sector for the elderly requiring support due to disability or serious illness, one can distinguish forms of assistance that allow them to stay at home (care services, assistant services, respite care services for carers and day care homes), as well as in the current local environment but in a different apartment than before, i.e., in alternative 24-hour stay centres (protected housing, family nursing homes).

The social assistance sector, through communes, provides community (de-institutional) assistance to the elderly, mainly in the form of care services (Błędowski & Maciejarz, 2013). According to the current Act on Social Assistance (2004, item 593, Art. 50), they are dedicated mainly to people living alone who, due to age, illness or other reasons, require assistance. These services should help in meeting everyday life needs, maintaining hygiene, care recommended by a doctor, and ensuring contact with the environment. On the other hand, specialist care services Act on Social Assistance (2004, item 593, Art. 50(4)) are adapted to specific needs resulting from the



type of illness or disability. Both types of these services can also be used by dependent people living in multi-person households when the family cannot provide such assistance. In order to increase the availability of this type of support for the elderly, the Ministry of Family and Social Policy has prepared the “Opieka 75+” (“Care 75+”) Programme. Between 2016 and 2020, the number of municipalities that provided care services increased from 82.65% to 89.34% (MRiPS, 2023a).

Stationary and environmental services can be provided by the public sector, the private sector and non-governmental organisations, as well as by social economy entities. As a result, private nursing homes, non-public health care facilities, and long-term care facilities are established, which are run by associations, foundations, and church organisations<sup>10</sup>. There is an intensive effort to provide the non-governmental sector, social economy entities, and private entities with the implementation of care services, running day support centres as well as family nursing homes (Ziębińska, 2022).

The analysis of the social assistance law, the ministerial programmes of the Ministry of Family and Social Policy and the strategies defining the principles of social policy towards the elderly, or the strategy for the development of social services show that support and care for the elderly in Poland should be organised in accordance with the assumptions of modern social policy in the public, non-governmental, and private sectors, i.e., in a multi-sectoral and de-institutionalised manner. When looking for evidence for the pursuit of these ideas, it is worth recalling the document promoting the above-mentioned principles of social policy towards the elderly, namely, Social Policy Towards Older Persons 2030. Safety – Participation – Solidarity. (Resolution 2018, No 161, Polish Official Gazette), which talks about moving towards deinstitutionalisation, understood as the development of services in the existing apartments of the elderly and the development of alternative institutions to traditional social welfare homes. Deinstitutionalisation is also clearly mentioned in the Strategy for the development of services social: the process of transition from institutional care to care provided at the level of local communities, in the case of the diagnosed situation in our country, requires long-term actions – in the perspective of several decades – including the following stages and blocks of departments: “(i) increasing the supply, availability and ensuring appropriate quality of services provided in place of residence and in deinstitutionalised forms; (iii) preparation and implementation of local and regional plans for the development of long-term care services; (iii) gradual transformation and then possible closure of brick-and-mortar facilities” (Social Policy Towards Older Persons 2030. Safety – Participation – Solidarity Resolution 2018, No 161, Polish Official Gazette, p. 99).

Another principle according to which the contemporary care system in Poland is organised is multi-sectorality, which can be proved by the recommendations regarding

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<sup>10</sup> The catalogue of social economy entities includes primarily: social cooperatives, non-governmental organisations and entities referred to in art. 3 ust. 3 The Law on Public Benefit Activity and Volunteerism (2022, item 1327, 1265), as well as work cooperatives and cooperatives for the disabled and the blind, as well as reintegration units (including centre for social integration CIS, social integration club KIS, therapy workshops WTZ and vocational activity workshops ZAZ).

the transfer of social services to non-governmental entities such as family social welfare homes, or the inclusion of social economy entities in the document Act on Social Assistance (2004, item 593) as entities which can perform such tasks. The main directions of the policy towards dependent elderly people, which are included in the act, Strategy for the Development of Social Services, Public Policy by 2030 (with an Outlook to 2035; Resolution 2022, No 135, Polish Official Gazette, Item 767) are:

*(i) building an effective and sustainable system providing social services for people: in need of support in everyday functioning; (ii) implementing a coordination and standardisation system for social services; (iii) support of the family and people taking care of the person in need of support in everyday functioning; (v) development of environmental forms of support in the form of social services; (vi) change in the functioning of a stationary long-term care institution (nursing homes), inter alia by transforming it into community care centres; (vii) a sustainable system of financing long-term care in the area of social services; (viii) support and development of staff providing social services (Resolution 2022, No 135, Polish Official Gazette 2022, Item 767).*

On the other hand, in the document Social Policy Towards Older Persons 2030. Safety – Participation – Solidarity (Resolution 2018, No 161, Polish Official Gazette 2018) among the numerous directions of activities addressed to independent people, there is also a direction referring to dependent elderly people: (i) reducing the scale of dependence on others by facilitating access to services that strengthen independence and adapting the living environment to the functional capabilities of dependent elderly people; (ii) ensuring optimal access to health, rehabilitation, and care as well as nursing services tailored to the needs of dependent elderly people; (iii) a network of community and institutional services provided to dependent elderly people; (v) a system of support for informal carers of dependent elderly people by public institutions.

Actions that are part of the idea of deinstitutionalisation of social services addressed to the elderly, currently undertaken by the Ministry of Family and Social Policy, include such programmes as: “Opieka 75+” (“Care 75+”), “Rodzinne domy pomocy” (“Family Nursing Homes”), “Usługi asystenta osobistego osoby niepełnosprawnej” (“Services of a personal assistant to a disabled person”), “Opieka wytchnieniowa” (“Respite Care”), and “Senior+” (MRiPS, 2023b).

## *Conclusions*

We can list various factors that influence the shape of the welfare systems of Poland and Albania differently but they are also similar. Poland is characterised by a higher degree of the ageing of the population than Albania and, at the same time, by a higher percentage of elderly people living alone but also by a lower risk of poverty among Polish seniors and a declared greater possibility of using medical services. The results of this study confirm research reports on the care system in Albania (Poni, 2022), which identify significant problems of underfinancing the care system in this country

and the need to cover the costs of treatment and care out of one's own pocket (Druga, 2021). There is a large scale of migration in both Albania and Poland (although much larger in Albania) and there are large regional differences in both formal and informal care. Albanian researchers (Conkova et al., 2019) draw attention to the phenomenon of negative effects of migration for dependent seniors, writing about the loss of close family ties as a result of separation from adult children, especially in rural areas. This study shows that in both countries, there are regions characterised by a high migration balance, where elderly people are left alone, without family support, which is severe, and both Albania and Poland base their care systems mainly on family support.

An interesting and new topic which has not been explored in the literature on the subject is the differences between the studied countries regarding the health status of the population. What distinguishes Poland and Albania from one another, and is strongly related to the type of care, are also the types of chronic diseases experienced by elderly people in the surveyed countries. In Poland, apart from cardiovascular diseases, the main causes of disability include diabetes, digestive system diseases and respiratory system diseases. In Albania, on the other hand, neurological diseases appear much earlier than in Poland. It is also worth noting that the diseases women and men suffer from in both countries are distinct.

The scale of social services provided in both countries is far from sufficient, however, based on the figures, it can be said that support, both institutional and community, is much more widely available in Poland. Let us take into account the fact that in Poland only in every 10<sup>th</sup> commune no care services are provided, and in Albania only 40% of communes provide such services. The large differences in the forms and scope of social services for older people observed in post-communist countries have also been proven in comparative studies of these countries (Golinowska & Sowa, 2013). It was emphasised that deinstitutionalisation is limited by staff shortages in the field of medical and social care and the unsuitability of housing conditions for home care.

In Albania, the main provider of formal services is the private sector, and Poland is moving towards a multi-sectoral model, increasingly handing over the running of institutions, day care centers and care services to non-public entities, including more and more to the civil sector (volunteering, neighbours), and social economy entities. The directions of the care policy in both countries are similar, they aim at deinstitutionalisation and multi-sectoralisation. The system of care in Albania, based on service standards developed and enforced by the government, seems to be more in line with EU recommendations on care policy and limiting the public cost of care. This is evidenced by the organisational structure of the service system in Albania. Public entities play the role of coordinating, commissioning, and controlling services, while private entities perform the services. This model seems to be similar to the UK service model. The multi-sectoral nature of welfare systems in post-socialist countries is written by researchers of the Polish system (Błędowski & Maciejarz, 2013; Ziębińska, 2022), researchers comparing these welfare systems (Golinowska & Sowa, 2013; Bakalarczyk & Jurek, 2021) and those analysing the Albanian system (Poni, 2022) or Czech (Łuczak, 2016). Analyses of the Czech Republic and Albania emphasise the significant role of the private sector.

Albania is in the design and direction phase of care for the elderly and seems to be doing so in line with EU policy. In turn, recent years have shown that the policy of multi-sectoralism and de-institutional analysis is strong in Poland, despite the fact that the number of 24-hour care institutions and places in these institutions is much smaller than in other European countries. The implementation of the above-mentioned assumptions is evidenced not only by the policy directions set out in the programmes and strategies mentioned in the article but also by specific statutory solutions. In Poland, financing of care is mainly at the level of the municipality and beneficiary's funds (both in institutions and community care from the commune), long-term care from the healthcare system (nursing at home and institutions such as ZOL) is covered by health insurance. State funds cover only co-financing for community care development programmes (de-institutionalisation) – development of day care facilities and other types of care.

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## ***The use of reflecting teams and principles of reteaming in the teaching of social work – a tool for changing the paradigm in the performance of social work***

### ***Abstract***

The work aims to point out the possibility of using reflecting teams and the principles of reteaming in the professional training of social workers. It may also trigger a professional debate on the topics of the preparation of experts for practice and tools for continuous education. Another important element is to provide a practical tool that will allow further professionalisation of social work within the decommodification of services.

The theoretical background corresponds to situations, in which social work focused primarily on the provision of services and ceased to be a tool for developing the personality of clients, thereby changing the quality of their lives.

The methods used aim to show the history and principles of the reflecting teams in practice. The next part focuses on the reteaming method as a model of the approach between the helper and the receiver. Furthermore, the description of the use of these techniques in the professional training of social workers is discussed. In the conclu-

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sion, the results of the structured questioning of the graduates of the subjects, which utilise these methods, are summarised.

The change aims to restore the creativity of social work and the ability to help people to fulfil their lives.

Social work is based on the communication and retrospection skills of one's personal attitudes and work practices. We also present a tool to change the attitudes of social workers from the redistribution of services to the development of society as such.

**Keywords:** skills, paradigms, new teaching methods, reteaming

## *Introduction*

In the teaching and professional training of social workers, we often encounter the issue of motivating students to study the theories and methods of social work, or to understand their importance and meaning.

Over the past decades, social work has become more of a tool to redistribute help and services. Attention was already drawn to these risks by van der Laan (1998). This topic was explored further by Ziółkowski, Drozdowski, and Baranowski (2022) as a model of commodification of services. The results of these processes are described by Škoviera (2022)<sup>2</sup> in the framework of child protection. He discusses the situation of providing child protection instead of family education. Education is a two-way process, which helps to find the fulfilment (meaning) of life and affects both the surrogate parents and the children. On the other hand, commodified care provides primarily material essentials and life in a family environment, which can only be a service within this change.

We know similar processes from practice at all levels of social services and social assistance. As van der Laan states, during this process, the clients “lose confidence in their own initiative and believe that their fate is determined by institutions” (van der Laan, 1998, p. 14). Hubíková, Havlíková, and Trbola (2021) describe this issue in a similar way – as a model of the deprofessionalisation of social work and its shift into a redistributor of services and financial benefits.

In solving these challenges, after having discussed it with colleagues, we tried a total change of approach in teaching this subject as such. The goal of searching for change was to teach future social workers to work with the client's entire life (sometimes generational) story. We also want to bring back creativity and a certain passion for social work through decommodification (Ziółkowski et al., 2022). An important factor for the realisation of change in teaching was the completion of solution-oriented therapy training and supervision training, which are carried out with a similar focus in mind.

The above-mentioned training focuses, among other things, on using the reflecting team technique and the principles of reteaming as supporting tools for changing the

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<sup>2</sup> The lecture entitled “Foster care in the context of trends and changes in the concept of parenthood” was presented at the conference “Family Transformations XI”. To appear in print in *Social Pathology and Prevention*.

approach to both students and teaching as such.

The first part describes these techniques, their origin, and the authorial intent of their use in practice. The second part mentions the specific use of these methods in the teaching process. It includes the aforementioned change in the approach to teaching as such, and to students, considering them as partners, who actively co-shape the change of the entire learning process. This shift can be, in a certain sense, seen as a Copernican revolution, with the teacher becoming an expert in the teaching process and leaving the freedom of the choice of the path to the goal to the student. The subject matter is created from the bottom up and not from the lectern. In parallel, we enable the professional training of new social workers who are willing and able to think in the categories of a therapeutic paradigm rather than a counselling one (Fabián, 2021). The final part of the contribution deals with the personal views of the students on the implemented changes. The data collection was carried out through a structured interview with students after the final exam. This was a form of evaluation that focused on their emotional and informational experience, as well as the strengths of these changes, and the space for future development.

### *Reflecting teams*

Reflecting teams are a technique, or perhaps a method of work, popular in postmodern or systemic approaches to therapy or supervision. Its development is attributed to the Norwegian therapist Tom Andersen (Zatloukal & Vitek, 2013). Others associate this process with the Milan Approach (narativ.cz) but the evolution and practical use of this technique is tied to the aforementioned Andersen who aimed at involving a wider range of perspectives in therapy. The therapy was conducted in spaces that are now commonly used for interrogations (rooms with a one-way mirror), with a team of experts, who were supposed to contribute to the development of therapy with their insights and observations.

Andersen followed the postmodern idea and social constructivism in his work. It is an effort to understand the interactions and ways of thinking that take place in the therapies. Andersen expected that with this approach, he could get answers to the questions regarding the psychosomatic context and social impact of mental illnesses.

As professionals, we often talk about our clients. We tend to describe the pathology, even without the presence of the clients but this process gives us expertise (or sometimes overview) on the issue and creates a sense of distance, however, it can reinforce the problem (De Shazer in Zatloukal & Vitek, 2013, p. 3)

Postmodern approaches are collaborative, and reflecting teams present a tool thanks to which otherwise “hidden” voices can be heard in the help-seeking process. It often shows the experience of the assistants and their emotions but also the concerns about changes, experiences, and emotional states of the clients.

Working with a reflecting team is also used as a practical teaching tool in psychotherapy training. However, the reflective process should not be (and is not) understood only as a technique or a simple exercise. The philosophical roots of this work method, respectively, what Andersen calls a philosophical stance, should not be

omitted. “For Tom Andersen, a reflective approach was a way of life, a way of being with others, the belief that one lives in relationships, in conversations, in interactions, and is, therefore, an active participant in all events, not just an observer” (narrative.cz), so the therapist, just like a member of the reflecting team, is not separated from the clients and their situation. The therapist thus becomes a participant (as opposed to an observer) by sharing a common process with the client.

### **Advantages of using reflecting teams**

Zatloukal and Vitek (2013, p. 3) discuss the technique and work in a reflecting team, and emphasise its possible benefits:

- emphasising local instead of universal knowledge
- including multiple perspectives (voices) in the conversation
- respecting different points of view without trying to find the “correct” one and rejecting others (not using either/or approach)
- emphasis on co-creation in the dialogue with clients and colleagues
- devoting the effort to disrupting hierarchical relationships and taking on a more partner-like relationship with the clients.

According to Zatloukal and Vitek (2013) it is a solution-focused approach. The clients, who come looking for help, play the main role, and they mainly gain control over their situation. No directive approach is applied here. In parallel, the clients gain control over their lives and stop being dependent on the service. They describe the general characteristics as:

1. The basis for mastering the technique successfully is the skill to reflect – the process that takes place between the therapist and the client, personal emotions, the therapist’s ability to stick to the client’s instructions (see below), and safety. This skill also includes the ability to ask questions and formulate them. Another important precondition is the fact that the clients are experts in their lives.
2. Contract negotiation – what brought the clients to therapy and what are their needs? There is an emphasis on their motivation, which is tracked with questions such as: “What would you like to take away from today’s consultation so that you find the time meaningful to you?” (joint project), “What will life look like when the problem disappears?”, “What has already been achieved?”, “What helped the process?”.
3. In the therapeutic process, the reflecting team sits as if remote from the client-therapist interaction, still, they are in the same room and watch the consultation.
4. For the client (in our case, the student), the reflecting team may present several things in the process:
  - possibility of consultation with several experts
  - loss of security
  - gaining a broader perspective on their lives
  - understanding the process of change.
5. Team reflection. During the consultation, the roles can alternate and the therapist can use the reflecting team for discussion, especially on the topic of how the

reflecting team perceives the whole matter. Following the convention and principles of practice, team members focus on:

- What goes well (appreciation) – highlighting exceptions, resources or progress, with reference to what the client reported in his narrative.
  - Ideas (alternatives) – they can refer to new perspectives, reframing or proposals for an experiment.
6. Continuation of the consultation – “What was inspiring for you?”, “Is there something you want to return to?”, “What were your thoughts?”.
  7. Experiment (or better – feedback) – to observe with the clients the elements that should remain unchanged (what works), to observe where the problem does not occur (exceptions), or to pretend improvement (preferred future).
  8. Reflection of the meeting – what the course of the meeting was, and what was important for the clients and for those reflecting? This part is also crucial for the use of this technique in teaching (Fook, 2002).

A discussion in a reflecting team must resolve according to the following rules (Andersen in Zatloukal & Vitek, 2003). Team members only talk to each other and they do not bring clients into their conversation. The clients thus gain a reflection on their story. The members lead a conversation; it is a dialogue, not a series of monologues. The consultation focuses on here and now, the members do not refer to what was said during earlier consultations, or to assumptions that may be an accompanying phenomenon of our work and our conception of the clients' lives. The reflection should be formulated in such a way that the clients can be inspired by it but can also refuse it. Different options should be created intentionally so that the clients may choose or reject them – to take control over their lives. The use of metaphors is allowed. The technique allows for unusualness, not to be bound by conventions. The safety of the clients is handled by the therapist and the team members can be more daring. Time economy is also an important factor in the reflection of the team as it should not be longer than 5 to 10 minutes. Where Zatloukal and Vitek (2013) recommend looking at the appreciation of the team and its focus on change.

Reflecting teams represent a safe environment for learning new skills (Zatloukal & Vitek, 2013). In this part, we introduced the reflecting team technique. Another philosophical basis is the technique of reteaming. If we were to describe these two techniques as a computer, then the reflecting team is the hardware, and the reteaming is the software.

## ***Reteaming***

Reteaming is a model of work in coaching and therapeutic process, the author of which is Ben Furman (Zatloukal & Vitek, 2014). Furman noticed that many support conversations and group work are oriented towards problems that need to be addressed. He described this approach as a popular concept in therapeutic, supervisory or coaching practice. In the introduction to the book on reteaming, which was mediated for the Czech environment by Zatloukal and Vitek (2014), Furman describes his team

noticing that in practice, the search for a problem created problem cycles that stirred emotions such as anger, dissatisfaction, frustration, blame or sadness. However, a solution-oriented approach rather encourages the search for resources for a change towards a desirable (preferred) future. The process, which is focused on the preferred future, encourages the exploration of new ways and non-traditional solutions, and above all, works with the resources that the clients or teams already possess.

Reteaming is, therefore, a coaching technique, which we utilised in teaching as a tool for a specific process of working with the clients – in this instance a casuistry. The goal was to achieve a certain basic mastery in navigating the life of the clients differently and to leave the well-worn paths of the traditional way of teaching and education, which are (in our opinion) based on controlled conflict. The social worker learns to see the complexity of the client's situation within her or his life story, does not only work with symptoms but helps to discover tools to change the causes. As Zatloukal and Vítek state in their publication, “coaching is the art of facilitating the performance, learning, and development of others” (2014).

Methods other than coaching, but often used in the practice of social work include the following:

- **Counselling** (consulting) – the counsellor is an expert on a certain issue and they are the bearer of clear answers and advice for solving problems. We are sometimes unable to avoid these approaches but we must be aware of when and for what purpose we use them.
- **Mentoring** – this usually involves experts accompanying less experienced workers.
- **Management** – this is associated with authority and power. As described by Erikson, it is a parental role towards children.
- **Education and training** – the purpose of education is to transfer knowledge, and sometimes also skills. In the spirit of reteaming, coaching is working with already acquired skills and sources that are available.
- **Therapy** – approaches that work with therapeutic models exist within the theories and methods of social work. On the other hand, it is often a specific work focusing on the very existence of the clients, and within social work, they are rather sporadic therapeutic inputs or deeper analyses of the problems.

The process of working in the reteaming model has its basis in the process of learning and working with existing resources. This is an effort to increase the competence of the clients to have control over their life, giving them the sense of empowerment (Fook, 2002).

Reteaming focuses on the client's wish (what is attractive and achievable), resources (finding and using skills and knowledge that the clients already have in their cultivation and development), transformation (defining and planning incremental steps towards a desired future), and co-creation (cooperation). In short, this is a model of SMART goals that we know from case management in social work. However, it should be noted that we work purposefully on the partnership level here. We want the clients to be in control of their life, and the workers to serve just as guides, which means it is a completely different philosophy of working with the client.



For a closer understanding of the reteaming philosophy, the Dalet<sup>3</sup> team focuses on the following principles: developing solutions, not problems; efficiency; cooperation/co-creation; process expertise; inevitability of changes, and individual approach (Zatloukal & Vitek, 2014, p. 22).

**Table 1.** Developing solutions, not problems

Clients' situation in time	Focused problems	Focused solutions
past	past failures	past achievements
present	present shortcomings	present resources
future	future limitations	future possibilities

Source: Zatloukal & Vitek, 2014, p. 22, own adjustments

From the beginning, we talk with the clients about their goals (dreams) and not their problems. Then are we able to aim at methods that work, what worked in the past, and how can these tools be used to develop clients' lives. As Zatloukal and Vitek (2014, p. 51) point out, the solution is not interested in where the problem arose.

The change in the approach is quite apparent in the table. Historically, we are taught to talk about things that do not work and describe the problems and conditions which prevent us from living. Reteaming focuses on what the lives of the clients should ideally look like, and then we discuss skills (resources), and past and present good experiences (while questioning the exceptions). We begin with the assumption that, as opposed to a therapist or a social worker, the clients are experts on their lives.

Efficiency

Efficiency in reteaming is meant as an idea that, from the very beginning, we work towards the resolution of the cooperation. A solution-oriented approach is also called “short” (Zatloukal & Vitek, 2014, p. 23). It is about doing the work without delays, making the clients aware of their goals and skills, and handing over the responsibility for the implementation of necessary changes.

Cooperation/co-creation

According to Zatloukal and Vitek (2013), cooperation based on the client's point of view on the whole matter is important for the co-creation of solutions. The self-respect of the clients and their respect for life experiences is also essential. The art of agreement does not mean agreeing to everything. According to the above-mentioned authors, any resistance is a signal to change our approach or point of view.

<sup>3</sup> Dalet is a Czech company which focuses on training in psychotherapy and supervision.

## **Process expertise**

We are historically used to authoritarian approaches. Parents, teachers, educators, and other authorities always know better than us what we should do, what we should learn, and how we should behave, etc. Process expertise deals with a change in approach. The clients themselves are the experts on their own lives and we are only experts on the process of change. Our style of conversation should only help the clients to define their goals, describe their tools of work, and set partial and achievable goals. Here lies a significant similarity with SMART goals, with the key difference being that the clients set the goals, tools, and timeframes themselves.

The expertise of the social worker is primarily at the level of the client's life story and the ability to see and believe in the potential for change.

## **The inevitability of change**

Any change with the clients is at the centre of our interest. If the problem diminished or was limited, it is an exception with a reason and we are interested in it. The awareness of changes is closely related to the process expertise, as well as to the ability to slow down major changes for the safety of the clients.

## **Individual approach**

The individual approach process is based on respect for individuality. Each client has their own ideas regarding the tools and the solutions that they want to utilise. There is a certain amount of fascinating discovery in this process as we are drawn into the clients' world. Unlike consulting, where we have a certain checklist of individual steps, here we leave it up to the clients to make their individual choices.

## **Reteaming process map**

Connecting to clients with "small talk". Getting to know the clients, talking about their interests, hobbies, and abilities. At the same time, there is a space for the client's questions. During the process of connecting, we get information about who we work with, not about their problems. This is important because past achievements, skills, etc. are the tools for change (see: Table 1). At the same time, we create a feeling of safety, while we "automatically" think about what to offer for the development of the client. The services are only an accompanying tool for solving an acute threat, not a tool for changing the quality of life.

## **Questions about the dreams**

These questions can be directed to the topic of what should happen during the consultation to make the client satisfied, or even to long-term plans, e.g., what will life look like should the problem be solved?

The key is the worker's ability to distinguish between what is a request for change from others, and what the clients want to do themselves (they are in control of their lives). There are also questions regarding how will the clients' emotions, thoughts, and behaviour change, and how their surroundings will recognise the change. With this, the dream becomes comprehensible and tangible.

## **Goal**

A goal is something very specific in reteaming. Whereas a dream is very broad and provides many different objectives to choose from, specific goals are, in a certain sense, quests. The goal must begin and end with the client, it is dependent on their actions. For instance, the goal "I will be happy when my children are happy" is a task for the children and not the client.

An obtainable goal must fulfil the following characteristics and it must be: specific; formulated positively as something desirable; achievable (the client believes that they can achieve it); and realistic (the clients have the tools necessary for the implementation, or they can acquire them).

Only the essential points of the reteaming process were presented here. The aim of these chapters was primarily to introduce the tools we use in teaching, where we try to convey not only information but also a certain skill that is methodologically anchored in reflecting teams and reteaming.

## *The change of view*

In the following part, we discuss the ways of adopting methods and theories from social work into teaching as well as possible changes of the way we teach social work.

## *Information and us*

Today's world gives us unprecedented possibilities. Anyone with a phone and Internet connection has access to the newest information – if they know how to search for them. The students may also have more up-to-date information than their teachers.

People and information are connected in a new way, which also brings new needs. The main ones can be described as the skill of finding relevant data and their critical analysis, the courage to leave the comfort zone of one's beliefs and willingness to change our opinions and views.

These new possibilities deny the traditional form of teaching and even discredit it in a way by making it look absurd. How do you want to convey information when the students have everything in their pockets (on their mobile phones) to a greater extent than the teachers have in their heads (including mistakes and inaccuracies)?

## *Experience and us*

As students, we were taught that when we come to practice, we should not be surprised, as theory and practice are two different quantities. Then, what is the point of learning anything that will not help us in practical situations, where we will need to react to different stimuli?

Experience comes from the fact that I have (or sometimes do not have) enough information and I try to implement solutions and use them in a safe environment. Subsequently, I can accept the importance of the information and possibly expand it further according to experience.

Thus we can say the following: INFORMATION + EXPERIENCE = SKILL. From the pieces of information, combined with experience, a skill is developed. Skills are a completely different category. They show that I know how to work with certain topics, I have experienced the patterns, and I know the effects on reality. Ideally, I have already tried several formulas and I can practically alternate and modify them according to the current situation.

## *Experience and education in social work*

### **Change of teaching methods**

The change in the teaching principles is based on the students' experiences and their views on the matter. Thus, the student's views on the matter are important and supporting elements in the whole process, as opposed to the lessons themselves. We prefer personal experience to generally accepted information or beliefs.

The teacher brings creativity, the ability to think critically and a departure from the old patterns of redistribution of services, as the goal of social work. To change the teaching method, we utilised the technique of reflecting teams (Zatloukal & Vítek, 2013), which was implemented in a case study related to the "Theory and methods of social work" and "Socio-legal protection of children" subjects. The case studies do not change during the semester – there is one, or two at most.

### **Reflecting teams and reteaming in teaching**

In the previous chapters, we introduced both reflecting teams and the principles of reteaming. In teaching, these two models were combined into one, creating a model for the development of students and their competencies within the framework of teaching the theories and methods of social work. A similar procedure that is used in training at Dalet is called reteaming nests. The work in lectures is, therefore, organised in small teams. The basis of the reflecting teams is described within the systemic approach during the therapeutic process.

The entire process is preceded by familiarisation with the relevant theory, followed by work in a reflecting team. The work with the theory itself is always focused on the client's entire life story, abandoning the instrumentalisation of social work (Fook, 2016).

Two people carry on a conversation on a given topic (a view of the case study concerning the discussed theory) and the other two remain silent and take notes. The conversation time is limited. One person describes her or his view of the given problem and the other actively listens and asks questions that should not start with “why”. Differently posed questions encourage thinking and creativity while offering the creation of a change process.

In the end, they receive feedback from the observers regarding their thoughts throughout the conversation, its course, and the way the questions were phrased (e.g., supportive, closed, open, problem-oriented, solution-oriented, etc.) Another point is defining what is the supporting theme for the questioner and the responder (Fook, 2002).

In the process of active teaching, we use one or (at most) two comprehensive case studies throughout the whole semester. For the “Theory and methods of social work” subject we used one, and for the “Socio-legal protection of children” subject, we used two less extensive case studies.

## **The first lecture**

We consider it a very important lecture, as the teaching methodology is introduced (what reflecting teams, reteaming, and the “solution-focused” approach are) as well as some small talk facilitating connecting with others. The reflecting teams, which (if possible) do not change during the semester, are formed during the first lecture. This process of social interactions is based on the reflecting team technique, where one introduces themselves, somebody asks questions, and the remaining ones observe the process that takes place between the participants. It is essential to follow the process from the point of view of the quality of the questions, to ask about the skills and experience of the other, not to follow the problems, and to refrain from the “why” questions.

## **The following lectures**

The following lectures have an established script. In the beginning, the theory of the given issue is presented, followed by the work in reflecting teams. The recommended roles in the team are one person in the role of a client, another in the role of a social worker, and others as supervisors of the process. After the specified limit, the students return to the whole group and we share our experiences. By doing so, we mean grouping different solution proposals of solutions together and describing what was important for the proposals of individual teams. We also focus on feedback on the process that took place in the teams, including the emotional side of the participants.

In conclusion, we get several different ways to solve the problem, together with descriptions of various models of thinking about the given situation. At the very end, the results from all groups are combined. Questions regarding the feelings and emotions of the participants are also included.

Through this process, we get a plastic image of the discussed issue, while the supervision-like process takes place in parallel. In our opinion, the fundamental advantage is when the students are our partners in the process and they construct their way of working – creating thought and practical structures. Another advantage is the fact that the students are aware of their attitudes and approaches on which they receive feedback throughout the (rather supervisory than instructive) process.

### **A summary of benefits for teaching and social work**

In the cases of big theories such as critical or environmental theory, there was an interesting outcome. In the same case study, different groups chose different clients. Based on the case study, sometimes the primary client was the family, for some teams it was the mother or the father, for other teams it was the children. As all the answers are correct, this opened the discussion about how the participants think and what leads them to this choice, which is one of the most important elements of critical theory (Fook, 2002).

The students gained an interesting experience with role-oriented theories in how the social worker's approach changes when they are paternalistic, and how the dynamics of the conversation shift when they keep the philosophy of reteaming – adult-adult interaction. Since casuistry also works with family history (a description of the model of the original family), it was possible to pinpoint transgenerational transmissions, which also have their strengths (i.e., psychoanalytic theories).

All participants in the teaching process (i.e., the lecturer and students) undergo a change in their view of social work as such and shape their personal thought processes. The teachers should bear in mind that is crucial to maintain the basic line of thought – that social work is a creative activity bringing a changed quality of life to society, and not just an “ATM for services”.

### **The change of roles**

There is no student, patient, or client, there is only a person, who wants to deal with her or his current situation. The person, who needs the competence to change their way of life, to deal with the past and their acquired or inherited traumas, to find their truth of being (Heidegger, 1993). In other words, a change in the approach to oneself, and thus a change in the approach to life. There is also no doctor, teacher, or social worker. There are only experts on the process of change, who are ready to guide other people through it.

All participants in the process are active participants in the process of education, recovery, and social services. By the term active participants, we mean a state, where the people involved revise the process of change that is taking place. This process corresponds to the view of the critical theory of social work as presented by Jan Fook (2002). One of the most important elements of critical theory is an insight into one's personal approach to work performance, observing what is important for a social worker, and how one works with power.

## **From the point of view of the guide**

For the guides, the fundamental advantage of this technique lies in the contact with the way of thinking of the next generation, their priorities, goals, and views on social work in the context of the times they live in.

Each generation has its way of thinking, which frames and describes social reality. Our academic social work can, in the process of capitalisation, easily get into the practical and institutionalised isolation of social work (Bergmann & Luckmann, 1999, p. 56) This phenomenon has already affected us in the system of social work standards and the monitoring of their fulfilment. Standards were supposed to stimulate development, however, with a system of inspections, they become more of a tool of uncertainty.

The principles of liberalism and democracy have become more ingrained in new generations of students, but so have a sense of responsibility or sensitivity to the abuse of services. Most of them enter the university with the concept of social work as a tool to reduce poverty, primarily as a means of caring for vulnerable groups with a service delivery model (commodification of social work). For all participants in this process, the search for creativity, working with the client's life story and finding ways to develop their competencies is a relief.

## **From the point of view of students**

The examination also had its specifics. The students chose one of the theories, which they were supposed to briefly present. This was followed by a very brief version of another case study, on which they were supposed to demonstrate the way of working and thinking in the spirit of this case study.

Subsequently, they should evaluate themselves, thus applying the learned skill of perceiving the process and their strengths. In the end, they were asked about the benefits of the teaching method, what should be further improved, and eventually, avoided.

The proposed change brings new challenges for students. During the semester, they are encouraged to self-study topics aimed at the problematics of theories to be discussed in the following lecture. This change mainly concerns students of the combined form of studies (remote learning and blocks of lectures on weekends), as there is less time for the students to get acquainted with the overall idea of the theories during the semester.

Another interesting factor is the feedback from the students:

*At the beginning, the case study was completely clear to me, who was the culprit and what needed to be done. Now, I rather perceive what the possible views on the whole situation are, and that some things may seem different, and how important it is to follow our views as well. I am also aware of the number of possible solutions and the influence of the internal motivation of the participants on the process of change.*

It is important for other students to engage in interaction, to verbalise and communicate their views, and be able to describe them, and possibly, even defend



them. They describe it as: *There is nowhere to hide, and suddenly, I find that the unspoken thoughts are something different from the verbalised.. It develops the ability to communicate, and we also get to know each other more as colleagues.*

The students of the combined form said that: *We have to come to the lectures already prepared, having read the chapters so that we better understand the use of the theory in practice.*

A fundamental view also emerged: *Social work is not just services, it is thinking in the context of the client's life so that they can manage themselves in the future without social benefits.*

We, as the authors, also perceived the assessment as free of judgment: *No opinion was wrong; it was just different from the others. We were, above all, colleagues, we were equal, and the lecturer took all of our opinions seriously while taking notes and introducing the ideas back into the lectures.* It was one of the fundamental observations.

## Conclusions

In the article, we dealt with two techniques that are known in therapies and coaching. We described these techniques and subsequently discussed their implementation to change the approach to teaching theories and methods of social work so that the practice can return to creativity in social work – decommodification.

The last part was dedicated to their practical, alongside a description of the work with students. For the evaluation, we used a structured interview with students to capture their views on the benefits of the change in teaching.

In general, it can be said that the methodology of transactional analysis follows the child-parent-adult approach (Lister-Ford, 2006). Harris (2020), who uses these principles in his practice, describes how important it is to come to an adult decision “I am OK, you are OK”.

In the presented model of the change in teaching, everyone is (or is trying to be) in an adult role. This teaching method allows students to try the theory in practice and develop skills based on “information + experience = skill”. At the same time, the lecturer (guide), gains insight into generational changes in thinking.

Students also gain insight into their way of thinking – whether they are problem-oriented or solution-oriented. They can also realise situations, where a person seeking help is a child, they are looking for parents, but the process is directed towards adult roles.

One of the advantages is that students can gain more “expertise” in the methodology of the clients being experts in their lives. In this process, they are guides and lead the client to become independent or to find a way towards growth.

In the author's opinion and from his own experience, a change in the approach to teaching brings a necessary change in the perspective of social work as such. Social work is supposed to be both practical and scientific. The basic tool facilitating change is thinking of the next generations, as they have different access to information and sources, some go through different models of education (Montessori, democratic schools, etc.) and mere theory is no longer enough for them.

The process of state exams may also be influenced by subsequent changes when instead of demonstrating encyclopaedic knowledge, students will process solutions for specific case studies from the point of view of all the state exam subjects.

Students also benefit greatly from gaining practical interviewing skills and feedback from colleagues on how they think and what they focus on.

The teacher serves here more as a guide, who supplies the theory but, at the same time, also experiences the change of thinking of the next generation. This also means a constant change of the lecture topics and materials. The course of the lectures must also constantly return to the context of the entire subject – to help students realise the broader background of the discussion.

The essential contribution of this paper is, in our opinion, the return to the debate that van der Laan describes as the problem of the process of “disciplining” (van der Laan, 1998), which casework models in social work followed, but did not go beyond service commodification framework. Similarly, the authors Hubíková, Havlíková, and Trbala (2021, p. 14) describe the current state of social work performance as politically directed to ensure services and benefits.

We offer the topic of decommodification of social work as such, not only on a theoretical level, but also on directly with a tool for practical use in the preparation of a new generation of social workers. There is an opening of a possibility for change, which van der Laan (1998) describes as a “newly formed reality” and which Berger and Luckmann (1999) portray as “successful socialisation”. These changes stem from the proactive and creative thinking of social workers, who cease to be redistributors of services.

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## ***Exploring the content of blindness rehabilitation programmes in Lithuania: models and approaches***

### ***Abstract***

The field of research on blind and visually impaired services is broad, diverse, and dominated by empirical and interdisciplinary research. It is determined by the object under study, which includes a whole range of services, starting with social services and ending with personal health. On the other hand, the achievements of ophthalmologists in this field (compared to scientists in other fields) are significantly higher. However, it is noticeable in academic studies that NGOs must be professional and ready to provide more complex social services (research reveals that NGOs provide these services to the blind and partially sighted in about half of the world's countries). This article aims to conceptualise the social rehabilitation policy, legal regulation, and models of the blind and visually impaired in Lithuania. Scientific and expert literature analysis, semi-structured interviews, and case studies are used to achieve the goal. The current research found that a gradual development of services is necessary to increase the

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availability and effectiveness of rehabilitation services for blind and partially sighted persons. It is necessary to ensure the expansion of the service system to achieve the interoperability of health and social services. Systematic monitoring and evaluation become important to ensure the quality of such services.

**Keywords:** visual impairment, social rehabilitation, blind person, blindness rehabilitation programme, non-governmental organisations

## *Introduction*

Rehabilitation programmes and services for the blind and low vision are fairly widely studied in the field of interdisciplinary research, as revealed by meta-studies and general reviews (van Nispen et al., 2020; Binns et al., 2012; Ryan, 2014). Obviously, this is determined by the nature of the applied programmes or the services themselves. Most of the time, the problems with programme availability, content, application of individual measures, benefits for participants and other issues are raised and analysed by ophthalmologist researchers, less often by optometry specialists. On the other hand, the research field has notable publications authored by occupational therapists, psychologists, sociologists or social work researchers (Ravenscroft, 2019). It is noteworthy that hundreds of publications have been published in various approaches, on different topics, since 1986, when the modern model of visually impaired rehabilitation programmes was developed at an international conference (USA, Canada, and UK) supported by the American Foundation for the Blind (Markowitz, 2016). Similar content-responsive models have been developed for individuals with vision loss. On the other hand, both Samuel N. Markowitz, one of the leading research scientists in the field, as well as some scholars of the World Health Organization and other researchers emphasise that there is no best or evidence-based “gold standard” – Preferred Practice Pattern (Markowitz, 2016; Mogk, 2016).

Based on the publications summarising the research field, it can be observed that the following thematic directions are mostly examined: 1) the need for services and barriers that reduce accessibility (aspects of service financing, acceptability to clients, timeliness, etc.); 2) content of programmes (models, nature of applied interdisciplinary interventions and contexts, cases of their application); 3) benefits of provided services (projects, multi-annual programs, etc.) and their effectiveness; 4) rehabilitation programmes in personal health or social service systems (Ravenscroft, 2019; van Nispen et al, 2020; Binns et al., 2012; Ryan, 2014). It is difficult to find a clear research direction that combines service providers, compatibility with service systems (personal health, social), funding and the like. There are indeed quite a few individual studies but there are no groups connecting researchers at conferences or anything like that. Looking at the field of research, it is important to note that most studies are empirical in nature, based on a quantitative or qualitative research approach, however, there are also generalising studies.

The field of research on blind and visually impaired services is broad, diverse, and dominated by empirical and interdisciplinary research. This was determined by the

object under study, which includes a whole range of services, starting with social services and ending with personal health. On the other hand, the achievements of ophthalmologists in this field (compared to scientists in other fields) are significantly higher.

This article will contribute to the discussion of the concepts of social rehabilitation for the blind and partially sighted (concepts, contexts of their application), the conceptual approach of studies and the results of empirical research. A separate subsection will examine models of social rehabilitation service provision and their application. Such an analysis of concepts and empirical research will allow us to evaluate the achievements of scientists and experts, and existing concepts.

### ***Rehabilitation programmes for the blind and partially sighted in national public policies***

There are many questions for decision-makers about the effectiveness of programmes for the blind and visually impaired (van Nispen et al., 2020; Wallace et al., 2022; Virgili et al., 2022; Binns et al., 2012). Also, policymakers put questions about their effectiveness, from a cost-benefit perspective (Longo et al., 2020; Binns et al., 2012; Ryan, 2014; Patty et al., 2014). Finally, the question arises as to which executive authorities (ministries, departments, agencies) are responsible for rehabilitation and how services are delivered (Longo et al., 2020; Fontenot et al., 2018).

**Factors determining the choice of organisational model.** As the research shows, the responsibility for social rehabilitation programmes for the blind and partially sighted depends on complex factors: 1) the structure of state governance (federal or regional states have more pronounced differences from unitary states); 2) nature of public policies and service systems (health care, social, rehabilitation systems are sufficiently different); 3) regimes and traditions of legal services. In general, the institutions of the central government (how different it is in federal or what is referred to as regional states, e.g., in Spain, Italy) are responsible for a significant part of rehabilitation services. Thus, social rehabilitation programmes are part of health, social security or rehabilitation public service policies (they are integrated into health service systems more often, but inevitably overlap with social services) (Markowitz, 2016; Luu et al., 2020; Longo et al., 2020; Rabiee et al., 2015; Jaiswal et al., 2021). A significant number of countries do not have special rehabilitation programmes for the blind and partially sighted (e.g., based on multidisciplinary access or special psycho-emotional therapeutic programmes). Residents of parts of Europe can receive services that are an integral part of rehabilitation systems (LRS, 2022).

When examining organisational models of blind and partially sighted services (it is important to distinguish them from multidisciplinary team models here, which are related to interventions/services and their content), we can see that we are dealing with five different types (see data in Table 1).

**Table 1.** Organisational models of blind and partially sighted rehabilitation services

Organisational model	Main features and advantages and disadvantages
<b>Institutions controlled by state and subnational institutions, also called “in-house”</b>	<p><b>Key features:</b> Blind and visually impaired programmes are an integral part of systems (usually of integrated health care). Services are mostly provided by specialised rehabilitation service centres.</p> <p><b>Advantages:</b> More consistent integration into service systems, and better hierarchical coordination is possible. The state, regional authorities or municipalities monitor and control the activities of subordinate institutions and can change the directions of activities based on incremental decisions. Financing is directly linked to budgets or insurance funds.</p> <p><b>Disadvantages:</b> Procedures in institutions and institutions are sometimes bureaucratised, procedures are formalised, etc., i.e., it reduces the acceptability of the programmes. Several studies reveal that their costs are significantly higher than purchasing services from businesses or NGOs. Institutions of different areas of management and subordination have cooperation gaps, horizontal coordination is insufficient.</p>
<b>National blind unions (friendships, associations)</b>	<p><b>Key features:</b> Unions of the blind (membership-based NGOs) as accredited institutions take over separate rehabilitation programmes or carry out activities in this field on a project basis. The role of these organisations is greater in countries which have not developed service systems, e.g., in Central Europe and the Baltic States. Unions of the blind have created specialised support centres and specialists who can be used to provide rehabilitation services.</p> <p><b>Advantages:</b> Blind unions, as strong membership organisations, have accumulated considerable resources (members, hired staff, volunteer networks, sponsors, material assets) and developed systems of communication, self-help, and (often) professional services. Trust and support in society also come from interested actors. One of the benefits is the organisations’ networking and connections with their members and potential new programme participants. Specialists of blind unions have a good understanding of the complex needs of potential programme participants and their changes.</p> <p><b>Disadvantages:</b> Limited opportunities to provide a wider range of services, difficulties in cooperation with other organisations, and a lack of professional specialists.</p>
<b>NGOs (or more broadly NPOs, social economy enterprises)</b>	<p><b>Key features:</b> The model is implemented by financing the services provided by NGOs: 1) from foundations, NGOs or rehabilitation service support programmes; 2) after accreditation, providing for continued financing. In the USA, Canada, and some European countries, services are often provided by university clinics or specialist teams working in their vicinity. People working in the rehabilitation of the disabled or similar and having specialised centres are experts in this activity. In some countries, services are provided through community organisations.</p> <p><b>Advantages:</b> NGOs better assess the needs of the participants and their relatives and can choose more precise interventions and solve problems more quickly. NGOs can involve volunteers in their activities and are more flexible in terms of service delivery. They are more trusted. It is important in long-term or staged rehabilitation, where blind and partially sighted people</p>

	<p>receive some part of their services at or near their homes. NGOs are more creative in proposing interventions. They create cooperation networks in communities and with other organisations. NGOs can bring together multidisciplinary teams of professionals and provide organisational and other support. NGOs can raise additional financial resources from sponsors.</p> <p><b>Disadvantages:</b> Limited opportunities to provide a wider range of services due to specialisation (social and psychological consultations are provided more often), which can reduce the quality of services (it is more difficult to apply the model of multidisciplinary teams). Greater possible risk of non-completion or extension of services if services are financed through projects (pressure due to insufficient funding or increased costs).</p>
<b>Contracting-out model (and accreditation or certification to include business in service provision)</b>	<p><b>Key features:</b> Rehabilitation services are purchased from private clinics, specialised centres, specialist teams, etc. The contracting-out model envisages participation by NGOs and public institutions. Services are purchased based on established procurement legal procedures (organisation of tenders, evaluation of offers according to established criteria, conclusion of contracts) or based on accreditation models.</p> <p><b>Advantages:</b> The possibility of purchasing services in the absence of government agencies, NGOs, and the like. It is a common belief (there is not enough evidence, only a few studies support this) that this way is more beneficial (in terms of price and quality) to get the best value services.</p> <p><b>Disadvantages:</b> Contracting out does not provide certainty or strengthen specialised businesses or other organisations (especially in smaller countries). Some studies reveal that contracting-out increases the cost of services (according to several studies in the UK).</p>
<b>Individual rehabilitation model</b>	<p><b>Key features:</b> Individual services are provided by individual specialists on the basis of accreditation. This method is usually combined with others. Its advantage is attracting the necessary specialists.</p>

Source: OECD, 2015; EBU, 2018; Longo et. al., 2020; Rabie et al., 2016; Rabie et.al, 2015; LRS, 2022; Fontenot et al., 2018; Luu et al., 2020; Jaiswal et al., 2021

The most commonly used model is a government-controlled agency(ies) model, or it is combined with others, otherwise outsourcing service provision to NGOs, national blind organisations or businesses. The model of government-controlled institutions allows for complex and integral coordination of multidisciplinary teams and/or ophthalmic services (at all three levels in the health system – clinical, secondary, and primary). On the other hand, this model has its drawbacks. First, not all countries have integrated healthcare service systems or integrated social and personal health services. In addition, it is relatively expensive (for others, see: Table 1). Some studies reveal that national or regional blind and partially sighted rehabilitation programmes have significant coordination gaps, and lack good planning or sufficient funding (Swift et al., 2021; Jaiswal et al., 2021).

A more effective (admittedly, there is insufficient evidence) alternative can be considered the provision of services to the blind and partially sighted using the rehabilitation centres and teams of NGOs and national blind unions. As already discussed, they have experience (most national blind unions are more or less active in these areas) (EBU, 2018; review of web pages of 20 national blind unions). Their



accumulated resources, rehabilitation service centres or specialists, the trust of society and the disabled, and their work are or can become a prerequisite for effective cooperation. Furthermore, such collaborations respond to contemporary paradigmatic attitudes and values related to the ideas of public governance, service transfer/delegation, co-production, and co-creation (Dvorak, 2013; McMullin, 2022).

We should stop at one question, which way of involving NGOs or blind unions in the provision of services would be the most appropriate? In terms of conceptual access, the involvement of the blind union would correspond to the concepts of commissioning and co-production. The latter would mean that the organisation representing the blind and partially sighted provides services in cooperation with the authorities. As can be seen from scholarly publications, membership in institutions would make it easier to implement services (Park, 2020). Organisations themselves are both service providers and represent user groups, and such roles and interests can be useful for quality assurance. Research conducted in recent years reveals that these models of social care and mental therapy services are promising (Park, 2020). On the other hand, national organisations of the blind are very strong as NGOs and can provide quality rehabilitation services for the blind and partially sighted. This argument reduces doubts about the limited capacity and potential risks of such organisations. Social mission and representation of public interest can be singled out as another argument in favour of disabled NGOs as service providers. It is true that they partially represent the interests of their members, but at the same time, through their activities (often providing services to members or other beneficiaries), they also carry out a social mission.

However, even for large organisations, financial certainty and long-term service provision are important, as evidenced by empirical and conceptual ideas based on the New Collaborative Governance theory (Kekez et al., 2019; Loeffler, 2015; Sturgess, 2018). Commissioning services through accreditation (i.e., non-competitive provision under short-term or long-term agreements). Clearly, accreditation or similar models have been used in social services in most European countries, and their choice has been determined by established policy priorities (Wollmann, 2018; Erlandsson et al., 2013).

### *Research issues of rehabilitation programs: accessibility, acceptability, quality in national public policies*

**Service demand and its research.** Researchers, when starting an analysis, first notice that often, even in the richest countries, services are available only to a part of the visually impaired. This is determined by the extent of the need. Researchers estimate that around 10–30% of people require these services (reported data by researchers varies due to different methodologies for assessing needs) population and it is on the increase in Western societies (Cruess et al., 2011; Jaiswal et al., 2022; Ryan, 2014; Markowitz, 2016).

Bright et al. (2018) conducted a meta-study (examining data from 27 empirical studies) which revealed that access to services is low in all continents and especially in

countries with medium and low economic development. In addition, the researchers' study showed that services are more accessible to urban residents and groups of people with a higher socio-economic status. When explaining the reasons for accessibility, researchers explained it by several factors: lack of services (unavailability), transport, and unacceptability (no understanding of the importance of such services, etc.) (Bright et al., 2018). Similar research results have been obtained by other researchers who have examined accessibility and related issues in the rehabilitation of the blind and partially sighted (Lam & Leat, 2013; Kaldenberg, 2019; Matti et al., 2011; Fraser et al., 2019). After summarising all the research data, the following four limiting factors (also called barriers by scientists) can be distinguished (see: Table 2).

**Table 2.** Factors limiting rehabilitation services for the blind and partially sighted

Limiting factors	Presentation of factors
<i>Factors significantly limiting accessibility</i>	
<b>Accessibility</b> (service delivery gaps)	Waiting for service, no service.
<b>Awareness – acceptability</b> (gaps related to service recipient and social environment)	Low awareness and awareness, lack of perceived need (both by the potential client and their family/relatives), emotional fears, other priorities, side effects of illnesses, shame/stigma, psycho-emotional state, mistrust of service providers, stereotyping, and interactions with other individuals.
<i>Minimal limiting factors</i>	
<b>Geographical availability</b> (gaps related to service provider and/or service recipient)	Distance to the place of service, transport problems, lack of escorts.
<b>Quality</b> (service delivery gaps)	Discrimination and poor quality services, bad relations with suppliers, communication difficulties, and lack of skills of the service provider. Insufficient customer-oriented services. Insufficient coordination and other organisational problems.

Source: Lam & Leat, 2013; Kaldenberg, 2019; Matti et al., 2011; Fraser et al., 2019; Bright et al., 2018, Nguyen et al., 2008

Understandably, the most limiting factor in the availability of services is their absence (see: Table 2). As already discussed, in many countries such public services do not exist or are provided in a highly specialised and limited manner. This is a systemic problem that cannot be solved on organisational level and using operational solutions. Naturally, in such a case, it is necessary to address issues and change public policies. On the other hand, it is a certain space for blind and partially sighted representatives (NGOs, medical organisations, etc.) to act and try to influence decision-makers. Availability is also reduced by the limitation of waiting for the service. True, scientists do not agree on this limiting factor. Scientists, especially psychologists, believe that participation in rehabilitation programmes is individual and can be determined by psycho-emotional status, and negative effects of the social environment (e.g., after a sudden loss of vision, a large number of patients experience depression).

Patient awareness is another significant barrier (see: Table 4). Many research studies discuss why information does not reach target groups and what factors could help solve the problems. For example, studies in Western countries show that not all ophthalmologists, and nursing professionals (both in clinics and on the secondary level) are well informed and do not refer blind and visually impaired people to these programmes (Basiliou et al., 2019; Lam & Leat, 2013). A similar problem exists with general practitioners and their awareness of the potential support available to patients. Some studies have suggested that the problem can be solved by educating doctors and other medical professionals (Lam & Leat, 2013; Swift et al., 2021).

On the other hand, not all blind or partially sighted people are ready and motivated to apply for services and participate in rehabilitation programmes. A number of studies reveal that there is a notable gap in service delivery due to lack of understanding, misconceptions, and triggering stigma among patients and their relatives (Fraser et al., 2019; Jaiswal et al., 2021; Kaldenberg et al., 2019). In general, psychological factors that form barriers are quite numerous and they are significant enough. In this case, it is very important to get help and understanding from people who can help overcome the barriers of “fear” – doctors, psychologists, social workers and, of course, relatives. There are quite a lot of customer-related factors that lead to low motivation of service users and they affect some people in a complex way. Factor analysis requires attention from researchers and appropriate research.

An unfavourable social environment and other people’s attitudes are considered by scientists as additional obstacles. For example, a group of researchers led by Sarah Fraser conducted a qualitative study and concluded that stereotyping of others, and social stigmas limit participation in rehabilitation programmes (Fraser et al., 2019). Attempts are undertaken to solve these problems through public education and changing attitudes on the basis of information campaigns and more targeted informing of people. It is also said that proper counselling (proper explanation of benefits) can be an effective tool in increasing motivation to join a blind and partially sighted programme (Jaiswal et al., 2021).

Barriers to getting involved in programmes are not only factors of an individual nature or an unfavourable social environment but also related to the poor quality of services provided by service providers (see: Table 2). These factors are not critically important, but they are significant for some people who are blind or visually impaired. As research reveals, quality is primarily determined by failure to meet expectations due to complex factors (Jaiswal et al., 2021; Fontenot et al., 2018; Basiliou et al., 2019).

The quality of rehabilitation services is examined through several research approaches. As already discussed in the previous part, it is usually analysed in terms of the impact on the patient, introducing the criteria of impact on vision-related quality of life and health-related quality (Binns et al., 2012; Luu et al., 2020). This approach is also called post-intervention, where quality is understood in a complex way (includes a whole group of factors: physical, social, functional, psychological) and examines quality in terms of effects on behaviour and health. In this perspective, research optometrists and ophthalmologists use special questionnaires and research methodologies (Selivanova et al., 2019). This approach aims to holistically measure the pre- and post-engagement characteristics of programme participants. Also, on the basis of these research concepts, the effects of close people are also examined.

**Visual impairment and interpersonal effects.** Some researchers (mostly psychologists, and ophthalmologists) focused on the topic of the effects of blind or visually impaired relatives (Mamali et al., 2022; Lehane et al., 2017; 2018). These studies partially cover the themes of help, and coping with disability by relating them to the involvement of people with visual impairments in rehabilitation programmes. For example, a team of Danish and Canadian researchers led by Freideriki Carmen Mamali (2022) examined several topics in a qualitative study: 1) the changing life contexts of a visually impaired person and their loved ones (spouse, children, subjects) while living together (new challenges and problems, difficult emotional condition and disorders, communication problems); 2) adjustment and readjustment to new problems by creating coping strategies and accepting or rejecting help. Importantly, researchers examine coping strategies in relation to effective help from loved ones for the blind, using several concepts: 1) accepting and rejecting help; 2) positive and negative support (van Nispen, 2016; Mamali et al., 2022). The findings of other researchers show that relationships between loved ones after major visual impairments are affected by complex factors, and it is quite difficult to evaluate all of them by operationalisation (van Nispen, 2016; Mamali et al., 2022). After examining the literature, it is important to distinguish the main categories that can help clarify the emotional and social dimensions which comprise the interactions of loved ones (see: Table 3).

**Table 3.** Interactions between the blind and partially sighted and their relatives as well as their implications for rehabilitation programmes

Conceptual dimensions	Categories and subcategories
<b>Problems and challenges with vision loss</b>	<i>Psycho-emotional effects</i> (frustration, depression, tension, isolation, etc.); <i>reduced activity and social limitations</i> (orientation – mobility, reading, travel, sports, job loss, mobility, isolation, communication difficulties); <i>reactions of other people</i> (little understanding, stereotyping, others do not adapt, discrimination, family members doubt the disabled person's ability to adapt); <i>feeling of loss of one's self</i> (loss of self-esteem, being treated as less capable).
<b>Support and coping</b>	<i>Assistive measures</i> (assistance with the application of technical measures). <i>Social support</i> (finding positive optimism, deciding to live a quality life, gratitude, learning experiences after losing sight). <i>Recognition</i> (help in coming to terms with visual impairment, raising self-esteem, ...). <i>Avoidance and denial</i> (avoidance of acknowledging the effects of disability on self and others; failure to recognise limitations; avoidance of situations that will reveal disabilities). <i>Strategies for overcoming problems</i> : 1) support in order to receive services (vision rehabilitation, family counselling, support and services provided by the state-municipalities); 2) social support (emotional support and daily care of family, friends and other people with vision loss).

Source: van Nispen, 2016; Mamali et al., 2022; Lehane et al., 2017

Analysing the data presented in Table 3, it can be observed that the involvement of a blind or partially sighted person in rehabilitation can be determined by an active relative (family members, friends) but can also become a limiting factor. Researchers have studied extensively how effective the involvement of relatives in coping strategies for a blind or partially sighted person is. Effective support mechanisms related to finding information, counselling, motivation, etc. are established. Research reveals that unexpected blindness or severe low vision places a significant burden on families and solving the problems requires the cooperation of all family members. In this case, blind relatives are the main source of coping with the disability and managing strategies can be coordinated according to it (Mamali et al., 2022). On the other hand, spouses, children, parents, and friends can act as mediators.

### *Data and research methods*

The article is based on a case study of Lithuanian blindness rehabilitation policy. At the same time, the conceptual basis of the study is based on the concepts of public management (reforms of public services, transformations of applied models, public policy formation process) and evaluation of social rehabilitation programmes (barriers to rehabilitation services, family involvement in rehabilitation, adequacy of rehabilitation activities).

During the research, the following methods were used: literature analysis, case study, and semi-structured interview. *Analysis of scientific and expert literature:* we conducted scientific literature to determine the concept of rehabilitation services for the blind; updated the classification of blind and partially sighted rehabilitation programmes in national public policies. *Semi-in-depth structured interview:* semi-structured interviews were conducted to analyse the attitudes, experiences, and performance of the research participants. Targeted sampling was chosen for the study by predicting categories of informants. The aforementioned choice was based on several grounds such a sampling: 1) responds to several different topics included in the study; 2) responds to conceptual access; 3) is frequently used in service provision research for the blind and visually impaired (Rapley, 2014; Colorafi & Evans, 2016). The data collected in the semi-structured interview is taken from a larger study and used here in this study to support some of the arguments. The number of respondents is not presented separately, because the method of individual interviews was not used exclusively for this research. We asked the respondents pre-prepared questions. However, some questions were rephrased or additional questions were asked. *Case study:* we chose the case study method for empirical research because, according to Yin (2009), a case study is an empirical inquiry that examines contemporary phenomena in a real-life context, when the boundaries between the context and the phenomenon are unclear. Blind rehabilitation programmes as research objects have a project structure, which means that the research object is constantly changing, something disappears, and new elements appear.

## ***Social rehabilitation of the blind and partially sighted in Lithuania: policy, legal regulation, and models***

In order to better understand and reveal the rehabilitation policy for the blind and partially sighted in Lithuania, this chapter will examine the goals and assessments of this policy, examine the existing legal regulation, allocate financial resources and describe the service delivery model.

**Policy objectives.** In Lithuania, the rehabilitation policy aims to include disabled people in society, ensuring a higher quality of social life in the community. Lithuania is obliged to develop this policy on the basis of ratified treaties (UN Convention on the Rights of Persons with Disabilities) and on the basis of European strategic documents (LRS, 2010). These documents determined one of the directions of state policies – ensuring sustainable and fair access to rehabilitation. National strategies for the integration of the disabled, legal acts (Law on the Social Integration of the Disabled), and the programme documents implementing them (the Action Plan for the Social Integration of the Disabled 2021-2023) identified the main goals and principles (SOCMIN, 2020; LRS, 1991).

Without delving into the general principles and goals of the integration of the disabled, it can be seen that the Lithuanian state's policy for the disabled aims to: form or restore their social and independent life skills, help them acquire education, ensure opportunities to participate in public life, and the labour market (LRS, 1991). The National Action Plan for Social Integration 2021–2023 details these goals and stipulates that the state's objective is to: *ensure the continuity of the implementation of social integration measures for the disabled, implement new measures necessary to include the disabled in social life, encourage state institutions to cooperate with non-governmental organisations working in the field of social integration of the disabled.* In this policy, the state emphasises cooperation with NGOs specialising in the aforementioned management area. This corresponds to the priorities of the 18<sup>th</sup> Government (led by Ingrida Šimonytė) related to the transfer of social services and adequate financing (Item 93.2 of the Government Programme) (LRS, 2020; LRV, 2021).

One may wonder what area of government social programmes for the blind and partially sighted belong to. As discussed earlier, in some countries blind rehabilitation is classified as personal health management because it involves medical service interventions. On the other hand, it is determined by the specificities of national health and social security systems and the management responsibilities of their overlapping areas. In Lithuania, social rehabilitation services for the disabled are a subsystem of the social integration system of the disabled (Valstybės kontrolė, 2020).

**Institutional responsibility for the implementation of the social rehabilitation policy for the blind and partially sighted.** This policy is implemented by the Government of the Republic of Lithuania, based on the Ministry of Social Security (SOCMIN), as the institution responsible for the management area (LRS, 1991; Valstybės kontrolė, 2020). SOCMIN organises and coordinates the implementation and controls the implementation of the social rehabilitation policy (LRS, 1991). The Department of Disability Affairs (DDA) subordinate to the Ministry, with the help of other organisations and associations of the disabled, is responsible for policy implementation



and administers programmes and their measures, and projects (LRS, 1991). It should be noted that disabled people's associations are understood as actors of policy implementation and have a clearly defined status. In addition, Article 7 of the Law on the Social Integration of the Disabled defines and clarifies the possible functions of the associations of the disabled: represents the interests of the disabled, helps implement measures and projects for the social integration of the disabled: *organises the provision of social rehabilitation services for the disabled, recreation for the disabled, sports, tourism, cultural activities, international cooperation. When organising their activities, associations of the disabled cooperate with state and municipal institutions and can receive financial support from these institutions and institutions* (LRS, 1991). The norms of this article presuppose and specify the fact that the state grants disabled associations the right to provide public services (they are legalised actors of the integration policy and social rehabilitation system of the disabled). Such a system and roles could be determined by the historical context of 1991. At that time, some of the disabled organisations were significant service providers due to the available capacities and a large number of subordinate companies and institutions, as well as concentrated specialists. However, later (2016–2022), the concept of association of disabled people is no longer unused in the accompanying orders of the Law on Social Integration of Disabled Persons, adopted quite recently (SOCMIN, 2020; 2021).

**Objectives, model and organisation of comprehensive social rehabilitation services for the blind.** The rehabilitation service policy for the blind and partially sighted (with severe visual impairment; RA less than 0.05) was introduced in 2017. The provision of services (what is called trainee programme) is defined by the description of the procedure approved by the order of SOCMIN (SOCMIN, 2017). The purpose of this policy is *to restore, develop, and consolidate spatial orientation and independent movement (mobility), daily life, and communication skills, increasing their independence and opportunities to participate in public life* (SOCMIN, 2017). The goal defined by the legal act foresees the desired results – improvement of the quality of life of the blind and partially sighted through the formation or consolidation of abilities and skills. It also defines an expectation that changes behaviour and allows participation in social life. It is also important that service integration is defined using a team of professionals and a holistic approach to integrate a number of interventions. On the other hand, the goal definition does not include ophthalmic and optometric care services as recommended by WHO, authoritative ophthalmological associations, and numerous studies (as discussed, although there is no “gold standard” for such programmes, a number of recommended models have been developed). This is a significant shortcoming and potentially limits interventions. In the interview study, the informants explained that the gap arose due to the fact that there is no way to systematically integrate personal health and social services in Lithuania due to the closedness of management systems, institutional interests, and deficiencies in management coordination (interviews with INF12; INF17).

Moving on to the analysis of service provision procedures, it should be noted that complex social rehabilitation services for the blind are organised, supervised, and controlled by DDA. The created legal regime provides that the aforementioned services are provided in accordance with the Law on Public Procurement (SOCMIN, 2017).



The procedures established by the order of the Minister of Social Security and Labour also determine rehabilitation interventions for the blind, which include: 1) orientation in space and development of independent movement (mobility); 2) development of everyday skills; 3) the help of a medical psychologist; 4) professional counselling and guidance. According to the established procedures, these services must be provided by a team of five specialists, including social workers, medical psychologists, special educators, and computer literacy specialists (SOCMIN, 2017). The work process is also defined according to the established procedures. It includes assessment of complex needs, planning, and delivery of interventions. The procedures established by the legal act provide that the multidisciplinary team should work in a coordinated manner under the guidance of a designated manager.

The complex social rehabilitation service is small in terms of its scope (see: Table 4). Relatively few blind people participate in it (an average of 18 disabled people). Relatively little time was devoted to work with the blind and partially sighted (2,781 hours, mostly devoted to spatial orientation and independent movement and the development of daily skills). By the way, these services were provided in specialised service centres (see: Table 4).

After completing the services, the blind cannot continue to receive complex social rehabilitation services for five years and can participate in the new programme only after five years (this is partially compensated by LBU using its territorial networking and the work of specialists, branch chairpersons) (Interview 3 focus group; SOCMIN, 2017). This does not ensure the continuity of the service and greatly reduces its availability to people in need (e.g., due to the decreasing residual vision).

The empirical material reveals that three organisations provided comprehensive social rehabilitation services for blind persons (see: Table 4). The state-controlled institution – VšĮ Valakupių rehabilitation center (Kaunas branch) won the procurements twice and provided the services. The rights and obligations of this owner are implemented by DDA.

**Table 4.** Provision of comprehensive social rehabilitation services in Lithuania in 2017–2022

Year	Service provider	Type	Number of participants	Scope of services, hours	Financing, thous. EUR.
2022	LBU southwest centre	NGO, Organisation of the disabled persons	22	2,392	32
2021	LBU southwest centre	NGO, Organisation of the disabled persons	18	2,104	40
2020	VšĮ Valakupių rehabilitation centre	State-controlled, owner rights DDA	21	2,713	40
2019	VšĮ “Vilties žiedas”	NGO, NPO, social enterprise	15	3,554	21
2018	VšĮ “Vilties žiedas”	NGO, social enterprise	16	3,564	21
2017	VšĮ Valakupių rehabilitation centre	State-controlled, owner rights DDA	18	2,361	21

Source: LASS, 2022b; SOCMIN, 2022

VšĮ Valakupių rehabilitation centre is one of the largest providers of social services. It specialises in providing a full range of services – medical and professional rehabilitation, social care, and nursing services for seniors, the disabled, people with poor health and families (VšĮ Valakupių reabilitacijos centras, 2022a). This institution has employed 102 employees and provides services in several service centres. It received 128,311 euro of income for the provision of rehabilitation services. (VšĮ Valakupių reabilitacijos centras, 2022b). After reviewing the positions of this service provider in the rehabilitation services industry, it can be seen that it is not a specialistic institution and it does not work exclusively with disability groups. On the other hand, it has service centres, general competence specialists (medical, social field). This institution participated in the public procurement competition in 2022. It would be interested in continuing to provide services, as it has a service centre and specialists (a clarifying interview with the head of the VšĮ Valakupių rehabilitation center).

NGO “Vilties žiedas” (legal form Public Entity; shareholders – two private individuals) is another institution that participated in public procurements and provided rehabilitation services to the blind after winning several times (see: Table 4). This institution has the status of a social enterprise and provides vocational rehabilitation for the disabled, vocational training, provides social services, and manufactures and adapts orthopaedic devices. It received an income of 1,064,110 Euro in 2021 (no income from social rehabilitation was received) (VšĮ “Vilties žiedas”, 2022a; 2022b). By its very nature, it is a social (or social economy) business enterprise, and this is revealed by its declared social mission. VšĮ “Vilties žiedas” has accumulated considerable experience working with disabled persons. However, social rehabilitation is not, as publicly published reports reveal, a permanent area of activity for this company. The aforementioned institution faced difficulties in forming a multidisciplinary team of specialists for work with the blind, as the interview material reveals (interviews with INF10; INF14).

LBU also participated in the provision of complex social rehabilitation services (see: Table 6). This union of the blind and partially sighted (with approximately 5,425 members) entered with a considerable track record of project activities and service delivery. It has both a service delivery centre (the LBU southwest centre of the public entity, which is one of the three regional institutions under LBU) and a multidisciplinary team. In addition, LBU cooperates with the Palanga recreation and rehabilitation centre “Pušynas” (an institution under the Ministry of the Interior), where its members and other people with visual impairments receive medical and social rehabilitation services (social typhlopedagogical assistance is provided by a specialised employee). A fairly large number of blind people received services here (in 2020 – 21, in 2019 – 46; in 2021 – 38) (LASS, 2022c). It is true that this is not the programmatic provision of public services but works with clients according to their needs (LASS, 2022c; 2021). In 2021–2022, two LBU specialists provided mobility skills development services for the blind throughout Lithuania (outbound services are financed by DDA, with support through the funding instrument for supporting disabled associations) (NRD, 2021; LASS, 2022d).

The organisational model of providing social rehabilitation for the blind and partially sighted was one of the main themes of the qualitative research. While

examining it, it was explained what the experts' views are. Most informants (both LBU representatives and experts) prioritised the accreditation model (see: Table 5). True, at the same time, the opinion was clearly expressed that after the accreditation of LBU or another NGO with the transfer of services, financing that meets the needs of disabled people and continued financing according to objective criteria should be ensured. On the other hand, some informants noticed that LBU can also provide services by participating in public procurements because the quality of their services is higher (the truth is that, as examined, it is faced with more than one limiting factor) (see: Table 5).

**Table 5.** LBU contributions and activities in providing complex social rehabilitation services and ensuring their continuity

Roles	Quotes from participants	Guidelines for the development of an organisational model
<b>LBU representatives</b>	<p><i>We are still in the process of deciding which model we want which laws should be changed and which sources of funding should be available. When we clear up, then maybe we will discover what we want, what we expect [...] Because until now, LBU itself wants to do that. There was an attempt to give it to the state but it turned out that it would happen during public procurement. It was thought that maybe some rehabilitation institution would get involved and do it well. However, we have come full circle and come back to this model. We want to make a reasonable proposal to the state so that there will be opportunities to enter one or the other in the law so that funding will appear for one or another institution to do so, and so that a system will appear (Focus group 3).</i></p> <p><i>Well, now is better than nothing. The department [DDA] understands that there will be quality here because of the participation of the LBU centre and they can do to win. Because it is always based on quality. The Finns are also following the path of competition. That's what I asked them, that's how you win them. They answered that we provide such quality services that others cannot compete with us. But, they say, we noticed that another organisation is emerging, which has already accumulated (interview with INF12).</i></p>	<p>1) The vision for the development of the blind and partially sighted system and the choice of ways to realise it (related not only to LBU involvement but also to members and public interests); 2) the most sustainable ways of financing rehabilitation services and compatibility with the service delivery model are sought with state institutions; 3) investments are made in the provision of social services in communities to ensure the highest possible quality of consultations and other services; 4) in the complex model of providing social rehabilitation for the blind, the social rehabilitation model is preferred (based on interviews with INF10; INF11; INF14; 3 focus group opinions).</p>

<p><b>Experts</b></p>	<p>[...] My basic position is that NGOs should get involved and provide social, and social rehabilitation services. But everything happens systematically and there are areas where NGOs have a network throughout Lithuania. If NGOs have their network, they can be trusted to provide services at the national level (interview with IDV16).</p> <p>When NGOs are systematised, when there is a very clear algorithm, some kind of service structure and allocated resources, there is nothing for state and municipal institutions to do in the service sector. Then all resources are attracted by NGOs, starting with members and volunteers. And when NGOs work, they become a community together with service recipients. It seems that this could also be the case with LBU (interview with IDV17).</p> <p>Now it is hard to say. After all, now, NGOs can participate. After that, there are evaluations of project proposals and some win and some don't. And the one who provides the best, highest quality services does not necessarily win. Be aware that there is a question of which model is better. It is also effective to give accreditation to one NGO to make the system work. Similar to the case of the supportive care service. Then it was aimed to create such a model so that the system would work [...] I don't know, but if there are strong associations like LBU, for example, then maybe it would be more useful. Maybe it would be better than this kind of practice, where different organisations always win competitively. Lithuania is not big and everyone knows each other, and they don't want other organisations to start learning (interview with IDV12).</p> <p>Regarding monopolisation, your first part question. Even in vocational rehabilitation, different organisations and their capacities are ambiguously evaluated. The same is true of the foster care system. There are suppliers who are not trusted and the state does not enter into a contractual relationship with them. On the other hand, I would say there is also a disadvantage to the first step. We need to start taking that first step and talk to the ministry with LBU, as a partner, not as an executor who we suspect is doing something wrong. Because that relationship is like this, first the money is shared, and then the control is carried out. But there is a lack of such</p> <p>1) LBU is accredited for 3–5 years (making it possible for other NGOs to enter the service provision sector later); 2) a sustainable funding scheme is agreed ("uncut" allocations for the service facility after a year, and increased according to reasonable need); 3) a quality objective algorithm for determining the need is created, quality supervision is ensured; 4) assumptions are made for higher quality of services; 5) relations between institutions representing the state interest and LBU are based on trust; 6) politicians remain aware and leave room for criticism that LBU carries out on behalf of the blind and partially sighted (based on interviews with INF12; INF16; INF17; INF13; opinions of experts who participated in focus group 3).</p>
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<p><i>a serious, high-quality discussion about what is important for the system, and how the system needs to be developed. Such a reflective relationship is missing or very little (interview with IDV17).</i></p>
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Informants, considering the importance of choosing an organisational model of services, also saw the need for a comprehensive restructuring and to include such elements in the entire rehabilitation system for the blind as 1) development of complex social rehabilitation services for the blind in stationary centres ensuring greater accessibility and continuity and quality (higher competencies of multidisciplinary teams, medical involvement); 2) provision of professional services in communities or clients' homes (systematic funding of mobile teams and wider involvement of competent professionals) (see: Table 5). It was also noted that LBU, with its resources and networking, could complement the system through consultation and other assistance from members and others.

After analysing the opinions, the proposals of LASS representatives and experts who participated in the study were summarised, and how the organisational model can be improved. These were then compared with research evidence and recommendations based on it. It would be important for state decision-makers to 1) provide for the gradual development of services by ensuring greater accessibility and effectiveness of rehabilitation services (both in homes for the blind and visually impaired, closer to the place of residence, and in professional centres). Make services available not only to blind but also to other visually impaired persons; 2) expansion the service system (ensuring the continuity of social rehabilitation; provision of interoperability elements of health and social services); 3) transition to LBU accreditation for 3–5 years under a trust-based arrangement (making it possible for other NGOs to enter the service sector later); 4) quality monitoring and evaluation is created and thus the prerequisites for higher service quality are created; 5) expansion of the multidisciplinary team by integrating doctors (optometrists and possibly ophthalmologists) and supplementing the mobile team with specialists of other specialisations (according to individual needs).

## Conclusions

After analysing the organisational models of blind and partially sighted rehabilitation programmes, it was observed that four main organisational models are applied – institutions controlled by state and subnational institutions, national blind unions, transfer NGOs, and public procurement. The most commonly used model is a government-controlled agency(ies) model, or it is combined with others, otherwise outsourcing service provision to NGOs, national blind organisations or businesses. This model has a number of advantages (more consistent integration into service systems is possible, better hierarchical coordination; financing is directly linked to budgets or insurance funds), but at the same time, there are also significant disadvantages. State, regional or municipal institutions are too integrated into health

care systems (not all of them include social services), sometimes inflexible and expensive. A more effective (admittedly, there is insufficient evidence) alternative can be considered the provision of services to the blind and partially sighted using rehabilitation centres and teams of NGOs as well as national blind unions. Their accumulated resources, rehabilitation service centres or specialists, the trust of society and the disabled, and their work are or can become a prerequisite for effective cooperation.

Concluding the analysis of rehabilitation service providers, it should be noted that the public procurement model has faced some competition between service providers. Some public contracting theorists and proponents of neoliberal ideology (or public management doctrine) argue that it was to reduce cost and ensure higher quality (Greve, 2007; Hodge, 2018). On the other hand, empirical studies based on meta-analyses do not confirm the correlation between the purchasing model and lower service prices (some utilities have a lower price) and higher quality (no effect) (Hodge, 2018; Petersen et al., 2018). As shown by a meta-study by Danish researchers, service purchases do not usually reduce the price of the service (Petersen et al., 2018). Examining the procurement model, one can notice another factor that could potentially lead to opacity and reluctance to change the service delivery model. The organiser of the blind and partially sighted policy is the DDA. It also purchases the services in question. At the same time, the department is also the founder of VšĮ Valakupių rehabilitation centre. This may lead to several potential risks: 1) reluctance to change the model and transfer service provision to NGOs outside of public procurement; 2) possible interest in supporting a subordinated and controlled institution; 3) less attentiveness in monitoring and evaluating the service provision process and results. In addition, through the relationship of indirect subordination, VšĮ Valakupių rehabilitation centre falls under the management area of the Ministry of Social Security and Labour and may influence the interests of the policy maker (e.g., support state-controlled institutions in this steering area).

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***Towards community psychiatry.  
The effects of the implementation of the pilotage  
of the Mental Health Centre in Wrocław,  
with particular emphasis on non-medical  
forms of therapy and support***

***Abstract***

This article deals with the issue of paradigm shift in an important area of health policy, which is the mental health care system. Despite the beginning of changes towards the transformation of the model of care, from one based on solutions characteristic for the asylum model to community psychiatry already in 1996, through the adoption of the Mental Health Protection Act, and then subsequent National Mental Health Protection Programmes, in practice, until 2018 no comprehensive real attempts have been made to transform this system and move away from the dominance of hospital treatment in favour of solutions characteristic of community treatment. The preparation and commencement of pilot projects under the programme for the preparation of social innovations financed by the European Union was the first systemic attempt to develop solutions that fully meet the European standards of deinstitutionalisation of support

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and treatment of people with mental problems and diseases and to fully implement these models in practice along with integrating them with existing solutions under the public health insurance system.

**Keywords:** community psychiatry, social innovation, efficiency of the institution

## *Introduction*

The article, based on the case study methodology, will show the process of reform of the Polish mental health care system after introducing changes and acceleration, after years of stagnation, in 2018. Its reform, although initiated shortly after the fall of communism as part of the ongoing political transformation, stalled for over three decades. As a result of the Act on Mental Health Protection adopted in 1994 and changes to other legal acts, including the Act on Social Assistance, psychiatric hospitals could discharge people who did not meet the legally defined absolute grounds for hospitalisation (posing a threat to one's own life, or other people). As part of the social assistance system, daytime community self-help homes were also created to provide support and social rehabilitation to people who had previously been subject to hospital treatment. Due to the lack of political will and the weakness of civil society institutions, resulting in a lack of advocacy for the rights and interests of people with mental illnesses, the process of change has been stalled, even though subsequent mental health protection strategies adopted assumed a thorough change in the direction consistent with the community-based treatment model. It was only the assessment of the state of the public psychiatric treatment system made by the main evaluation and control institution of the Polish system (Supreme Audit Office, 2016), which revealed that the activities related to the implementation of the ending National Strategy for Mental Health Protection were complete mockery. It assumed the reconstruction of the system from one based on inpatient treatment to the environmental model and the increasing power of patient organisations, as well as the growing awareness of the growing crisis in this area of treatment, which is strongly reflected in the media, resulted in a cross-party consensus around the need to introduce quick and radical changes in psychiatry, and the ruling team treated the reform as a priority. It was decided to make up for years of neglect in a short time, which resulted in general chaos at the stage of preparation and implementation of system changes. At the first stage, the government decided to use funds from the European Social Fund to develop the target model of the Polish psychiatry system. The Ministry responsible for managing European funds, in consultation with the Minister of Health, held a competition for the development and testing of community treatment models, in which the most active entities dealing with psychiatric treatment, including non-governmental organisations, participated. The recruitment formula required building partnerships composed of medical entities and organisations operating in the field of social services. The key assumptions and effects of implementing one of the presented models will be presented in this article. Shortly after the start of the reform in the above formula, the Ministry of Health decided to implement its own, alternative pilot project based on principles common to all entities, which were

specified in the government regulation of 2018. The solutions adopted by the regulation completely changed the method of financing psychiatric treatment, replacing fee for service with a fixed lump sum per population. Thus, one of the main reasons for keeping patients in hospital wards disappeared (no one paid for an empty bed, so avoiding hospitalisation meant that the often very bad financial situation of Polish psychiatric hospitals would worsen). However, apart from the revolution in the method of financing and the forced reduction of the waiting time for admission of urgent cases to a maximum of 72 hours from notification, the law did not force radical changes in the way patients were treated. Additionally, access to this second pilot programme signed by the Minister of Health was limited only to hospital entities. As a result, innovative solutions were tested in the first announced pilot based on ESF funds and principles, where the origin of the funds forced the compliance of the developed solutions with European Union policies, in particular, the deinstitutionalisation strategy mentioned above. The first results of the Ministry of Health pilot implementation showed very poor results in terms of qualitative changes. Hospitalisation has decreased very little, and hospitals have not started a voluntary transformation towards community psychiatry standards, which, in fact, have not been included as a standard in government regulations or in contracts with the national payer for health services, which signs, finances and controls them. Currently, due to the completion of innovative projects financed by the ESF on a Polish scale, the solutions used in Mental Health Centres (Centrum Zdrowia Psychicznego, CZP) have been introduced to the operating standards of CZP centres, consistent with the spirit of community psychiatry and the assumptions of deinstitutionalisation of psychiatry in the EU. The community psychiatry model discussed in this article was tested in 2019–2023 in Wrocław (Wrocławskie Centrum Zdrowia, 2017). The model was developed and applied in the form of a project implemented in partnership since 2019 by the leader, a medical entity that was already the largest provider of non-hospital mental health services in the Lower Silesia region – Wrocław Health Centre (Wrocławskie Centrum Zdrowia, WCZ), and partners – non-governmental organisations, municipal organisations, structures social assistance in Wrocław.

Due to the current routine of the mental health care system in Poland, which boils down to the extreme medicalisation of the therapeutic process and the lack of social therapy (Wciórka, 2000), these forms are associated primarily with the so-called social support, which hides various new institutions (services, benefits) based on organising non-medical resources in the process of therapy of people with mental illnesses and problems. In addition, as a result of the involvement of non-medical resources, there are a number of innovations related to the change in the organisation of the support process consisting primarily in the large-scale introduction of coordination and integration of various activities (services) including the creation of multidisciplinary teams, as a result of which some due to the incorporation of social resources, services that have so far been strictly medical gain a more complex, somewhat „hybrid” medical-social character. Within the framework of the discussed project, support consisting in comprehensive therapy was provided to over two thousand people with experience of mental illness or mental disorders; women predominating among them, constituting about 60% of project patients. In medical terms, the necessary condition for participation was to have a diagnosis in the F00-F99 range, excluding addictions.

### *Theoretical aspects and methodology of the study*

The assessment of the solutions constituting community psychiatry as a de facto current and currently not questioned, both in theory and practice, a paradigm of approach to the therapy of patients with mental problems took place in individual countries over a dozen or so years after implementation of the solutions replacing the ones constituting a negated asylum model, both due to the criteria of therapeutic effectiveness and ethical considerations. These results quite clearly indicated not only a decrease in the number and duration of hospitalisations (Tansella, 1986) but also a gradual improvement in the mental well-being of the population, including a significant decrease in the number of suicides (Vichy, 2010). The main problem was not whether the remnant, atrophying asylum model should be replaced but how to effectively implement it quickly and how to properly assess it. Of course, there were disputes in both theory and practice, still they concerned not whether but how deeply to reform the psychiatric system. Whether we should strive to completely marginalise hospital treatment and pharmacotherapy, including the most serious diseases, such as schizophrenia, as exemplified in the disputes surrounding the Finnish experience in the Western Lapland region (Seikkula, 2011)

The article was developed on the basis of the analysis of existing data. As a result, by merging the existing and available data in the research process the previously dispersed data is integrated in the analysis process, which will ensure the acquisition of the desired information and drawing conclusions regarding the subject of the analysis. For the purposes of the assessment the following were used in particular: questionnaires completed by persons qualified to participate in the project (patients) and members of their families and relatives of the participants; the questionnaires were completed three times during the therapy of a given patient: immediately after admission to the project, and before starting therapy, during therapy and after its completion. Completing the surveys was neither obligatory nor based on random or purposeful sampling, so we cannot talk about representativeness in the statistical sense. However, the high percentage of patients who completed the surveys allows us to conclude that the answers provided are likely to be representative of all project beneficiaries:

- data on the socio-demographic characteristics of participants and statistical data
- application for project co-financing,
- project implementation reports,
- change sheets for the model,
- data on the implementation of project indicators,
- documents produced for the external evaluation, including CAWI interviews with project staff.

As part of a two-stage study, computer-assisted surveys were conducted with 37 members of the project staff representing the leader (26 people) and partners (11 people). The study was carried out after two years of implementation and completion of most project activities; activities not covered by the pilot programme of the Ministry of Health (Regulation of the Minister of Health of 27 April 2018..., 2018) were still being implemented, for which the project was extended in this part until



mid-2023. In this case, the study covered, by assumption, the entire population of direct project implementers (psychiatrists, psychologists, psychotherapists, social workers, occupational therapists, and nurses). Due to employment fluctuations, absences, and other random factors, not all direct implementers of the project participated in the study during its implementation, however, the participation rate in the study in relation to the size of the entire population defined in this way was approximately 75%. In addition, the materials collected by the author during the participant observation were used, in the form of notes from the meetings of the project management team, meetings regarding the monitoring of the project implementation, including meetings devoted to the analysis of the adopted solutions and the assessment of the proposed modifications to the model. The above data sources contained extensive empirical material, both qualitative and quantitative, enabling the assessment of the model elements mentioned in the previous part of the article and drawing conclusions regarding the proposed innovations and, indirectly, the entire model. During the whole project implementation period, the author performed a strategic management function, making key decisions, which resulted from the role he played in the entire organisation implementing the project. The author was not directly involved in its implementation, nor did he receive any additional financial rewards from it.

The aim of the research was to verify the effectiveness of the model previously developed at WCZ in cooperation with the Wrocław City Hall, which, in accordance with the acts on municipal and district self-government, is responsible, among others, for meeting the needs of the local community in the field of health care and organising the social assistance system. Due to the fact that the innovative solutions in the field of health and social services implemented under the Model were closely modelled on solutions used for years in other countries which had previously transformed mental health care. It was assumed that the implemented solutions would be characterised by high therapeutic effectiveness and positive patients' opinions. At the same time, it was hypothesised that the attitudes of staff and patients may be a factor that reduces the effectiveness of the model. In the case of staff, it may have resulted from adaptation to functioning under the existing system. This factor, as a significant risk to the success of the project, was managed at the staff recruitment stage and through cyclical training (e.g., on the use of ICF in the treatment and rehabilitation of people with mental problems) and study trips to leading psychiatric centres (Trieste and Verona in Italy). In the case of patients, this could be due to the more conservative orientation of patients and attachment to existing forms of support, which often accompanies mental illnesses, and the reluctance to make quick changes in this area, which would result in relatively more frequent refusals to use new forms of support and relatively greater stress related to participation in the pilot, especially in the initial phase of therapy.

The opinions expressed by the staff and participants regarding the most important aspects of their patients' functioning were adopted as indicators of the overall assessment of the model:

- health condition,
- quality of social relations,
- the level of professional activity,
- direct assessment of individual forms of support.

Due to the limited space of this article the assessment regarding many aspects will be signalled briefly. A detailed discussion of all aspects that make up the overall assessment of the project would require a more extensive formula.

*Model characteristics.  
Innovation of the Mental Health Center  
with particular emphasis on social services*

The project was implemented under Measure 4.1 of the Operational Programme Knowledge Education Development dedicated to social innovations (Ministerstwo Infrastruktury i Rozwoju, 2014). Its aim was to develop and test a model of treatment organisation in the area of mental health that would provide comprehensive support, and quick help (without waiting in urgent cases) and would be complementary to the existing system solutions, both in the field of health care and social services functioning in the social assistance system. Due to the competition requirements (Ministerstwo Infrastruktury i Rozwoju, 2014), the model had to be innovative at the organisational, product, and process levels. In each of these usually distinguished dimensions of innovation, the essential component that made it possible to exist was the inclusion of various social institutions, in particular, related to the person's living environment, in the therapeutic process of people with mental problems and diseases. The postulate of integrating medical and social activities has been present in strategic documents which are to define the shape of the system for many years (Regulation of the Council of Ministers of 28 December 2010... , 2011), however, until the start of the pilot programme under the PO WER, it has never been implemented in practice in Poland, even as part of a limited pilot project. It is true that services dedicated to people with mental illness have been operating within the social assistance system for years (Community Self-Help Homes type A and specialist care services), however, their activity is in no way integrated with the treatment process under the system financed from the common health insurance. Also, housing support (in the form of sheltered housing, i.e., municipal resource management policy) is in no way related to the process of medical therapy, or even to the previously indicated social services. In addition, Polish social policy lacked a number of institutions (forms of support) which, in the experience of other countries that had previously deeply reformed their own psychiatric treatment systems, turned out to be very important for the success of the reform and obtaining better therapeutic results (Mokrzycka et al., 2015). Such instruments were the coordination of support, individual case management, the use of ICF in the therapy management process, various forms of work in the environment with the patient and his social environment (family and other significant people). The systemic nature of the change forces, for its effectiveness, deep shifts of an innovative nature in each of the traditionally distinguished areas of innovation. The key innovations that the model contained in each of these areas will be discussed below.

### *Organisational innovation*

In the case of the discussed model, organisational innovation was not an end in itself but a necessity resulting from the product and process innovation assumed in the competition requirements and the need to meet the formal condition which was the implementation of the project in partnership. Organisational innovation had to appear both at the level of the medical entity itself, which has been providing health services in the field of psychiatry and addiction treatment so far, by separating an organised part of the entity in the form of the Mental Health Centre as well as at the level of institutionalised cooperation between entities that are part of the partnership and, in fact, in the field of separate activity serving the implementation of the project's objectives, at the Mental Health Centre (CZP). As a consequence, a CZP where the project was launched, a separate unit of WCZ SPZOO structure-wise, an entity of superior level as well as an institution defining the operational model of several organisations such as WCZ SPZOO, Ostoja Association and Opieka i Troska Foundation. This required the development of appropriate management procedures, information exchange mechanisms, and monitoring of activities at the CZP level in relation to the tasks carried out by individual partners. Its efficient implementation was a *sine qua non* of the implementation of product and process innovations and their effective management.

### *Product and process innovation*

In practice change in psychiatry is often perceived through product innovation consisting in the development and implementation of completely new or modified benefits (services) available to patients. This type of innovation is important both from the point of view of patients and staff directly providing services, and is very often perceived as the essence of change. Other aspects of innovation include the method of organisation and the process of providing services and their interconnection, recede into the background or are sometimes not noticed at all. Therefore, product innovations can be defined as the key elements of institutional change, while management and process innovations as the skeleton and glue, respectively, which in turn are noticed primarily by the management staff and those responsible for constructing and evaluating public policies. At the same time, due to the purpose of the model, in particular, ensuring the comprehensiveness and continuity of treatment and individualising its form, it is impossible to separate the product from the process innovation in it. Many of the services offered to patients constituted a series of activities that made up the process innovation, in other product innovations there was also a process innovation "sewn in". In the light of the available knowledge this should have a direct impact on therapeutic effects (Cook & Copeland, 2012).

For example, the coordination of the recovery process is both a service for a patient due to a serious clinical condition and potential problems resulting from it in the patient's self-management of her or his own therapy, as well as an innovative process of comprehensive organisation of the therapeutic process, under which the coordinator

of the recovery process manages information on an ongoing basis and coordinates all forms of support that the patient receives, and also, within her or his own competence, supports this person therapeutically. Therefore, in the further part of this article both types of innovation will not be separated from one another. Virtually all products and process innovations were social or hybrid services. Key innovations for the model, the assessment of which will be presented later in the article, include (Wrocławskie Centrum Zdrowia, 2017) Coordination Centre, Therapeutic Team, individual management and coordination of the recovery process, day support centre, Shared House, and vocational rehabilitation.

**Coordination Centre** (*Ośrodek Koordynacji, OK*). In the model it served as a place for coordinating all services offered to patients and for organising the therapeutic process, including accepting applications and registering patients to the CZP. After reporting the patient a medical assistant was assigned to her or him, whose task was to initially diagnose the patient's situation and health through an interview and assistance in completing the information questionnaire. The data obtained during the initial qualification were transferred to the head of the therapeutic team on duty, who then called for a team meeting and diagnosed the patient. In the case of a decision to provide support by a mobile team, in a place indicated by the patient, the OK coordinated this process. The OK also coordinated the institutional cooperation of all project partners in the field of services provided to patients.

**Therapeutic Team** (*Zespół Terapeutyczny, ZT*). It was made up of an interdisciplinary team of specialists whose rules of operation described detailed procedures. It included both medics (psychiatrist, psychiatric nurse, clinical psychologists, psychotherapists) and non-medical personnel (social workers, community and occupational therapists, recovery process coordinators, career counsellors). Their task was to provide immediate, comprehensive support to the patient after admission to OK. The support provided in the ZT consisted of an initial diagnosis performed by the sub-team on duty recruited from specialists of various professions; each time, a clinical psychologist or psychotherapist and at least one additional ZT member had to be present; whereas the attendance of a psychiatrist was optional and dictated by the course of the diagnostic process. The composition of the team was individually supplemented on the basis of pre-defined needs during the patient's qualification in the Coordination Centre and during the initial diagnosis. If necessary, this configuration was modified ad hoc. The subsequent tasks of the ZT included: making an initial diagnosis of the patient on the basis of a diagnostic form based on the ICF methodology (ICF, 2009), ordering the necessary tests and consultations, undertaking short-term psychotherapy, family intervention, psychoeducation or other necessary forms of support until the diagnosis is completed and a full treatment regimen. ZT also made a decision, in cooperation with other units of the model that dealt with a given patient, to provide the patient with support in the form of the care of a recovery process coordinator and to develop an individual therapeutic plan (Wrocławskie Centrum Zdrowia, 2017).

**Individual management and coordination of the recovery process according to ICF methodology.** This innovation was dedicated to people who, due to their health and life situation, required the development of individualized therapeutic solutions to substantiate the success of therapy, including restoring the ability to fulfil social roles

characteristic of a given period of life, e.g., starting a job, education, and establishing satisfying social relationships. The basis for the solution was providing the patient with constant support from a care coordinator and developing a recovery plan in cooperation with other CZP units and the patient himself, and then implementing it. The solution was reserved for people in the most difficult health situation who were not able to independently manage their own therapy. The form of support was implemented as soon as possible, and the coordinator was assigned to the patient within one working day after the decision to include her or him in this form of assistance was made (Wrocławskie Centrum Zdrowia, 2017).

**Day support centre** (*Ośrodek wsparcia dziennego*, ODW). According to the model, it combined the functionalities of a psychiatric day ward with the specificity of a type A community self-help home. Depending on the individual needs of the patient, her or his stay at a given moment was characterised by more emphasis on elements of social or medical therapy. At the same time, the solution was dedicated to patients with relatively the greatest health problems, so in the practice of CZP functioning all its patients were covered by individual recovery plans and were meanwhile under the care of process coordinators. From this perspective, staying in a day centre has always been one of many elements of individualised therapy. The main objectives of the ODW, defined in the model, were:

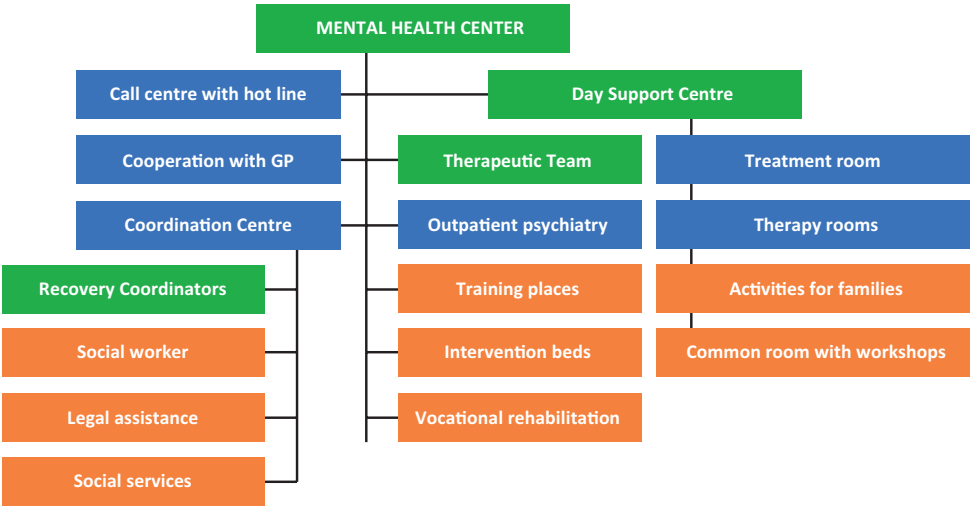
- supporting participants and their families and compensating for health effects in the field of mental health;
- creation of permanent support mechanisms consisting in a systematic, planned and targeted set of actions addressed to groups remaining on the social margin as a result of a mental crisis;
- creating opportunities for people with mental disorders to function independently or partially independently in their environment, while supporting their careers and families;
- extending the time of disease remission and reducing the scale of hospitalisation;
- creating an environment of mutually supportive people and a place where they can meet and seek help (participants and their families);
- promoting the model of a healthy family (Wrocławskie Centrum Zdrowia, 2017).

**Shared House** (*Dom wspólny*, DW), including self-empowering flats, self-empowering training, and crisis beds. DW provided support in one of the most deficient areas of support for people with mental illness (Skiba, 2021). There are very few hostels in the country where such people have a chance to change their living environment, which in many cases is a prerequisite for effective therapy. The model, in addition to providing a hostel function, which is sometimes contracted by the National Health Fund, went much further by offering comprehensive self-empowerment training on site, and in cases of short, acute crises, also crisis places, thanks to the 24-hour presence of staff. In practice, support in this form was always provided in conjunction with other forms of support, e.g., DW patients often started their stay after therapy in a day ward or during it, or used psychotherapy as part of CZP. Due to the characteristics of people requiring this form of assistance, in practice,

staying in a shared home was always part of an individual recovery plan, and DWD patients were under the care of recovery process coordinators. They also often took advantage of the possibility of vocational rehabilitation. As part of the therapeutic interventions, DW residents had the opportunity to develop or restore social and professional skills (e.g., cleaning, cooking, working in the garden, living in a group, looking for a job, etc.). A detailed support programme is determined individually by the therapeutic team together with the recovery coordinator and DW personnel, as well as other personnel engaged on a case-by-case basis (e.g., job coach). Support in this form was organised by the project partner, Opieka i Troska Foundation, which has many years of experience in this area (Wrocławskie Centrum Zdrowia, 2017).

**Vocational rehabilitation.** This form of support in accordance with the assumptions of the model was the culmination of the entire therapeutic process. Its form depended on the needs of the patient. In some cases, it boiled down to career counselling and support in relations with labour market institutions and potential employers. However, in a large proportion of cases it was the final form of an individual recovery plan and was based on the Supported Employment and Work Training programme. This action was the responsibility of the project partner, the Ostoja association, a pioneer of supported employment in Poland and with many years of experience in implementing this form of vocational rehabilitation among people with intellectual disabilities and mental illnesses.

A general diagram of the forms of support envisaged in the project is presented in the figure below. Colours differentiate their characteristics. Medical benefits are shown in blue, social benefits in red, there are also what is called hybrid benefits, integrating both types of interactions, in green.



**Figure 1.** Types of benefits for patients offered within the CZP in Wrocław

### *Effects of the implementation of the CZP model*

Moving on to the assessment of the implementation of the CZP model implemented together with partners by WCZ SPZOZ, it should be noted that the evaluation of the project in terms of model effectiveness and drawing conclusions regarding possible modifications was the main objective of the project. Of course, it was also important to provide, during the project, high-quality services in the field of mental health care for the inhabitants of Wrocław, however, the main goal was to answer the question whether the model effectively implemented the assumptions of community psychiatry and offered high-quality support contributing to the recovery of patients. The answers to these questions, regardless of this article, will also be provided by the Ordering Party (Ministry of Development) on the basis of the assessment of the implementation of the indicators and its own evaluation. The implementers achieved all the assumed goals, including the main one, which was to test the model, evaluate it and submit it to the contracting authority in a corrected form, ready for possible implementation in other places. The data presented below comes from the sources of the project and the participant observation of the author, who, performing a key management role for the project leader, is a co-author of the model, and due to his role in the organisation has access to all the information, made key management decisions and used open participant observation as a method based on which he supplemented the data necessary to prepare this study. The assessment of individual innovations will be based primarily on the analysis of existing data, the opinions of the staff implementing the project, treated as expert opinions, as well as opinions expressed by people using the services provided in the project, which was expressed in anonymous surveys on project services and self-assessment of health and activity which patients were asked to complete at the beginning, during, and at the end of using the project services.

### *Model evaluation*

The evaluation of the model was made primarily through the prism of the opinions and expectations of project team members and patients regarding the effectiveness of individual innovative services tested in the project. In accordance with the rules of the competition under which the model was verified, it was to be primarily effective, cost-effective, and complementary to the existing systemic solutions in mental health care. Adequate assessment of the quality of medical services is a very complex issue that requires multi-dimensional measurements and ensuring appropriate accuracy of indicators. Currently, the dominant view in the literature is that patient satisfaction should not be considered the basic element in assessing the quality of care. According to, e.g., Salisbury (Salisbury et al., 2010), only less than 5% of discrepancies in the level of satisfaction result from the process of care, and the rest is a derivative of other variables, such as patients' ideas about optimal care and related expectations as to its shape, socio-demographic, in particular, education and social status, the time that has passed since the benefit was provided. Studies have shown that from the patient's perspective, sometimes groundbreaking changes that actually had a very significant impact on the actual quality of services, improving it, such as the introduction of care



coordination in primary health care in Western countries (see the footnote), do not increase patient satisfaction (Sitzia & Wood, 1991). Of course, it does not in any way mean that patients' opinions are useless for a full assessment of quality, quite the opposite. Especially in psychiatry, this assessment must be a prerequisite for assessing the quality of services. For example, in the Netherlands, patients with chronic mental illnesses are monitored using several types of measures at appropriate time intervals (Schrijvers, 2017). However, the problem becomes more complicated when assessing the tested innovative solutions that make up a complex model and relating their quality to the existing system solutions.

### *Evaluation of implemented organisational innovations*

We can talk about the success or failure of the developed model on several levels. From the point of view of health policy and the health care system it was important to answer the key question whether the model provides a more effective support system for people with mental problems and illnesses.

In the organisational dimension, it implied an answer to the question whether the organisational formula of the project (partnership) and the implemented innovations functioned in the practice of project implementation, or whether they turned out to be dysfunctional, or required correction of the form of cooperation or the scope of services provided by individual partners

Another issue was the availability of the services offered and shortening the waiting time for support. In this area, the testing conditions prevent a full evaluation of the model. Although the waiting time for support during the project implementation never exceeded the agreed two working days, however, due to the fact that in the area of testing the model (former Wrocław Fabryczna district, but in practice, patients from all over Wrocław were admitted) the existing system of organisation of services contracted by the National Health Fund, as a result of which most patients in the model testing area were treated outside the pilot project, which made it impossible to assess the efficiency of the model in the conditions of the need to take care of the entire population for which such a centre was to operate. However, performance testing was not the intended and required purpose of the pilot. In the organisational dimension, the aim was to assess the effectiveness of the partnership as the assumed model of organisation of the provision of services. The source of data for evaluation here are primarily observations of the management and substantive staff of the entities implementing the project, and in particular the project team itself. Obtaining an evaluation of the project was also the aim of the evaluation studies, including the conducted survey of the project staff.

The selected organisational formula for CZP consisting in the implementation of tasks in partnership turned out to be effective and efficient. Despite the boundary conditions of the project implementation, e.g., in the form of a subsidy agreement, which formalised and hindered the efficient implementation of a number of activities, especially when tasks were performed by three independent legal entities, and was associated with a significant risk of non-eligibility of expenditure, all tasks implemented in the project, in particular the innovative instruments discussed above support were fully available to

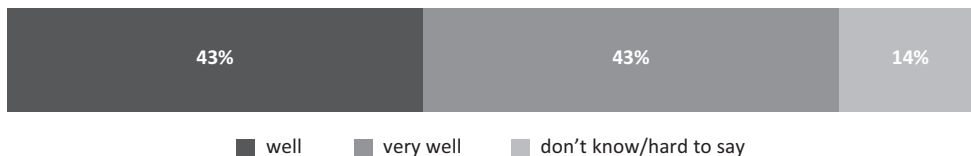
patients, there were no situations of limiting individual services or suspending their provision as a result of factors attributable to project partners (some services were not provided due to legal regulations during the state of epidemic). Organisational effectiveness would certainly be improved by testing the model under an agreement with an entrusted global budget, and not as part of a subsidy with rigidly defined expenditure items and their respective limits, as well as unit rates approved in advance for an hour of work, or the cost of individual services, and also assigned forms of staff involvement. The fact that the assumed goals were achieved despite the dysfunctionality of the financing model imposed by the Ordering Party, which often generates praxeologically absurd risks for the settlement of incurred expenses (e.g., mandate contract, instead of the desired employment contract), proves the proper way of organising cooperation between partners and within each entity. Chart 2 illustrates the evaluation of the project staff in relation to the tested organisational innovation, consisting in running the CZP in a partnership formula. None of the implementers of the project expressed a negative opinion in this respect, and more than four fifths of them gave this formula good and very good marks.



**Figure 2.** How does the cooperation of people and institutions involved in the project help respond to the needs and challenges of the environments in which the project is implemented?

Source: Study based on the PSAT survey for project partners, N=37

The project staff was also asked about the impact of the partnership formula of project implementation on the effectiveness of the implementation of individual activities that integrate various forms of support, and thus constitute the previously signalled “hybrid” formula containing both medical and social activities as part of one service for the patient. As many as 32 out of 37 people participating in the study positively assessed this impact. The others had no opinion on this matter. The analysis of the surveys showed that these were the people working in the project for the shortest time.



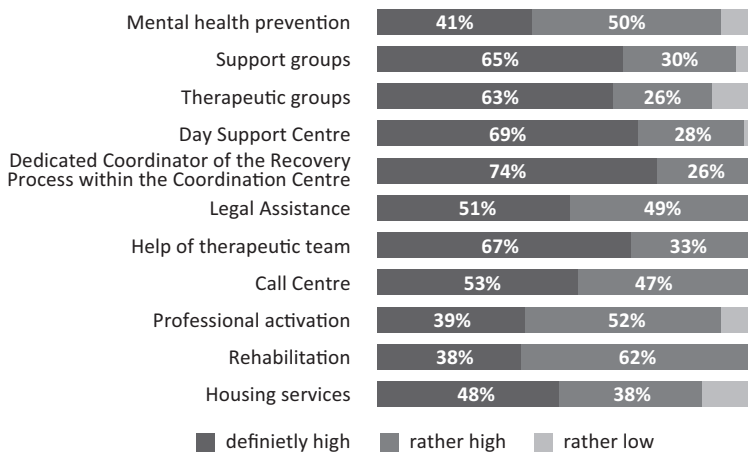
**Figure 3.** How does the cooperation of people and institutions involved in the project help to implement activities integrating various types of services and support, creating a complete and coherent offer that meets the needs of recipients?

Source: Study based on the PSAT survey for project partners, N=37

### *Evaluation of implemented process and product innovations*

In this area, the author will present an assessment of eleven services available to patients in the model. In particular, the project staff was asked to assess the effectiveness of various forms of support based on their experience in the project. Virtually all innovative forms of support were rated very highly. The coordination of the recovery process with the development of individualised therapy plans and the continuous management of the therapeutic process and evaluation of its effects within the coordination centre received the best ratings, where nearly three-fourths of the respondents rated its effectiveness as very high, and the rest highly. Such a high rating corresponds to experiences from other countries. For example, in Germany, where this therapeutic form has been used for years, not only for people with mental problems but for all those who, as a result of complex, severe health problems, are not able to independently manage the process of their own recovery, its effectiveness, measured as previously held social roles, is estimated at approx. 90% (Botti & Hagdorn, 2014). One hundred per cent of high and rather high scores were also given to benefits in the form of: assistance from a therapeutic team, legal assistance, hotline, and rehabilitation. There were no definitely negative opinions at all, or rather, they were few and concerned only some of the innovations. Their housing services received relatively the most (5 out of 35 indications) and therapeutic groups – 4 indications. In the case of housing services, negative assessments may have resulted from the insufficient number of staff initially involved in this form of support, which resulted in problems with providing adequate 24/7 support. However, this issue was resolved during the project implementation. Another problem in this area, which could result in negative assessments, were the limitations resulting from the common house formula and the inability to provide project participants with support in the form of social housing or self-empowering apartments, which were originally established in cooperation with MOPS in Wrocław. However, limited municipal resources in the area prevented such support.

Treating the project staff as competent judges – managers in organisational matters, and medical and social staff in therapeutic matters, it should be stated that the substantive solutions of the model, in particular, the most important innovative solutions, which, according to the assumption of the competition of the Ministry of Development, were to be complementary to the existing solutions have proven themselves in practice and had a great positive impact on the therapeutic effect achieved in individual patients. Services which make up the current model of care, which were not modified in the project in any way, such as the functioning of the Mental Health Clinic contracted with the National Health Fund, were not assessed. The distribution of answers to the question regarding the fulfilment of the expectations placed on the model by individual members of the implementation team, in the context of the results achieved, is shown in Figure 5. It is worth noting that the answers corresponding to the assessment “completely does not correspond (value 1) did not appear at all, and the lowest score the model received was a four (only one indication); ambivalent evaluations but with a shift towards a positive evaluation (six) were given by three implementers, the remaining evaluations were positive and definitely positive”.



**Figure 4.** How do you assess the effectiveness of individual forms of support made available under the project?

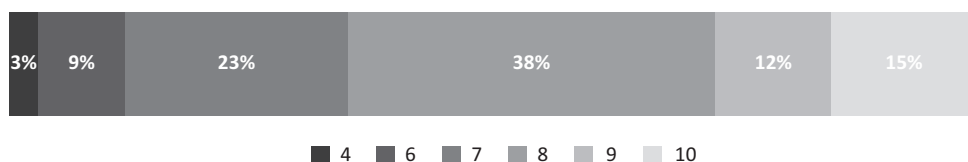
Source: Study based on the analysis of existing data; CAWI surveys among project team members, N=35

According to the project staff, the Model is effective, and its efficiency is determined primarily by the synergy of many elements that make up it: fast time to provide support, comprehensiveness of support, individualisation of assistance and management of the recovery process in difficult clinical cases, inclusion of families, and other relatives in the therapeutic process, supplement widely available support with a range of social services. It was possible to achieve the assumed effects, such as a smaller number of hospitalisations of participants, shortening the time of stay in inpatient care facilities and supporting the improvement of independence of the person receiving support. In addition, this model allows for the most comprehensive holistic impact of all currently available models of action within community psychiatry.

The staff emphasised that the scale of the effects achieved largely corresponded to the expectations of the authors of the model. The belief that the scale of the achieved effects is in line with the expectations of the authors of the project accompanied the participants of the research at every stage of the evaluation. During the implementation of the project, additional positive effects were identified, confirming the positive course of the recovery process and the positive assessments and information in the questionnaires completed by patients. In particular, the following should be mentioned here:

- taking up work and creating relationships by participants with large deficits,
- greater involvement of families in the health situation of patients,
- awareness of professionals whom they may need and expect help,
- high level of patient satisfaction,
- increasing the level of patients' trust in the staff,
- high level of awareness of some project participants about their illness (higher than expected).

As good practices implemented as part of the project, the broad and adequate scope of support, the system of cooperation between various specialists developed in the model and high efficiency of communication between members of the entire team were indicated above all. The next chart illustrates the assessment of the extent to which, in the opinion of the project staff, the expected results in terms of patient support were achieved during the project implementation.



**Figure 5.** Please assess to what extent the scale of the achieved results corresponds to the expectations you place in the developed support model (1 – does not correspond completely, 10 – corresponds perfectly)

Source: Study based on the analysis of existing data – surveys among project team members, N=35

The assessments made were justified primarily by pointing to the results achieved so far such as:

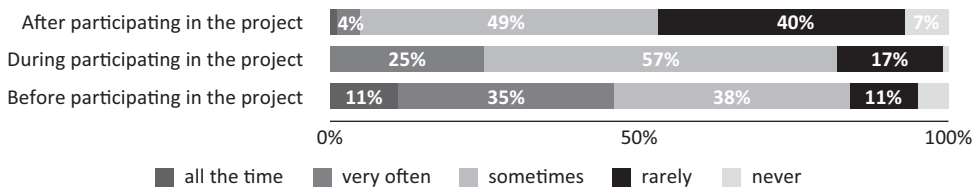
- development of an innovative model of a facility combining therapeutic and socio-environmental functionality,
- developing inter-institutional cooperation,
- greater openness of participants to change and greater willingness to accept help,
- implementation of design assumptions,
- visible recovery process of patients (including fewer hospitalisations, maintenance of remission),
- return of patients to social and professional functioning much more frequent than in the current model of psychiatric care.

### *Model effectiveness based on participants' feedback*

The second most important assessment dimension is the therapeutic effectiveness of the model. In order to fully assess the effectiveness of the model and refer the support schemes assumed in it to the existing forms of therapy offered under health insurance, it would be necessary to conduct comparative studies and strictly control a number of variables related to the health characteristics of patients, in particular, the type of disease, socio-demographic variables, duration of treatment, or forms of therapy. Therefore, in this article, we will not answer the question whether the therapy within the model is more effective than that offered within the framework of the health services package financed by the National Health Fund. The opinions of patients on the change in their health and the quality of functioning in various dimensions of life, including life activity, will be presented, which in many ways can be used to assess the quality of the services provided and, consequently, the quality of the proposed or

functioning systemic solutions in health care. It was assumed that the indicator of effectiveness here will be the declared improvement in the health of patients and their social functioning (work, family, undertaking activities in various fields).

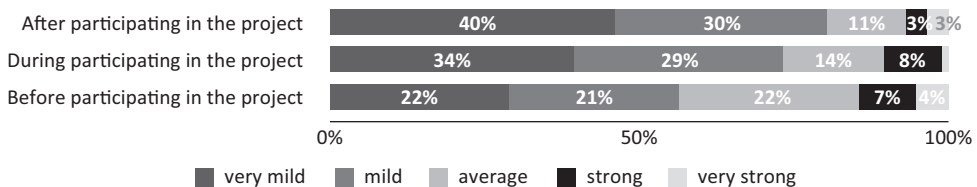
Based on the analysis of the collected questionnaires, it can be concluded that the therapy within the model had a positive impact on the level of activity of patients. During therapy and immediately after it, they indicated much less, often that their health problems (physical, emotional) had a negative impact on their social relationships. While before participating in the project as many as 52% of them claimed that it happened quite often or very often, after the project this percentage dropped to 9%. A significant lack of such an impact was initially declared by only 18%, and after the end of the therapy (participation in the project), it increased to nearly half of the respondents. The detailed distribution of responses, together with data from the mid-term survey, is presented in the chart below.



**Figure 6.** In the last month, have your physical or emotional problems affected your social and social life, i.e., contacts with family, friends, neighbours or other people?

Source: Study based on questionnaires completed by CZP patients, N1=315, N2=261, N3=315

The distribution of answers to the question about the occurrence of physical pain is similar. Physical and mental pain can be treated as one of the indicators of disease or mental disorders and correlate with the severity of symptoms (Chodkiewicz, 2013). The frequency of severe and very severe pain decreased from 11% to 4% of all respondents.

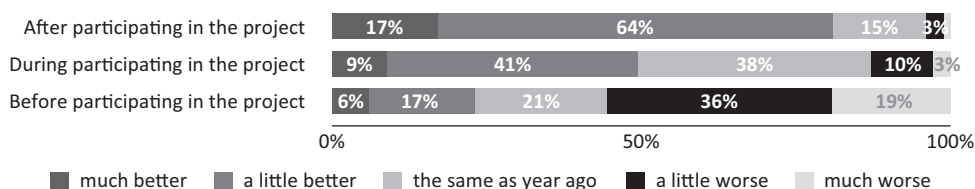


**Figure 7.** Have you experienced physical pain in recent months?

Source: Study based on questionnaires completed by CZP patients, N1=315, N2=261, N3=315

Patients were also asked to make a comprehensive assessment of their health by indicating how it had changed in relation to the perceived state of health a year ago. Also in this respect, patients indicated more positive assessments in the questionnaires

completed after participation in the project than immediately after starting treatment under the model, which indicates a positive correlation between this form of therapy and the improvement of patients' well-being. While initially 23% of the respondents indicated an improvement in their health in the last year, after the end of participation in the project, as much as 81% of the respondents indicated such an improvement. The deterioration of health was indicated by 55% before and 4% after participation. The indicated results should be considered very promising and indicate the effectiveness of social therapy methods, which, as emphasised by Jacek Wciórka (Wciórka, 2000), is an equal therapeutic method. The above data may indicate that the tested model can significantly increase therapeutic effectiveness in the area of mental health care.



**Figure 8.** How do you assess your health compared to last year?

Source: Study based on questionnaires completed by CZP patients, N1=315, N2=261, N3=315

## Conclusions

On the basis of the collected materials and the conducted analysis, despite the objective limitations listed in the text for a full assessment and comparison with the parallel functioning system solutions under the common health insurance, the model should be assessed as effectively implementing the assumptions of community psychiatry, which, in practice, translated into satisfactory results, and often surprisingly good therapeutic effects. Thus, the model confirmed the previous experience of other countries in the field of implementing community psychiatry, e.g., Italy, confirming the correctness of the adopted direction of transformation of the mental health care system on the population of people supported. As in the macro-scale Italian example cited above, in the case of the population of beneficiaries of the Wrocław model, both the number and duration of hospitalisation of patients treated under the project were reduced. In the opinion of the staff, good therapeutic effects were obtained using the implemented innovative methods of influence, often strictly social or hybrid activities, and not only medical therapy. The effect of reduced hospitalisation and shortening the length of stay in the case of hospitalisations of patients treated in CZP is, however, an observation of the project staff based on available data, not supported by a statistical analysis of full data from medical registers for a specific population, and should, from a methodological point of view, be treated as the opinion of competent judges, not as empirical observation. The reduction of hospitalisation was possible mainly thanks to alternative therapy methods directly related to the innovations implemented in the



project, primarily the functioning of the Common House, coordination of the treatment process and continuous, multidimensional support within this process, comprehensive day care.

The therapeutic effectiveness of the model, according to its implementers, was a derivative of the change in therapeutic methods. In particular, the inclusion of the family and relatives of the sick in the therapeutic process as well as a full diagnosis of needs and provision of adequate support in other, previously overlooked areas, such as legal assistance, organisational support, assistance in finding a job, trainings developing personal and social competencies.

The observation of the patterns of action and attitudes of the project staff showed that initially the main barrier to the effective implementation of innovative solutions, especially social and hybrid ones, by the medical staff were the existing patterns and therapeutic schemes used in previous workplaces or acquired during education. The initial reluctance to quickly start community therapy, consisting in visiting the patient's place of life, was visible. This was done only when the patient was waiting or unable to appear at the CZP. Especially at the level of diagnosis, in the Therapeutic Team, the need to carry out inspection of the living environment was rarely seen in the development of the therapeutic plan and was based only on the transfer of a sick person. Intensification of community work took place only at the stage of incorporating the Coordination of the Recovery Process.

The pilot under the PO WER Programme was held in competition with the Ministry of Health's pilot, the rules of which were set out in the Regulation of the Minister of Health on pilotage (Regulation, 2017). Already at the level of analysis of assumptions, it seemed highly probable that pilot projects under the PO WER programme, due to significant differences in assumptions and requirements, as well as the concentration of a significant part of the most active environments working for institutional change in psychiatry, have a greater chance of developing solutions which significantly shift the Polish system of psychiatric treatment towards community psychiatry. It seems that this is confirmed by the results of the implementation presented above and their comparison with the results of the first stage of the pilot project of the Ministry of Health (Balicki, 2020), as well as the announced changes that are to be gradually introduced to this pilot project by developing a diagnostic standard and a therapeutic standard, in which The introduction of many solutions tested in the PO WER models, including the Wrocław model discussed here, is expected.

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## **Acts of law**

Regulation of the Minister of Health of April, 27 2018 on a pilot programme in Mental Health Centres ([Polish] Journal of Laws of 2018, item 852).

Regulation of the Council of Ministers of 28 December 2010 on the National Mental Health Protection Programme ([Polish] Journal of Laws of 2011, item 24).

Regulation of the Council of Ministers of 8 February 2017 on the National Mental Health Protection Programme for 2017–2022 ([Polish] Journal of Laws of 2017, item 458).

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