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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 SPZOZ structure-wise, an entity of superior level as well as an institution defining the operational model of several organisations such as WCZ SPZOZ, 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.

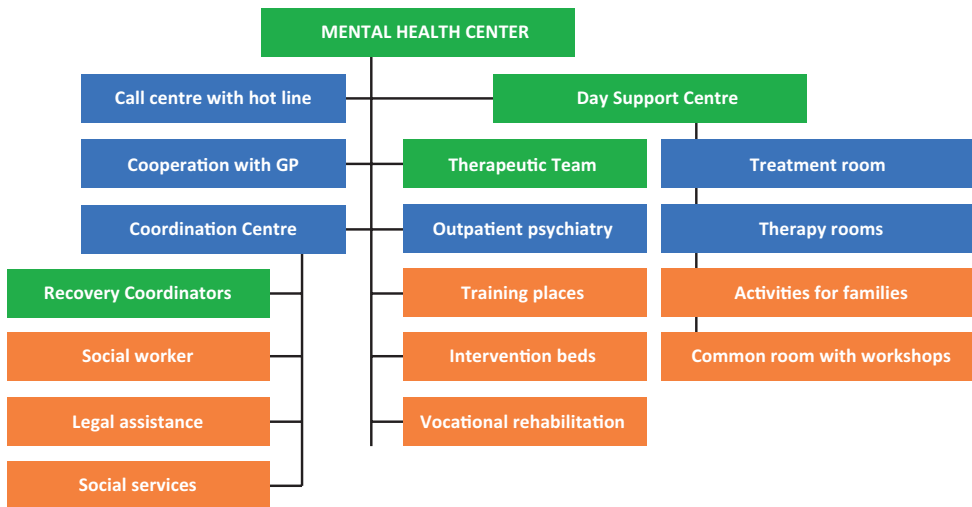


Figure 1. Types of benefits for patients offered within the CZP in Wrocław

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.

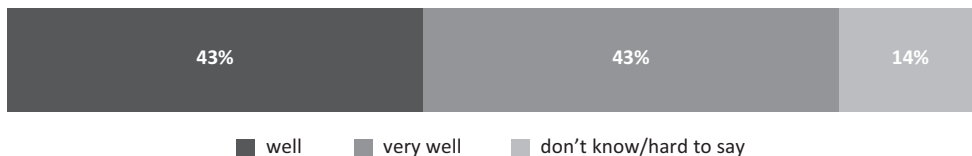


Figure 3. How does the cooperation of people and institutions involved in the project help to implement activities integrating various types of services and support, creating a complete and coherent offer that meets the needs of recipients?

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.

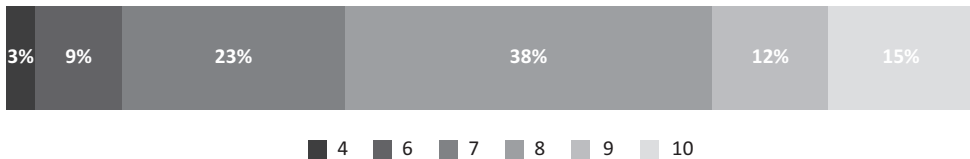


Figure 5. Please assess to what extent the scale of the achieved results corresponds to the expectations you place in the developed support model (1 – does not correspond completely, 10 – corresponds perfectly)

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.

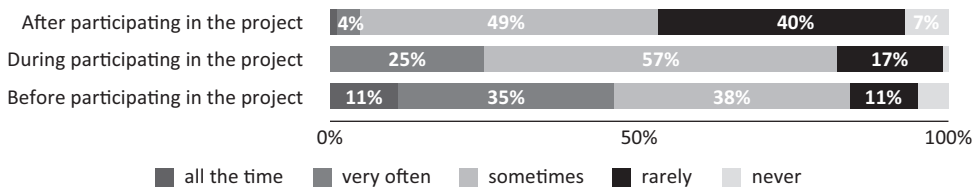


Figure 6. In the last month, have your physical or emotional problems affected your social and social life, i.e., contacts with family, friends, neighbours or other people?

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

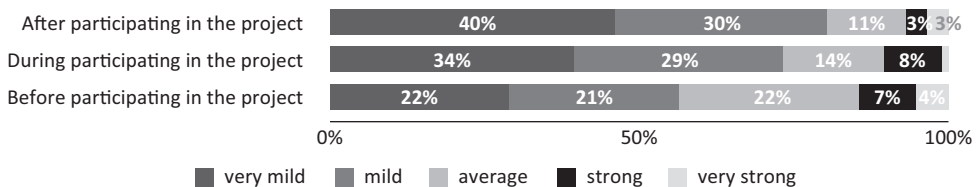


Figure 7. Have you experienced physical pain in recent months?

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.

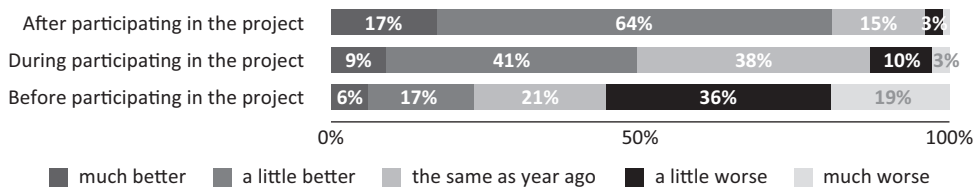


Figure 8. How do you assess your health compared to last year?

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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