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Poland Country Report. A mismatch between policy and reality

Mental health and integration Provision for supporting people with mental illness: a comparison of 30 European countries

The Poland country report, part of a series of country reports based on the Economist Intelligence Unit's Mental Health Integration Index, is published with the permission of the Economist Intelligence Unit. The research was sponsored by Janssen. This report is available on http://mentalhealthintegration.com/#!/countryreport/PL

Highlights

Poland's ranking in 15th place in The Economist Intelligence Unit's Mental Health Integration Index reflects the country's strengths in its official policies. A closer look, however, shows that its result is much less indicative of reality on the ground. Probably more accurate overall is the country's 21st place in the "Access" category, a part of the Index wherenon-policy elements have greater weight than elsewhere. As Jacek Moskalewicz — former head of the Department of the Organisation of the Health Service at Warsaw's Institute of Psychiatry and Neurology — notes, although there has been ashift away from large psychiatric hospitals, "opportunities to get treatment close to your place of residence are still limited and access to care and protected housing is insufficient"

Worse still, despite all the positive ideas in Poland's current National Mental Health Protection Programme (Also commonly translated as the National Mental Health Programme) its implementation is very far behind schedule, and officials are often not bothering to put it into practice at all. The policy's fate reflects a deeper barrier to progress on mental health issues: a large degree of official indifference. Slawomir Murawiec, assistant professor at the Centre for Mental Health of the Institute of Psychiatry and Neurology and a practising psychiatrist explains that integration of those living with mental illness receives "no [political] support from the state. Not many people on the government side talk about these problems. They want to hide the issue."

Good ideas left hanging because of indifference

As Dr Murawiec says, Poland's National Programme is "a very good one". Its three main objectives are (1) information dissemination and raising awareness to promote mental health, prevent illness, and reduce stigma; (2) research and development around more effective data systems in the field of mental health; and (3) the primary objective of the effort: making sure that those

Mental Health Integration Index Results

Overall:	64.1/100 (15th of 30 countries)
Environment :	80.0/100 (13th)
Opportunities:	72.2/100 (9th)
Access:	45.5/100 (21st)
Governance:	62.1/100 (10th)

Other Key Data

- Spending: Mental health budget as a proportion of government health budget (2011): 5.1%.
- Burden: Disability-adjusted life years (DALYs) resulting from mental and behavioural disorders as proportion of all DALYs (World Health Organisation [WHO] estimate for 2012): 10.9%.
- Stigma: Proportion of people who would find it difficult to talk to somebody with a serious mental health problem (Eurobarometer 2010): 34%.

with mental illness have the suport they need to live in the community. The centrepiece of the last of these is the planned creation of a network of roughly 800 Mental Health Centres across the country, which, using multidisciplinary teams, would provide „co-ordinated" inpatient, day-patient, and outpatient clinic provision along with mobile community care teams. These would be based either in a common location or benefit from organisational integration.

All of the programme's reforms, and especially the last one, are intended to shift the locus of care away from large hospitals into the community [1]. The problem, made clear in a damning report published by Poland's public Ombudsman, is that the programme is grossly underfunded and that the various levels of government responsible for the implementation of its component parts are largely ignoring it. Even the annual progress reports, intended to give information on delivery of a detailed set of measures laid out in the programme, are presented to parliament late, if at all, and show very little progress. Most planned indicators are far behind, while the Council of Mental Health, established within the Ministry of Health to oversee implementation, has met only twice between 2011 and 2013 [2]. As Dr Murawiec says, "there has been no implementation in practice and no resources provided. It does not work at all.". The issues are in part operational. Mr Moskalewicz, for example, notes that the current healthcare payment system, which covers specific services, hampers the provision offered by the Mental Health Centres, which provide integrated care for the person as a whole. The National Programme acknowledges the need for new funding structures, but has not put them in place.

The fundamental problem, however, is one of attitude. This is best reflected in the lethargy surrounding the formation of policy. Poland passed its Mental Health Act in 1994. It took three years to appoint a Committee for Mental Health Promotion based on this legislation, which had the task of creating a national programme. The Committee completed its work in 2001, but parliament did not adopt the resultant programme until it amended the Mental Health Act in 2008. The executive then waited until near the end of 2010 formally to adopt this programme, and the regulation confirming the implementation of the programme went into effect in February 2011, more than two years after the act had been passed.

The Polish Ombudsman's Human Rights Defender said that this last delay indicated that the "legislative work of the Ministry [of Health] is not properly organised" [3]. A lack of focus or interest is also an issue. Mr Moskalewicz notes that "politicians and policy makers do not acknowledge the mental health burden on the health services, economy and society at large. Therefore, the National Mental Health Programme ceased to be a priority immediately after its adoption." Dr Murawiec agrees. Policy makers "want these people to be somewhere else. They do not want to face the problem." This is also apparent in the funding levels. The latest WHO figures indicate that in 2011 some 5.1% of overall health funding went to mental health, but even this low number may be a substantial overestimate.

Data from Poland's National Health Fund, the sole payer for public health services, set the number even lower, at 3.5% in 2011— a figure that has not increased since the introduction of the National Programme: another clear sign of inaction [4].

A system that requires attention

Despite this general indifference, the Index does show that some strengths exist in Polish mental health. Compared with its neighbours, the number of psychiatric beds per head in Poland has never been high and, as most care is provided through outpatient clinics, the Index gives the country full points for deinstitutionalisation. Poland also scores well for the existence of home care and the provision of personal care budgets to all disabled individuals, a group in which those with a mental illness are included.

The broader picture is far less encouraging. Most mental health care is delivered in outpatient clinics. With roughly 1,100 spread around the country, these are, as Wanda Langiewicz — an expert on the organisation of Polish mental health provision based at the Institute of Psychiatry and Neurology — says, "a significant strength of the system". On the other hand, the care that the clinics provide is sometimes very basic. About 30% of them are open only between and one and three days a week, and overall about half provide largely, and sometimes exclusively, drug-based care, as opposed to integrating psychological counselling with their offerings.

The others have a wider range of medical services, but are not open on weekends, only rarely provide social services, and do not necessarily have staff with expertise in specific mental illnesses. As Ms Langiewicz explains, "curative medicine, which focuses on services to treat a disease rather than on quality of life and social integration, dominates". Overall, of the 4.4 m appointments at these clinics in 2011—the latest year for which data on the Polish mental health system is available — only 3% involved psychotherapy [5].

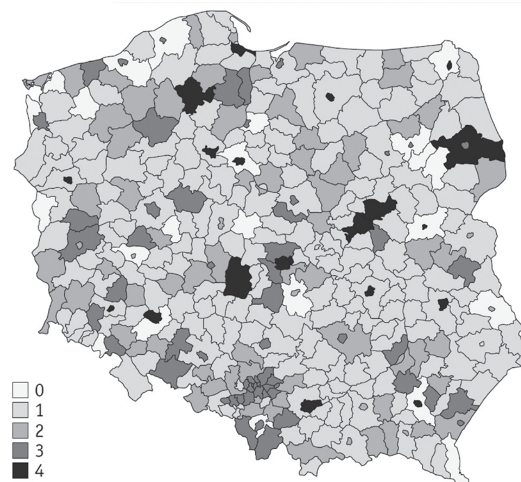
In addition, psychiatric hospitals and related institutions providing long-term care remain an important element of mental healthcare provision. They also dominate the

budget, taking up over 70% of the total, already small, mental health budget [6]. As in other countries, the number of beds per head in these hospitals has declined, but at a noticeably slower rate than in much of the rest of Europe. Furthermore, other aspects of institutional change have remained fairly static. Most psychiatric beds are still in specialist psychiatric hospitals, typically in geographically remote locations, while the growth of psychiatric wards in general hospitals is still slow. Moreover, since 1995 an increasing number — now 20% of all psychiatric beds — have been redesignated as long-term chronic care provision. Although organisationally separate, these are in the same building as the psychiatric hospitals and provide care for patients with mental illness, not a sign of imminent institutional demise. Worst of all, the quality of institutional care is often poor. In 2012 officials from the Polish government's Supreme Audit Office, the NIK, visited 17 psychiatric hospitals, or roughly one-third of the total. They found that 70% of these did not meet the required standards for psychiatric treatment and that half the wards were neglected and congested [7].

Often, however, hospitals end up backstopping mental healthcare because, if provision by outpatient clinics is basic, provision in the community is rare at best. In 2011 day units collectively served 20,000 people, compared with over 1.1m who used outpatient clinics. The 68 community care teams, meanwhile, gave care to 9,600 people, which explains Poland's full marks in the Index for indicators measuring the existence of home care and assertive community treatment (because these rely on a binary description of the existence or not of these services anywhere in the country). The facilities, however, are hardly sufficient to meet current needs. Going beyond medical care to social services, the situation is at least as bad. As Mr Moskalewicz notes, the institutions "that facilitate integration within family, school, work and the community either do not exist in Poland or are underdeveloped". A striking example is the lack of sheltered housing. Poland in 2011 had space in specialised hostels providing rehabilitation and other relevant services for 649 people. A few cities, notably Warsaw, Krakow and Lublin, have developed effective service networks offering housing and job-training services, but these are reliant on the cooperation of non-governmental organisations (NGOs) and local governments with social services, frequently have unstable funding, and are not present in much of the rest of the country [8].

The entire system is also bedevilled by a lack of expert personnel. Poland comes 29th in the Index for the size of its mental health workforce, scoring just 10.9 out of 100. The failings are widespread, with the country finishing in the bottom third of European states for the number of specialist physicians per head. The greatest lack, however, is that of social workers, with Poland having fewer than one per 100,000 head of population, making the poor integration of social and medical care even harder for service users to negotiate. Dr Murawiec is not surprised, saying "there are not enough professionals. There is a great need for psychiatrists in the public sector, especially away from the big cities. We also need a lot of psychologists, occupational therapists and community psychotherapists." Worse still, adds Dr Moskalewicz, emigration of psychiatrists is a growing problem and the number of psychiatric nurses has declined.

Presence of outpatient clinics, day clinics, community treatment teams and hospitals (one point for each) by county number of psychiatric nurses has declined.



Source: Wanda Langiewicz, Zakład Zdrowia Publicznego, IPiN, Warszawa

Finally, as Dr Murawiec's comment suggests, mental healthcare provision is highly unequal across Poland and is particularly concentrated in cities. Ms Langiewicz explains that "in many regions an outpatient psychiatric clinic is the only form of care available". Indeed, in the country's 300 counties, 25 have no specific mental healthcare provision at all, and for 205 there is only either an outpatient clinic, a community care team, a day unit or a hospital. Only 20, clustered around the main urban areas, have all four. General practitioners (GPs) are little help, as knowledge of mental illness in this group is poor.

Human rights require attention

Human rights are another area of weakness for Poland. The country gets only one point, out of a possible four, in the "Human rights treaties" indicator of the Index, for having ratified the Convention on the Rights of Persons with Disabilities (CRPD) but not its additional protocol.

Even this, however, may be overstating the influence of the CPRD on the country's human rights law. Upon signing the CRPD, Poland made an interpretive declaration stating that it did not feel bound to abandon guardianship (where someone makes a decision for a disabled person) in favour of supported decision making (where the affected individual makes the decision, to the extent that they are able to) in cases where "a person suffering from a mental illness, mental disability or other mental disorder is unable to control his or her conduct". This undercuts one of the main protections for those living with mental illness and, in practice, has meant that the legal situation surrounding guardianship has remained the same under Polish law — which is why the country scores zero in the Index for supported decision making. It also muddies protections on involuntary admission, where Poland's strong formal legal protections receive full points. An admission decision made by a guardian is by definition voluntary, but not necessarily what the affected individual wants. In other areas, the law is also more restrictive for people living with mental illness than in many other European states. For example, having a severe mental condition can lead to the loss of custody of one's children. Worse still, the legal protections that do exist are too often not respected. In almost all the hospitals examined in the NIK audit, the investigators found "gross negligence" when accepting involuntary admissions, with patients rarely being given a reason for why they were being held against their will, or their rights in the matter. Similarly, in none of the 64 cases reviewed where a court had ordered an admission were the detainees given the reason, or given an indication of their treatment plan [9].

Employment a relative bright spot

Poland's best category score (72.2 out of 100) is for "Opportunities", which considers workplace policy and in which the country ranks ninth. Its particular strength is in work placement schemes, where it receives full marks. In this case, those living with mental illness benefit not from policy specifically directed at them, but from the fact that they are covered by regulations designed to help disabled people as a whole find and retain work. These have created a substantial level of sheltered employment, most of which takes one of two forms. The first, known as "sheltered workplaces", involves an employer agreeing to have disabled employees make up a proportion of the firm's workforce — at least 30−40% of workers, depending on the degree of disability — and to provide appropriate vocational and rehabilitation training. According to Ms Langiewicz, roughly one-fifth of the approximately 200,000 disabled individuals working at such companies across the country have a mental illness. People working in these companies tend to have less severe disabilities. Those with more difficult conditions are more likely to find work in social enterprises run by „so-called"occupational workshops". The latter are non-profit organisations funded by local communities or NGOs that specialise in vocational and social rehabilitation. These enterprises must have a similar percentage of disabled employees to that required of sheltered workplaces, but a large majority of these employees — between 70% and 75% depending on the type of employment — must be severely disabled individuals. In return for meeting these conditions, the workshops are eligible for national and local funding. In effect, these are rehabilitation programmes organised around an enterprise. Notable examples include U Pana Cogito, a three-star hotel in Krakow run largely by people with schizophrenia, and EKON, a Warsaw waste-management and recycling organisation that employs several hundred disabled individuals, mostly those with mental illness or a mental handicap. As Mr Moskalewicz points out, however, "despite the impressive success of some of them, in general this form of employment is still in its infancy." The statistics bear this out. Around 60 of these organisations exist, employing about 1,900 people, of whom 23% have a mental illness [10].

The question mark over all these schemes is the extent to which they provide a route back into the mainstream workplace and the degree to which they offer something short of social integration. They are certainly better than unemployment and, as Ms Langiewicz points out, with unemployment rates in Poland near or above 10% for the last 25 years, those living with mental illness stand a "very limited" chance of finding a job. She estimates that these individuals make up only 3% of people with various disabilities employed in the regular labour market. Employer attitudes are also a problem. A 2007 survey of employers found widespread stigma, with 24.5% saying that they would stop the hiring process upon finding out that an applicant had a mental illness, and 10% indicating that they would dismiss any employee whom they learned had such a condition [11].

Despite the barriers, Dr Murawiec says that assistance and support programmes to help those with mental illness find and keep mainstream jobs are showing promise. As with so much in the area of mental health in the country, though, he adds that "these new programmes are very good and very promising, but available in only a few districts." Poland, then, is not devoid of examples of best practice. It has a number of positive stories to tell in the field of employment and, as noted earlier, pockets of medical and even social integration in

the largest cities. Too often, however, these are local government or NGO initiatives that function despite, not because of, the prevailing level of mental health provision. The National Mental Health Programme shows that the Polish government knows what to do. Now it needs to act.

About the research

This study, one of a dozen country-specific articles on the degree of integration of people with mental illness into society and mainstream medical care, draws on The Economist Intelligence Unit's Mental Health Integration Index which compares policies and conditions in 30 European states. Further insights are provided by three interviews — with Wanda Langiewicz, an expert on the organisation of Polish mental health provision based at Warsaw's Institute of Psychiatry and Neurology; Dr Jacek Moskalewicz, former head of the Department of the Organisation of the Health Service at the same institute; and Slawomir Murawiec, professor at the Centre for Mental Health of the Institute of Psychiatry and Neurology — along with extensive desk research. The work was sponsored by Janssen. The research and conclusions are entirely the responsibility of The Economist Intelligence Unit.

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