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item 458

REGULATION OF THE COUNCIL OF MINISTERS

of 8 February 2017

regarding the National Mental Health Protection Programme for the years 2017-2022

Under art. 2 section 6 of the Act on the Protection of Mental Health of 19 August 1994 (Journal of Laws of 2016, items 546, 960 and 1245), it is decided as follows:

§ 1. 1. The National Mental Health Protection Programme for the years 2017-2022 is established to specify the strategy for the activities aimed at:

- 1) providing people suffering from mental disorders with comprehensive, wide-ranging and commonly accessible healthcare and other forms of care and assistance necessary for living in the family and social environment;
- 2) developing proper social attitudes towards people with mental disorders, in particular understanding, tolerance, kindness, as well as preventing their discrimination.

2. The National Mental Health Protection Programme for the years 2017-2022 constitutes an appendix to the regulation.

§ 2. The regulation takes effect on the day after publication.

Prime Minister: *B. Szydło*

Appendix to the regulation of the Council of Ministers
of 8 February 2017 (item 458)

NATIONAL MENTAL HEALTH PROTECTION PROGRAMME FOR THE YEARS 2017-2022

1. The entities participating in the execution of the National Mental Health Protection Programme For the Years 2017-2022, hereinafter referred to as the “Programme” include:

- 1) the ministries with jurisdiction for the objectives of the Programme, in particular those responsible for: health, social security, family, labor, education, internal affairs, justice and national defense;
- 2) the National Health Fund (NFZ);
- 3) the self-governments of provinces, counties and communes.

2. The execution of the tasks resulting from the Programme may also be performed by social organizations, associations, foundations professional self-governments, churches and other religious groups, patient self-help groups, as well as the entities, the scope of activities of which includes the Programme objectives and tasks.

3. If the character of the tasks resulting from the Programme so allows, the entities, referred to in section 1 will execute the Programme in cooperation with the entities, referred to in section 2, taking into account the provisions of the Act on Public Benefit and Volunteering of 24 April 2003 (Journal of Laws of 2016, items 1817 and 1948, and of 2017, item 60).

4. The minister responsible for the issues related to health will manage the execution of the Programme, coordinate the performance of the tasks, referred to in §1 of the regulation, and should the results of the respective solutions be unsatisfactory, should data be obtained suggesting the activities within the Programme are ineffective or should it be deemed that they do not complement other activities for mental health protection, the minister will prepare amendment suggestions.

5. Until 15th May, the entities executing the Programme will submit reports on the performance of the tasks under the Programme in the previous year, to the minister responsible for the issues of health. The reports will include reference to the initial condition and the indices presented in the appendix to the regulation.

6. The necessary legislative activities, in particular those aimed at ensuring the rights of people with mental disorders are respected, include:

- 1) introduction of the regulations to facilitate the provision of comprehensive care to people with mental disorders, including the regulations associated with: mental health centres, conclusion of agreements for provision of services in the scope of mental care, and monitoring of the effectiveness of healthcare;
- 2) specification of the rules of cooperation among the healthcare entities, social welfare system, education system entities, for coordination of the care of people with mental disorders.

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Chapter 1

**DIAGNOSIS OF THE CONDITION OF AND THREATS TO MENTAL HEALTH,
INCLUDING OF REGIONAL DIFFERENCES****Prevalence of mental illnesses and disorders**

According to the statistics, over 450 million people in the world suffer from mental disorders. However, much more suffer from mental problems. Over 27% adult Europeans experience at least one symptom of poor mental health in a year. The situation is similar in the territory of the Republic of Poland, where the number of people treated for mental disorders has been rising systematically.

The epidemiology of mental illnesses and disorders among the citizens of the Republic of Poland was prepared on the basis of the data from the National Health Fund on the number of provided healthcare services in the scope of psychiatric care and treatment of addictions, as well as on the basis of the data obtained from the Report entitled “Epidemiology of psychiatric disorders and access to psychiatric healthcare – EZOP Polska, hereinafter referred to as the “EZOP study”. The report was prepared by employees of the Institute of Psychiatry and Neurology. The report allowed to examine the prevalence of the most frequently diagnosed mental disorders among the citizens of the Republic of Poland aged between 18 and 64.

Considering the health situation, it should be noted that, on the basis of the results of the EZOP study, in the tested sample (10,000 respondents in a random group of people aged 18-64), 23.4% people were diagnosed with at least one mental disorders out of the 18 disorders defined in the ICD-10 International Classification of Diseases and the DSM-IV Diagnostic and Statistical manual of Mental Disorders of the American Psychiatric Association. Every fourth person asked has experienced more than one disorder, and every twentieth person – three or more disorders. The group of patients in Poland who have experienced several disorders, contains almost a quarter million of people. About 10% of the tested population had neurotic disorders, with the following two most frequent ones: specific phobias (4.3%) and social phobias (1.8%). In turn, mood disorders constituted 3.5% of reported ailments, including 3% - depression. It should be emphasized that, as a result of growing prevalence, depression is becoming a more and more serious health and social problem. Impulsive behaviors were found in 3.5% respondents (table No. 1).

TABLE 1. PREVALENCE OF MENTAL DISORDERS AMONG THE CITIZENS OF THE REPUBLIC OF POLAND AGED 18-64

Disorder group	Detailed diagnosis	Share (CI95%)	Estimates (in thousand)	Lower limit (in thousand)	Upper limit (in thousand)
Neurotic disorders	Agoraphobia	0.6 (0.5-0.7)	153.9	122.8	185.0
	Generalized anxiety disorders	1.1 (1.0-1.3)	289.9	244.8	335.0
	Panic attacks	0.4 (0.3-0.5)	100.8	76.5	125.1
	Social phobias	1.8 (1.5-2.0)	455.7	395.2	516.2
	Specific phobias	4.3 (3.9-4.6)	1,103.5	1,010.4	1,196.6
	PTSD	1.1 (0.8-1.5)	291.7	203.4	380.0
	Neurasthenia	1.0 (0.8-1.2)	252.6	199.5	305.7
	Neurotic disorders, total	9.6 (8.9-10.3)	2,470.3	2,298.6	2,641.9
Mood (affective) disorders	Depression	3.0 (2.7-3.3)	766.2	692.8	839.7
	Dysthymia	0.6 (0.5-0.8)	160.4	127.9	193.0
	Mania	0.4 (0.3-0.5)	101.1	76.8	125.3
	Mood disorders, total	3.5 (3.2-3.8)	904.3	825.1	983.4
Impulsive disorders	Oppositional-defiant disorders	0.2 (0.1-0.4)	61.0	24.8	97.2
	ADHD	0.0 (0.0-0.1)	11.2	4.5	17.8
	Behavioral disorders	2.4 (2.0-2.8)	612.8	512.4	713.3
	Explosive disorders	0.8 (0.7-1.0)	204.7	165.0	244.4
	Impulsive disorders, total	3.5 (3.1-4.0)	906.9	789.0	1024.8
Substance use disorders	Alcohol abuse, including:	11.9	(10.9-12.9)	3065.4	2814.9
	alcohol addiction	2.4 (2.0-2.9)	616.1	495.6	736.6
	Drug abuse, including:	1.4 (1.2-1.8)	371.7	292.5	450.9
	drug addiction	0.3 (0.2-0.4)	69.6	37.5	102.1

Substance use disorders, total	12.8 (11.8-13.8)	3,297.1	3,040.6	3553,5
Total (at least one disorder), including:	23.4 (22.2-24.7)	6,053.5	5,751.9	6355,1
two and more disorders	5.7 (5.2-6.3)	1,475.5	1,343.2	1,607.7
three and more disorders	0.9 (0.8-1.1)	242.8	201.6	283.9

Additionally, the data included in table No. 1 indicates that a large group of disorders is the disorders associated with use of substances (12.8%), including disorders resulting from alcohol abuse (11.9%).

TABLE 2. PREVALENCE OF MENTAL DISORDERS BY PROVINCES

Province (Województwo)	Share (CI95%)	Estimates (in thousand)	Lower limit (in thousand)	Upper limit (in thousand)
Łódzkie	29.3 (24.8-34.2)	511.1	430.6	591.6
Świętokrzyskie	27.8 (22.6-33.6)	217.4	185.9	248.9
Lubuskie	27.8 (21.0-35.8)	183.1	145.7	220.4
Dolnośląskie	25.8 (21.0-30.8)	522.3	425.7	619.0
Lubelskie	25.6 (21.2-30.5)	373.3	31.6	435.0
Pomorskie	24.8 (19.2-31.4)	374.0	283.0	464.9
Małopolskie	24.1 (20.7-27.8)	526.1	452.6	599.6
Warmińsko-mazurskie	24.0 (18.2-31.1)	235.1	169.9	300.2
Śląskie	23.3 (19.4-27.7)	758.1	630.2	886.0
Podlaskie	23.2 (18.5-28.7)	179.7	137.9	221.6
Opolskie	22.9 (15.8-32.0)	144.6	95.5	193.6
Kujawsko-pomorskie	22.7 (16.9-29.6)	301.5	235.2	367.8
Mazowieckie	21.4 (18.5-24.6)	763.2	648.8	877.7
Wielkopolskie	20.9 (17.4-24.9)	494.6	410.4	578.7
Zachodniopomorskie	18.9 (15.1-23.4)	219.6	172.7	266.5
Podkarpackie	17.8 (13.6-23.0)	250.0	188.9	311.0
Kraj ogółem	23.4 (22.2-24.7)	6,053.7	4,645	7 183

Source: Report from the study: Epidemiology of mental disorders and access to psychiatric healthcare – EZOP Polska

The table above presents the prevalence of mental disorders by provinces. The provinces with highest prevalence include: Łódzkie 29.3%, i.e. the estimated number of over half a million people, Świętokrzyskie 27.8%, i.e. about 217,000 people and Lubuskie 27.8%, i.e. about 183,000 people. The lowest levels of prevalence were recorded in Zachodniopomorskie – 18.9% and Podkarpackie – 17.8%, with 469,600 people.

Depressive disorders

Depression is one of the most commonly described and diagnosed mental disorders. It is recognized on the basis of specifically prepared diagnostic principles. Depressive disorders often appear at a very young age, reduce the ability of proper functioning and are very often recurrent. Depression is a systemic disease, its occurrence and lack of proper treatment result in an increase in the risk of appearance of somatic diseases and vice versa – somatic diseases, particularly chronic ones, increase the risk of appearance of depression. That is why it is so important to undertake prophylactic activities aimed at prevention, early diagnosis and treatment of depression. One of the key problems associated with depressive disorders is the fact that they constitute a high risk factor for suicides.

TABLE 3. PERSONS WHO HAVE EVER HAD DEPRESSION

List	Total	Age – estimation in thousands			
		18-29	30-39	40-49	50-64
		in thousands			
Depressive disorders, total	766.2	154.7	173.8	155.1	282.7
Men	249.3	62.5	65.7	47.5	73.6
Women	516.9	92.2	108.1	107.5	209.1
Dysthymia, total	160.4	26.7	28.5	30.7	74.6
Men	56.4	12.6	6.4	7.7	29.7
Women	104	14.1	22.1	23	44.8

Source: Report from the study: Epidemiology of mental disorders and access to psychiatric healthcare – EZOP Polska

TABLE 4. PERSONS WHO HAVE EVER HAD DEPRESSION – AGE GROUPS, PERCENTAGES

List	Total	Age			
		18-29	30-39	40-49	50-64
Depressive disorders, total	3.0%	2.1%	3.0%	3.2%	3.5%
Men	1.9%	1.7%	2.3%	2.0%	1.9%
Women	4.0%	2.6%	3.8%	4.5%	5.0%
Dysthymia, total	0.6%	0.4%	0.5%	0.6%	0.9%
Men	0.4%	0.3%	0.2%	0.3%	0.8%
Women	0,8%	0,4%	0,8%	1,0%	1,1%

Source: Report from the study: Epidemiology of mental disorders and access to psychiatric healthcare – EZOP Polska

The above tables include the data on the persons who have ever experienced an episode of depression or chronic depression in their lives. It follows from the studies conducted that 3% citizens of our country (ca. 766,200 people) aged 18 – 64 have experienced at least one depressive episode. Dysthymia (i.e. chronic depressive disorder) was diagnosed in 0.6% people. It should be noted that the prevalence of depressive episodes is always higher in women than in men, regardless of age groups. Furthermore, the depression prevalence factor in women increases over age, while in men it stays at a similar level.

Suicide

The data on the number of suicides is collected by the General Police Headquarters of Poland. On the basis of the statistics available, in 2014 the total number of suicide attempts was 10,207, including fatal ones – 6,165. A suicide attempt was the cause of death of 5,237 men and 928 women. The most frequent method of suicide was hanging, falling from a height and other types of self-mutilation, while the least frequent one – poison. The most frequent recorded causes of suicide attempts include family misunderstandings, mental illnesses and chronic diseases, while the least frequent one – an unwanted pregnancy. The largest number of suicide attempts has

been recorded in the group of people aged 20-24 + 1,015 attempts and aged 30-34 – 1005 attempts.¹

The EZOP study confirms the existence of the problem of suicides in the Republic of Poland, as a significant health problem in the society. The data from the study is much more troubling than police statistics. That is because the study demonstrated that 0.7% working-age citizens of our country have experience something that may qualify as a suicide attempt. The extrapolation of the study results to our population demonstrates that the number of people who have attempted to commit suicide, is 189,000.

TABLE 5. PERSONS WITH SUICIDE ATTEMPTS (AT ANY TIME) BY SEX AND AGE GROUP

List	Total	Age			
		18-29	30-39	40-49	50-64
		in thousands			
Suicide attempts, total	189.2	54.1	48.1	24.6	62.3
Men	94.8	28.6	15.7	14.4	36.0
Women	94.3	24.4	32.4	10.2	26.3

Source: Report from the study: Epidemiology of mental disorders and access to psychiatric healthcare – EZOP Polska

No statistical differences were recorded among the age groups, but most suicides are attempted by women aged 30-39 (1.1%), and least – by women aged 40-49 (0.4%).

Persons treated for mental disorders in the years 2011-2014 on the basis of public statistics.

Health disorders recorded in the psychiatric treatment system provide the grounds for assessing the annual prevalence of mental disorders in Poland. The information included in table 1 concerns the prevalence of mental disorders (without addictions) in the population of adult Poles, recorded every year in various forms of psychiatric care. The patients with diagnosed schizophrenia have been counted separately in each form of care.

¹ Data from the General Police Headquarters of Poland – condition as of 5 May 2015
<http://statystyka.policja.pl/st/wybranestatystyki/samomójstwa/110594>, Samobójstwa-2014.html

<http://statystyka.policja.pl/st/wybranestatystyki/samobojstwa/110594,Samobojstwa-2014.html>

TABLE 6. ADULTS WITH MENTAL DISORDERS (WITHOUT ADDICTIONS) TREATED THROUGH HOSPITAL AND NON-HOSPITAL PSYCHIATRIC CARE IN THE YEARS 2011-2014

Form of care	Diagnosis	Year				Change
		2011	2012	2013	2014	2014/2011
Out-patient care	Total	1,073,172	1,199,880	1,261,556	1,223,427	114.0%
	schizophrenia	142,017	149,191	148,906	142,443	100.3%
	schizophrenia/total	13.2%	12.4%	11.8%	11.6%	
Community-based care	Total	9,594	22,587	37,783	29,778	310.4%
	schizophrenia	3,686	5,543	7,404	6,432	174.5%
	schizophrenia/total	38.4%	24.5%	19.6%	21.6%	
Daycare units	Total	14,708	15,906	14,733	15,982	108.7%
	schizophrenia	3,558	3,558	3,416	3,403	95.6%
	schizophrenia/total	24.2%	22.4%	23.2%	21.3%	
24/7 units	Total	102,532	102,704	101,608	103,325	100.8%
	schizophrenia	30,877	31,050	30,966	30,767	99.6%
	schizophrenia/total	30.1%	30.2%	30.5%	29.8%	
Care units	total	6,015	5,956	6,145	5,606	93.2%
	schizophrenia	2,733	2,695	2,738	2,502	91.5%
	schizophrenia/total	45.4%	45.2%	44.6%	44.6%	

Source: Study by the Faculty of Public Health of the Institute of Psychiatry and Neurology on the basis of public statistics.

Over 4 years, the number of people with mental disorders treated on an out-patient basis increased by 150,000, i.e. 14%, while the share of patients treated for schizophrenia only changed slightly.

The largest increase was recorded in community-based care (community treatment teams), in which the total number of patients tripled (from 9,600 to 29,800), and the number of people diagnosed with schizophrenia increased by 75%, which translated into higher dynamics in the number of patients with diagnoses other than schizophrenia (affective disorders in particular).

In 2014, psychiatric daycare units had almost 16,000 people, i.e. 9% more than in 2011, with a slight decrease in the number of patients treated for schizophrenia. In 2011, almost every fourth patient in daycare units was diagnosed with schizophrenia, while in 2014 – every fifth one.

The smallest changes between 2011 and 2014 were recorded in 24/7 hospital care, both in terms of the total number of patients and of the number of patients treated for schizophrenia.

The care units recorded a decrease in the number of patients, including those with schizophrenia, which, in this case, may mean longer average stay times.

TABLE 7. CHILDREN AND YOUTH WITH MENTAL DISORDERS (WITHOUT ADDICTIONS) TREATED THROUGH HOSPITAL AND NON-HOSPITAL PSYCHIATRIC CARE IN THE YEARS 2011-2014

Form of care	Year				Change
	2011	2012	2013	2014	2014/2011
Out-patient care	96,183	104,087	93,917	105,123	109.3%
Daycare units	2,325	1,835	2,157	2,399	103.2%
24/7 units	7,697	7,478	7,184	7,311	95.0%
Care units	67	81	74	73	109.0%

Source: Study by the Faculty of Public Health of the Institute of Psychiatry and Neurology on the basis of public statistics.

The out-patient care recorded a fluctuating number of patients in a year (lowest in 2013), with 105,000 patients at the end of 2014 (i.e. 0.9% more than in 2011).

The number of people treated in other units also changed: in daycare units – a small increase in the number of patients as of 2014, and in 24/7 hospital units – a small decrease (5%). In the analyzed period, the care units treated between 67 and 80 people younger than 18. Schizophrenia is diagnosed in children and youth relatively rarely – in out-patient care and daycare – between 1 and 1.5%, in 24/7 care – ca. 5% of all the patients.

Chapter 2

PROGRAMME OBJECTIVES AND TASKS

1. The main Programme objectives include:
 - 1) providing people suffering from mental disorders with comprehensive care adequate to their needs;
 - 2) conducting activities to prevent stigmatization and discrimination of people with mental disorders;
 - 3) monitoring and assessing the effectiveness of the activities executed within the Programme.
2. The specific objectives of the Programme include:
 - 1) in the scope of providing people suffering from mental disorders with comprehensive care adequate to their needs:
 - a) promoting the community-based model of psychiatric healthcare,
 - b) promoting diverse forms of social support and assistance,
 - c) supporting the employment of people with mental disorders,
 - d) coordinating the available forms of care and assistance,
 - e) providing psychological and pedagogic support to students, parents and teachers;
 - 2) in the scope of conducting activities to prevent stigmatization and discrimination of people with mental disorders:
 - a) developing detailed rules of conduct for presenting the image of people with mental disorders in the media,
 - b) conducting information and educational activities to teach the need to respect the rights of the people with mental disorders;
 - 3) in the scope of monitoring and assessing the effectiveness of the activities within the Programme – collecting and analyzing the reports with the information on the execution of the Programme tasks, submitted by the entities indicated in the Programme.

Tasks for the respective entities

I. Minister responsible for health issues:

Main objective 1: Providing people suffering from mental disorders with comprehensive care adequate to their needs.

Specific objective a): promoting the community-based model of psychiatric healthcare.

Tasks:

- 1) monitoring the progress of implementation by the National Health Fund of community-based psychiatric healthcare;
- 2) preparing – in cooperation with scientific societies dealing with the issues of mental health and with the entities participating in protection of mental health – of standards or recommendations for medical conduct within mental health centres;²
- 3) supporting and monitoring the process of development of a network of mental health centres;
- 4) determining the competences necessary for executing the community-based model of psychiatric healthcare, and considering – in agreement with the competent authorities of universities – the possibility of adapting the education programmes so that they take into account the needs of the community-based model of psychiatric care;
- 5) implementing – at the undergraduate and post-graduate levels – a staff training in the scope of the competences necessary in community-based psychiatric healthcare;
- 6) determining the tasks of basic healthcare within community-based psychiatric healthcare;
- 7) informing the authorities of the competent universities of the need to introduce, in the curricula of undergraduate education of physicians and nurses, and to specialized trainings for physicians and pediatricians, the tasks associated with the basic healthcare within the community-based model of psychiatric healthcare.

² Mental Health Centre – art. 5a of the Mental Health Protection Act of 19 August 1994 (Journal of Laws of 2016, items 546, 960 and 1245) – the medical entity that operates a mental health centre provides complex healthcare to people with mental disorders in the given territory in the form of interim, out-patient, daily, hospital and community-based aid.

Monitoring metrics, expected effects: the rate of staff undergoing the training within a year, the number of concluded agreements for mental health centres, drawn up document to approve the recommendations/standards.

Specific objective d): coordinating the available forms of care and assistance.

Tasks:

- 1) developing the assumptions for establishing or designating an authority to centrally coordinate the execution of the Programme at central level, with the following tasks:
 - a) perfecting, in cooperation with the competent scientific societies and with the entities participating in protection of mental health, of the organizational solutions and standards of conduct in the scope of mental health protection,
 - b) monitoring the execution of the National Mental Health Protection Programme in cooperation with the Mental Health Council,
 - c) drawing up annual reports on the basis of the information obtained from the entities executing the Programme;
- 2) preparing the institutional frameworks and rules of cooperation between the mental health centres and the entities that provide social support and social and professional stimulation in agreement with the minister responsible for the issues of social security. Expected effect: improvement in coordination of the Programme.

Main objective 2: Conducting activities to prevent stigmatization and discrimination of people with mental disorders.

Tasks:

- 1) developing detailed rules of conduct for presenting the image of people with mental disorders in the media;
- 2) conducting information and educational activities to teach the need to respect the rights of the people with mental disorders.

Main objective 3: Monitoring and assessing the effectiveness of the activities executed within the Programme.

Specific objective a): collecting and analyzing the reports with the information on the execution of the Programme tasks, submitted by the entities indicated in the Programme.

Task:

1) preparing and implementing a research programme to assess the effects and effectiveness of Programme execution.

Monitoring metrics: reports (2020 and 2022) specifying the fundamental organizational and staff resources of psychiatric care, metrics of prevalence of mental disorders, and of availability, quality and effectiveness of psychiatric care.

II. Minister responsible for the issues of labor, social security and family:

Main objective 1: Providing people suffering from mental disorders with comprehensive care adequate to their needs. Specific objective b): promoting diverse forms of social support and assistance.

Tasks:

1) supporting the local self-government authorities and other social welfare entities by expanding, diversifying and modernizing the assistance and social support for people with mental disorders, in the scope of social assistance, stationary assistance, community self-help, taking into account the family and senior policies;

2) monitoring the manner of implementation by local self-government authorities and other social welfare entities of the programmes of expanding, diversifying and modernizing the assistance and social support for people with mental disorders, in the scope of social assistance, stationary assistance, community self-help, taking into account the family and senior policies;

3) determining the standards of financing the services in the scope of social support and assistance for people with mental disorders.

Monitoring metric: an annual report specifying the resources and availability of social support and the number of people benefiting from various forms of assistance in Poland and in the respective provinces.

Specific objective c): supporting the employment of people with mental disorders.

Tasks:

- 1) implementing the legal and organizational solutions needed for developing various forms of supported employment and social entrepreneurship, adapted to the needs of people with mental disorders;
- 2) supporting the establishment and operation of non-government self-help movements:
 - a) of people who have experienced mental disorders or their families – for self-help and for representing the expectations and opinions in daily life and social dialogue,
 - b) of other organizations – operating to increase the activity and participation of people with mental disorders in social dialogue and life.

Monitoring metric: an annual report specifying the number of people covered by various forms of activity within the year.

Specific objective d): coordinating the available forms of care and assistance. Task:

- 1) preparing, in agreement with the minister responsible for the issues of health, institutional frameworks and rules of cooperation between the mental health centres and the entities that provide social support and social and professional stimulation, taking into account the family and senior policies.

III. Minister responsible for the issues of education

Main objective 1: Providing people suffering from mental disorders with comprehensive care adequate to their needs.

Specific objective e): providing psychological and pedagogic support to students, parents and teachers.

Tasks:

- 1) preparing, in agreement with the minister responsible for the issues of health, the institutional frameworks and rules of cooperation between the units of psychiatric healthcare and the units of the education system, in particular the youth fostering centres.

IV. Minister of Justice

Main objective 1: Providing people suffering from mental disorders with comprehensive care adequate to their needs. Specific objective a): promoting the community-based model of psychiatric healthcare.

Task:

1) providing the people in penitentiary facilities, in particular in youth penitentiary facilities, with access to psychiatric care and psychological support.

V. Minister responsible for internal affairs

Main objective 1: Providing people suffering from mental disorders with comprehensive care adequate to their needs. Specific objective a): promoting the community-based model of psychiatric healthcare.

Tasks:

1) developing the programme for adapting the activities of ministerial facilities with psychiatric wards, to the conditions of the community-based model of psychiatric care;

2) implementing the programme for adapting the activities of ministerial psychiatric to the recommendations of the community-based model of psychiatric care.

VI. Ministry of National Defense

Main objective 1: Providing people suffering from mental disorders with comprehensive care adequate to their needs.

Specific objective a): promoting the community-based model of psychiatric healthcare.

Tasks:

1) developing the programme for adapting the activities of ministerial facilities with psychiatric wards, to the conditions of the community-based model of psychiatric care;

2) implementing the programme for adapting the activities of ministerial psychiatric facilities to the recommendations of the community-based model of psychiatric care;

3) monitoring, supervising and protecting the mental health of: veterans of foreign operations and veterans injured in foreign operations, their families and families of the soldiers who died during operations abroad.

VII. National Health Fund

Main objective 1: Providing people suffering from mental disorders with comprehensive care adequate to their needs.

Specific objective b): promoting the community-based model of psychiatric healthcare.

Tasks:

- 1) financing the services of community-based psychiatric healthcare;
- 2) striving for a priority increase in the outlays on medical services in the scope of psychiatric care and treatment of addictions;
- 3) starting to finance the medical benefits in the mental health centres to allow to provide patients with comprehensive mental healthcare;
- 4) developing and implementing the rules of financing specialist psychiatric health services on the basis of a lump-sum rate for treating a person/an illness or group of illnesses.

VIII. Province self-governments

Main objective 1: Providing people suffering from mental disorders with comprehensive care adequate to their needs.

Specific objective a): promoting the community-based model of psychiatric healthcare.

Tasks:

- 1) updating the province programme of increasing the accessibility and decreasing the inequalities in access to various forms of community-based psychiatric healthcare, including of developing the mental health centres and psychiatric healthcare facilities for children and youth within provinces. The province programme may constitute an element of the regional mental healthcare programme;
- 2) developing, in cooperation with county self-governments, of a document specifying the strategy for development of the resources of mental healthcare taking into account the maps of medical needs in the scope of mental health centres, providing comprehensive healthcare services for the people with mental disorders in the given territory, and transferring the general psychiatric wards from province single-specialty hospitals to local multi-specialized hospitals or establishing them in local multi-specialized hospitals. The developed document may constitute an element of the regional mental healthcare programme;

3) supporting the implementation of the plan of locating the mental health centres providing comprehensive healthcare for people with mental disorders in the province, including by stimulating changes in the structure of the entities that conduct medical activities, established by province self-governments.

Monitoring metric: developed document.

Specific objective b): promoting diverse forms of social support and assistance.

Tasks:

- 1) updating the province programme of expanding, diversifying and modernizing the social support and assistance for people with mental disorders in the scope of social support and assistance;
- 2) supporting non-governmental organization projects aimed at developing the forms of social support for people with mental disorders, including by ensuring continuity of effective activities.

Specific objective c): supporting the employment of people with mental disorders.

Tasks:

- 1) increasing the availability of occupational rehabilitation, organizing occupational counselling and occupational trainings for people with disabilities, including people with mental disorders;
- 2) updating and implementing the province programme of development of diverse forms of supported employment and social entrepreneurship adapted to the needs of people with disabilities, including with mental disorders;
- 3) conducting a training and information campaign addressed to employers, to promote the employment of people with disabilities, including with mental disorders.

Specific objective d): coordinating the available forms of care and assistance.

Tasks:

- 1) developing or updating the regional mental health protection programme;
- 2) executing, coordinating and monitoring the regional mental health protection programme in the scope of the tasks entrusted to province self-governments;

3) preparing a guidebook, updated on an annual basis, with information on the available forms of healthcare, social assistance and occupational stimulation of people with mental disorders, including on the basis of the information provided by county self-governments, in electronic or paper version.

IX. County self-governments

Main objective 1: Providing people suffering from mental disorders with comprehensive care adequate to their needs.

Specific objective a): promoting the community-based model of psychiatric healthcare.

Tasks:

1) developing a local programme of increasing the accessibility and decreasing the inequalities in access to various forms of community-based psychiatric healthcare, including of developing the mental health centres and psychiatric healthcare facilities for children and youth within counties or communes.

2) establishing a mental health centre in compliance with the organizational principles included in chapter 4 of the Programme.

Monitoring metric: share of the facilities participating in the Programme within a year.

Specific objective b): promoting diverse forms of social support and assistance.

Tasks:

1) updating the programme of expanding, diversifying and modernizing the social support and assistance for people with mental disorders in the scope of: social assistance, housing assistance, stationary assistance, community self-help;

2) providing financial support for non-governmental organization projects aimed at developing the forms of social support for people with mental disorders;

3) increasing the share of issues of assistance to people with mental disorders in the activities of the county family assistance centres.

Specific objective c): supporting the employment of people with mental disorders.

Tasks:

- 1) increasing the availability of occupational rehabilitation, organizing occupational counselling and occupational trainings for people with disabilities, including people with mental disorders;
- 2) conducting a training and information campaign addressed to employers, to promote the employment of people with disabilities, including with mental disorders;
- 3) increasing the share of employment of people with mental disorders in the activities of the county employment offices.

Specific objective d): coordinating the available forms of care and assistance.

Tasks:

- 1) establishing, or continuing the activities of, a local team coordinating the execution of the Programme; the composition of the team will be specified so as to ensure proper representation of county or commune self-governments, entities performing the tasks in the scope of mental healthcare, non-governmental self-help organizations; the county council will provide the necessary administrative assistance;
- 2) developing or updating the local programme of protecting mental health, including a detailed plan of providing the inhabitants with coordinated medical and social services in mental health centres;
- 3) executing, coordinating and monitoring a local programme of protecting mental health;
- 4) preparing, and providing the inhabitants and the province self-government with, a guidebook, updated on an annual basis, with information on the available forms of healthcare, social assistance and occupational stimulation of people with mental disorders (in electronic or paper version).

X. Local self-government authorities

Main objective 1: Providing people suffering from mental disorders with comprehensive care adequate to their needs.

Specific objective e): providing psychological and pedagogic support to students, parents and teachers.

- 1) supporting the development of children and youth through psychological and pedagogic counselling centres, by providing children, youth and their parents with psychological and pedagogical assistance;
- 2) providing psychological and pedagogical assistance to children and youth in kindergartens, schools and facilities.

Chapter 3

PROGRAMME OUTLAYS

No.	Entity	Dedication of funds	2017	2018	2019	2020	2021	2022	Total 2017-2033
1.	Minister of Justice	Execution of programme tasks	4,800,000	4,800,000	4,800,000	4,800,000	4,800,000	4,800,000	28,800,000
2.	Minister of National Defense	Execution of programme tasks	6,000,000	6,000,000	6,000,000	6,000,000	6,000,000	6,000,000	36,000,000
3.	Minister of Internal Affairs and Administration	Execution of programme tasks	100,000	100,000	100,000	100,000	100,000	100,000	600,000
4.	Minister of Family, Labor and Social Policy	coordination	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	18,000,000
		Capital expenses*	30,000,000	30,000,000	30,000,000	30,000,000	30,000,000	30,000,000	180,000,000
	Total state budget		43,900,000	43,900,000	43,900,000	43,900,000	43,900,000	43,900,000	263,400,000
5.	Local self-government authorities**	Increase in availability of services	0	0	0	0	0	0	0
6.	National Health Fund	health services	3,491,530	3,493,908	3,490,530	3,491,500	3,491,530	2,491,530	14,951,518
	Total expenditure on the National Mental Health Protection Programme		46,391,530	46,393,918	46,391,530	46,391,530	46,391,530	46,391,530	278,351,518

* The Ministry of Family, Labor and Social Policy provided additional resources for investments.

** Lack of an amount in the table above does not mean that the local self-government authorities will not incur any outlays associated with execution of the tasks included in the Programme. However, the subject tasks included in the Programme, to be executed by local self-government authorities, belong to the group of their own tasks, and will be financed from the resources already at the disposal of the local self-government authorities. The Ministry of Health is only at the disposal of estimates concerning the outlays of the local self-government authorities in the previous years, and that data does not present the actual expenditure.

Apart from the costs of the Ministry of Health, any and all the costs for the state budget associated with implementation and execution of the tasks specified in the above project will be financed within the expenditure limits planned for the respective elements of the state budget for the given year, without the need to increase them, and the implementation of the drafted regulation will not provide the basis for applying for additional funds from the state budget.

Chapter 4

**RECOMMENDED ORGANIZATIONAL SOLUTIONS IN PSYCHIATRIC
HEALTHCARE**

I. Functions, structure and organization of mental health centres.

Mental health centres will execute the community-based psychiatric healthcare aimed at:

- 1) improving the quality of psychiatric treatment – its availability, continuity, complexity, its adaptation to the needs, the achievable effectiveness and decency of the conditions of providing aid;
- 2) assisting the patients in regaining their health, social position and expected quality of life;
- 3) developing conditions for social integration of people with mental disorders, and preventing stigmatization and exclusion;
- 4) limiting the length and the negative effects of hospitalization;
- 5) launching the initiatives and resources of local communities to support mental health protection.

Mental health centres for adults

1. Functioning

The complexity of the care provided by mental health centres results from:

- 1) individualization and coordination of the assistance provided to the respective patients;
- 2) diversity of the health services provided;
- 3) coordination of the health and social services;
- 4) adaptation of the organizational structure to the needs of a local community.

The mental health centres for adults will be established in order to provide assistance, for the target area inhabited by no more than 200,000 people, with the reservation that the number may be properly adapted to the respective territorial conditions in the given area or to other circumstances that might justify a different number of inhabitants. The density (distribution) of

the mental health centres and the scope of their territorial responsibility will be specified in the mental health centre location plan.

Territorial responsibility means the obligation to provide assistance to any inhabitant asking for help, residing in the administrative area of the given mental health centre. Location of mental health centres – the non-hospital infrastructure of the mental health centres should be, as a rule, located in full within the territorial responsibility area. In the case of lack of access to hospital facilities in the given area, it will be possible to provide 24/7 hospital services within mental health centres located in the hospital closest to that area (in particular through agreements with subcontractors, consortia).

Assistance in emergencies³ and urgent⁴ situations – mental health centres will provide, as far as possible, immediate assistance in emergencies, and in urgent situations – no later than within 72 hours. Mental health centres provide the following types of assistance:

- 1) active aid, i.e. treatment and support for people with chronic mental disorders that require continuous care, active contact and preemptive solution of problems;
- 2) long-term aid – to other people with chronic mental disorders;
- 3) short-term aid – to people with episodic or recurrent disorders;
- 4) ad hoc aid – in emergencies and urgent situations;
- 5) consultations – to other people that need diagnostic services or counselling. The first registration of a patient takes place in the out-patient clinic of the mental health centre, apart from exceptional circumstances associated with risk to the lives of patients or to the health or lives of other people.

The entity introducing a mental health centre may also have an agreement on provision of healthcare in the scope of treatment of addictions. 2. Structure

A mental health centre for adults will at least the following units:

- 1) out-patient unit – tasks: medical and psychological advice, individual and group aid in the form of psychotherapy, nursing services, social interventions;

³ The condition consisting in sudden or predictable (in the short-run) appearance of symptoms of poorer health, the direct result of which may include serious damage to the body or its functions or death, which condition requires immediate emergency activities and treatment.

⁴ If it is necessary to provide a service on an urgent basis due to the dynamic character of the disease process and the possibility of fast exacerbation of the disease or significant reduction in the changes of recovery.

- 2) community-based (mobile) unit – tasks: home visits, individual and group therapy, work with family, skill trainings, development of a network of social support, rehabilitation sessions and exercises;
- 3) daycare unit – tasks: daily psychiatric hospitalization for the purpose of intensifying the diagnostic, therapeutic or rehabilitation activities;
- 4) hospital unit – tasks: 24/7 hospital care in the situations characterized by high intensity of disorders or associated risk – the basic and target solutions will include the services provided by a psychiatric ward in a local general hospital.

The mental health centre may work simultaneously in more than one team.

A hospital ward will be managed by a physician specialized in psychiatry.

The registration and coordination office will provide quick registration, coordination of services and, in case of need – crisis intervention – it will be available 7 days a week, 24 hours a day if possible.

A mental health centre will closely cooperate in solving the health and social problems of the patients with the entities that provide social support, social and occupational stimulation and other aid activities in the area of the territorial responsibility of the given centre. Other specialized teams may be provided, in case of need, by the mental health centre to certain groups of patients (e.g. teams specialized in neurotic disorders, geriatric psychiatry, rehabilitation) or for the purpose of providing the necessary special services (e.g. crisis assistance, hostels, sessions).

Alternative forms of support and treatment (e.g.: crisis housing) may be established in the centre, if it is possible taking into account the legal regulations, the available funds and possessed competences, and if they meet the actual needs of the patients. If justified by needs and local resources, a team specialized in children and youth may operate within one medical entity, in cooperation with a mental health centre for adults.

Legal form – a mental health centre will be a medical entity/facility or will function as a consortium of entities or facilities.

A hospital team (ward) may be provided under an agreement with another medical entity.

The financing of the health services provided by the mental health centre should allow to provide the patients from the territory of functioning of the given centre with complex psychiatric care. The financing of social services will result from the applicable regulations.

Medical documentation – for the whole period of using the services in a mental health centre, there will be maintained one continuous, integrated documentation on the basis of the provisions issued under art. 30 section 1 of the Act on Patients' Rights and the Ombudsman of Patients' Rights of 6 November 2008 (Journal of Laws of 2016 items 186, 823, 960 and 1070).

Chapter 5

NECESSARY DIRECTIONS OF CHANGES AND CONDITIONS FOR DEVELOPMENT OF PSYCHIATRIC HEALTHCARE IN THE REPUBLIC OF POLAND

NECESSARY DIRECTION OF CHANGES

The implementation of a community-based model of mental health protection, i.e. providing people suffering from mental disorders with comprehensive, wide-ranging and commonly accessible healthcare and other forms of care and assistance necessary for living in the family and social environment. TASKS

1. Systemic reform of mental health protection to provide the aid that is:
 - 1) based on equal access (public responsibility under the preamble to the Mental Health Protection Act of 19 August 1994 - “mental health is a fundamental personal right of every person, and the state is obliged to protect the rights of the people with mental disorders”) adapted to needs, i.e.:
 - a) responsible in terms of territory – for the population residing in the given area,
 - b) diverse in functional terms: ad hoc, passive short- and long-term, active (so-called assertive outreach);
 - 2) complex: out-patient, mobile/community-based, daily, 24/7;
 - 3) coordinated: treatment, support system, social and occupational involvement;
 - 4) multi-professional: multidisciplinary teams with proper management;
 - 5) effective, i.e. respecting the available experience, scientific evidence and agreed standards of conduct;

- 6) decent and just (without violating the dignity or rights of individuals).
2. Improvement in system effectiveness indices:
 - 1) service availability: the target is to provide the basic services 7 days a week and 24 hours a day – on an emergency basis, and urgent services – within the period of 72 hours;
 - 2) health indices (based on ICD⁵, including incidence, prevalence, somatic co-prevalence, premature mortality, life expectancy, suicides, DALY's⁶);
 - 3) social indices (e.g. based on ICF⁷, including the level of functioning, independence, disability, temporary incapacity for work, life quality, exclusion and discrimination);
 - 4) economic indices (relationship between outlays and effects and effectiveness).
3. Empowering of the users of the system (respect for their rights and dignity, expansion of their participation and joint decisions, minimization of oppression).

CONDITIONS

- 1) an axiological-cultural change (values, attitudes);
- 2) a change in the social attitudes towards people with mental disorders, prevention of ignorance, stigmatization, unequal treatment and exclusion;
- 3) evolution of professional attitudes – towards understanding and acceptance of the assumptions of the community-based model of psychiatric healthcare, preparation by scientific societies of the standards of community-based psychiatric assistance;
- 4) a political change (responsibility, legislation, management);
- 5) undertaking of the challenges in the area of mental health protection adequately to the scale of needs and negligence – considering mental health protection to constitute a priority task of the health and social policies of the state, deinstitutionalization of psychiatric healthcare, i.e. replacing institutional care with the care provided at the level of local communities;
- 6) an organizational change (resources, institutions, staff, coordination, financing, investment).

⁵ International Statistical Classification of Diseases and Related Health Problems.

⁶ Disability-adjusted life years – applied to determine the condition of health of the given society.

⁷ International Classification of Functioning, Disability and Health.

4. Breaking the interdepartmental barriers in the scope of the health and social policies associated with mental health protection:

1) in mental health centres – indicating the required scope of the integrated offer of services financed from social welfare resources, and the integrated offer of the guaranteed services financed from public resources, and institutional coordination of the provision thereof;

2) in other units – the possibility to provide social services in health units, and health services in social welfare units (legal regulations, employment, financing).

5. Diversification and provision of social support resources, including the necessary social assistance, nursing services, support and self-help centres, protected and co-financed forms of housing support, support for development of self-help movements.

6. Diversification and provision of forms of occupational stimulation, including occupational rehabilitation, protected and supported employment, and social entrepreneurship.

7. Education of the necessary staff – increasing the level of psychiatric knowledge and competences of physicians at the undergraduate level, changing the specialist education programmes for psychiatrists, clinical psychologists and psychiatric nurses for the purpose of expanding the competences in the scope of community-based care, providing public funds for training community-based therapists, finishing the works on the act on the profession of psychotherapist.

8. Coordination and responsibility:

1) territorial responsibility (assessment of needs, resources, introduction of solutions);

2) regional (regional needs, resources and solutions, support for local solutions) and domestic coordination (planning, legislation, modelling, monitoring).

9. Financing: provision of services funded from the state budget:

1) in the scope of basic psychiatric care – gradual departure from the rule of financing single services and resources in favour of more complex methods of financing;

2) in the scope of specialized psychiatric care – gradual departure from paying for single services in favour of lump-sum financing for diagnosing and treating an illness;

3) in the scope of court-psychiatric and care services – based on the number of person-days.

10. Change management: providing various methods of education and additional education in the scope of management of mental health protection.