Review Article

Mental Health Care in Poland

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Abstract

Background: Like in other industrialized countries, the development of Polish psychiatry has followed a typical trajectory, initially marked by the establishment of large mental health hospitals using an isolation-based care model. Subsequently, there has been a decline in these institutions, characterized by a reduction in the number of hospital beds, and an ongoing evolution toward decentralized community psychiatry, specifically mental health-care centers. The hospitalizations are for emergency/acute care only. The authors describe how clinical services and personnel training in Poland that have been adjusted in response to societal changes and global trends in mental health care. **Methods:** The authors collected and critically reviewed information based on literature relevant to the organization of mental health care in Poland. In addition, official government publications such as reports from the Central Statistical Office and Ministry of Health were perused to gather data on the population structure, gross domestic product, and the organizational structure of the mental health care and relevant health-care indices. **Results:** Mental health care in Poland is evolving and gradually improving, providing more opportunities for collaboration and networking among nongovernmental organizations, patients' associations, and psychiatrists working toward common goals. Training curricula have been updated and/or modified, with new specialty and subspecialty trainings being offered to meet the demands of health-care professionals and patients alike. **Conclusion:** Demographic changes, the presence of Ukrainian war refugees, and global trends in psychiatry profoundly influence the delivery of mental health-care services in Poland.

Key words: mental health-care centers, postgraduate training, Ukrainian war refugees, undergraduate training
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Introduction

The Republic of Poland or Poland (PL, Figure 1) is a country in Central Europe covering an area of 307,236 km^2. The territory of Poland is divided into 16 administrative provinces called *voivodeships*, which are further divided into counties or districts (*powiats*). Warsaw is the nation's capital and its largest metropolis.

The neighboring countries include Germany to the West, the Czech Republic and Slovakia to the South, Ukraine and Belarus to the East, and Lithuania and the Russian province of Kaliningrad Oblast to the Northeast. To the North, Poland is bordered by the Baltic Sea.

According to the Central Statistical Office (GUS), the population of Poland amounted to 37,698,000 people at the end of June 2023, which makes it the fifth-most populous member state of the European Union. About 60% of residents live in urban areas. During the Polish census of 2021, 98.6% of the participants claimed Polish nationality, with Silesians being the largest ethnic minority (1.4%). In December 2021, the number of people who were equal or >60 years of age was about 26% of the total population.

Poland is an active member of several major international organizations, such as the United Nations, the North Atlantic Treaty Organization (NATO), the Organization for Economic Cooperation and Development (OECD), and the World Trade Organization, among others. In 2022, the total gross domestic product (GDP) and GDP per capita are equaled US$ 690.2 billion and US$17,959.9, respectively, classifying Poland as a high-income country by the World Bank.

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Figure 1. Map of Poland (Photo courtesy of One World - Nations Online, OWNO, www.nationsonline.org/oneworld/map/poland_map.htm).

In the article, we describe the development, current, and future organizational status of the mental health care in Poland. In addition, the educational background of the health-care personnel is briefly discussed, and some general information on the research conducted in the field of mental health is provided.

The Foundations of Modern Polish Psychiatry in the Historical Context

Poland became a recognizable unitary and territorial entity around the middle of the 10th century. The country continued to grow and develop, becoming a military and political power and a major cultural entity in Europe in the second half of the 16th century. But internal unrests and persistent warfare campaigns led to its gradual decline, culminating in the partition of the country territory among the Austria-Hungary, the German, and the Russian Empires in the second half of the 18th century.

The revival of the independent Polish state occurred in November 1918 after the World War I. The newly created state encountered significant issues integrating three different legal, financial, and health-care systems when organizing its social, medical, and scientific institutions.

The Polish Psychiatric Association was established in 1920 with the primary objectives of standardizing Polish psychiatric terminology and fostering the development of high-quality, independent Polish scientific research, thus giving rise to the Polish School of Psychiatry [1, 2].

The psychiatric care facilities were established not only in the academic setting (e.g., Vilnius, Kraków, Warsaw, Poznań, and Lviv) but also by local municipal authorities (e.g., Kobierzyn and the Dziekanka Psychiatric Hospitals), state or private institutions and the military. Some religious denominations and/or ethnic minorities founded and supported their treatment facilities, such as the Jewish Hospitals in Otwock or Warsaw. The novelty

introduced by the latter hospital was small, individual inpatient rooms as opposed to the large communal wards in other hospitals.

In an attempt to provide some insight into the situation of the mental health care in interwar Poland, Bernasiewicz and Łuniewski [3] collected data from 46 institutions, which reported having totally 11,652 beds reserved for psychiatric patients. The number of hospitalized patients amounted to 13,286, which showed the general phenomenon of hospital wards' overcrowding. The patients were looked after by 185 medical doctors, 2,084 nurses, and 166 other ward staff. Shortly before the Second World War, the number of beds was increased to about 14,000 and the number of physicians and nurses to 269 and 3,000, respectively [4].

Most of the psychiatric institutions were involved in an active pursuit of research activities involving not only psychological methods such as occupational therapy or psychotherapy but also the study of biological agents, including the application of insulin or fever (i.e., inoculation with *Plasmodium*) in schizophrenia treatment.

The newly gained independence ended with the invasion of Poland by Nazi Germany from the West on September 1, 1939, at before World War II, followed by the Soviet Union from the East two weeks later. The Nazi German and Soviet occupations had devastating consequences for Polish psychiatry, leading to the destruction of the medical infrastructure and the unprecedented loss of human lives. More than 100 Polish psychiatrists were exterminated being subjected to systemic prosecutions by the occupational forces, which involved, among other deportations, imprisonment in Nazi concentration camps or Soviet Gulags or mass executions (e.g., Katyń Forest Massacre) by the occupational forces. As a result of the genocidal Nazi T4 Action, 20,000 - 30,000 people with mental disturbances were killed or died of malnutrition in the occupied Polish territories [4-6]. The World War II trauma continues to have a profound effect on the mental welfare of war survivors in Poland, with the rate of probable posttraumatic stress disorder (PTSD), diagnosed according to *DSM-IV* = 38.3% [7].

The rebuilding of the country and the development of its entire health-care system begun in 1945 and was influenced not only by the major political changes in Poland but also by the evolution of mental health care in other countries. Polish psychiatry developed along a typical trajectory observed in developed countries [8, 9]. The initial establishment of large mental health hospitals, often located in remote and less densely populated areas (isolation-based care model), was followed by a subsequent decline of these institutions. The process of downsizing has been ongoing for years, primarily through the decommissioning of technically outdated or underused facilities and the improvement of conditions in the renovated ones (e.g., reducing the number of hospital beds).

The system is currently evolving toward a decentralized community psychiatry integrated into local communities. The core tenet is to provide most services to individuals in need within the vicinity of their residences (mental health-care centers [MHCs]). The hospitalization is reserved for acute psychiatric cases in general hospital wards, with a concerted effort to minimize hospitalization cases. This model underscores the accessibility, patient-centered care, and societal integration as fundamental principles in the landscape of mental health care. The pilot phase of the transformation begun in 2018 and it is anticipated that the program will become fully operational by the end of 2027 (for details, see below in this article).

Financing Health-care System in Poland

The Article 68 of the Constitution of the Republic of Poland of 1997 guarantees the rights to health protection financed by the public means to all citizens. This article additionally contains a provision obliging public authorities to provide for the special health-care needs of children, pregnant females, disabled, and older individuals [10].

National Health Fund (NHF)

The entire health-care system, including mental health care, underwent significant changes after 1990. The most crucial change involved replacing state budgetary funding with the insurance-based funding when simultaneously equalizing the rights of public and private entities to apply for public funds to provide health-care services. The main source of national social health insurance financing is an obligatory monthly contribution calculated as a percentage of a salary (redistributed tax).

The NHF is a proprietor of the funds acting in the system as the main payer, conducting periodical bids for the procurement of health-care services. Providers offering the most advantageous terms enter into contractual agreements with the NHF. The costs of the out- and inpatient health care are covered by the NHF in the form of a lump sum, a fee for a patient or specific services.

Although NHF benefits are broad in scope, there are important coverage gaps, such as for reimbursable medicines where significant cost-sharing is required and for dental services, which are largely excluded from the benefits package. Waiting lists apply for nonurgent outpatient specialist consultations, elective treatments, rehabilitation, and some diagnostics. Waiting times vary significantly depending on the area of care, region, and provider.

The total and public health expenditure reached 6.7% and 4.8% of the total GDP correspondingly. It is worth noting that the direct out-of-pocket expenditures on retail pharmaceuticals by households were also a significant source of health-care financing and represented an average of 65%, which is one of the highest indicators in OECD countries [11].

Voluntary health insurance (VHI) and out-of-pocket payments

Voluntary health insurance (VHI) and out-of-pocket payments (fee for service) play a supplementary and, to a lesser degree, complementary rôles providing a faster access to a better quality of mostly outpatient health-care services [12]. According to the data collected by the Polish

Insurance Association (PIU), about 4.5 million Poles held a VHI in 2023.

Legislative Regulations of the Mental Health Care

The most important legal acts currently forming the framework for the functioning of the entire health-care system are:

- The Act of August 27, 2004, on health-care services financed from public funds [13]
- The Act on medical/therapeutic activities of April 15, 2011 [14].

  For the area covering issues of mental health, the most relevant regulations also exit
- The Mental Health Act (MHA) of August 19, 1994, including the Regulation of the Council of Ministers of December 28, 2010, regarding the National Program for the Protection of Mental Health [15, 16].

The MHA ensured that both the central government (the Minister of Health) and local (lowest tiers of governance) public administration bodies, as well as the appointed institutions, are involved in providing the mental health protection activities. The Minister of Health had tasked with organizing the responsibilities of the entire psychiatric care system.

Furthermore, the MHA delineated the objectives and responsibilities for regional and local mental health programs, identifying the entities responsible for their design and execution. The MHA also stated that specific tasks are to be outlined in subsequent editions of the National Program for Mental Health Protection (NMHPP).

The NMHPP 2017-2022 of February 8, 2017 [17], set forth a strategy to deliver a comprehensive, diverse, and universally accessible health care, as well as other forms of support essential for individuals to thrive within their family and social settings. In addition, the program addressed the issue of shaping appropriate social attitudes toward individuals with mental disorders, emphasizing understanding, tolerance, kindness, and actively counteracting discrimination. To implement the ministerial regulations into practice, the mental health care reform has been initiated. In 2018, two regulations of the Minister of Health were passed to initiate a pilot phase of the development of the Centers for Adult Mental Health program [18, 19].

In 2023, the Council of Ministers elected to establish a successor of the NMHP 2017-2022 [17], namely the NMHP 2023-2030 [20]. This regulation will be followed by the development of regional mental health programs, specifying tasks in each of Poland's *voivodships*. First, the two major aims of the NMHP 2023-2030 are to ensure a comprehensive and tailored support, and care for the individuals with mental disorders, including those substance misuse issue and those undergoing mental crises, in a manner appropriate to their specific needs. Second, efforts to prevent the stigmatization and discrimination of individuals with mental disorders will be implemented.

The achievement of the first aim of the NMHP 2023-2030 should be facilitated by the popularization of an integrated and comprehensive model of mental health protection based on the community care model with a new mental health protection model for children and adolescents based on three reference levels. In addition, diverse forms of social support and vocational activation for individuals with mental disorders will be provided. Care and assistance efforts will be coordinated, and students, parents, and teachers will be provided with psychological–pedagogical support. The achievement of the second aim of NMHP 2023-2030 will involve various informational and educational activities regarding the portrayal of individuals with mental disorders in the media and the necessity of respecting the rights of such individuals.

Other important legal regulations covering the mental health-care provisions include:

- The Health Care Institutions Act
- The Act on Upbringing in Sobriety and Counteracting Alcoholism
- The Act on Preventing Drug Abuse
- The Act of Social Support/Assistance
- The Act on Vocational and Social Rehabilitation and Employment of the Disabled.

In addition, the Penal Code contains provisions concerning the mentally disturbed committing criminal acts and being admitted to the hospital for psychiatric examination/observation and/or treatment. The Minister of Health, in collaboration with the Minister of Justice, is responsible for maintaining a list of health-care facilities equipped with appropriate security measures.

Health-care Planning in Poland

Starting in 2016, the Ministry of Health initiated the release of Health Needs Maps (www.basiw.mz.gov.pl/en/analyses/), with a specific focus on psychiatric disorders as one of the analyzed disease categories. As outlined by the pertinent legislation of the Polish parliament, these maps play a crucial role in establishing priorities for regional health-care policy and providing insights into the feasibility of investments. Provincial branches of the NHF are expected to take these maps into consideration when devising plans for commissioning health-care services.

Tailored for each province in Poland, the Health Needs Maps consist of three key components: (a) demographic and epidemiological aspects, (b) an analysis of the state and utilization of resources, and (c) forecasts.

The first component includes vital information such as estimates of epidemiological indicators, morbidity rates, and mortality rates. The second component offers insights into health-care services provided to both adults and children, as reported to the NHF. The third component delivers a forecast of registered incidence. These maps are valuable tools for medical professionals, aiding in the strategic planning and allocation of resources within the health-care landscape.

Mental Health-care Personnel

One of the main problems of health-care system in Poland is the number and aging of the medical personnel. The number of practicing physicians and nurses per 1,000 population amounted to 3.4 and 3.7 compared to the average number of 3.7 and 9.2 for all OECD countries. The share of medical doctors aged ≥ 55 years was 38% [11]. The professionals providing mental health care include:

- Medical doctors – Psychiatrists, child, and adolescent psychiatrists (see trainings details below)
- Nurses – Nurses with secondary education (MSc), nurses with a bachelor's degree (BSc), and specialist nurse practitioners ("nursing in psychiatry"). The training follows a national curriculum with 3 years B.Sc. degree undergraduate university program followed by 3 years graduate M.Sc. studies. Specialist's training in psychiatric nursing follows a centralized national curriculum (total 1,190 h of instruction).Training is divided into three modules: general practical training (330 h), scientific theory training (330 h), and clinical rotations (560 h)
- Other health professionals with a degree – Psychologists/clinical psychologists, social workers, physiotherapists, "pedagogues" in health establishments (see trainings details below)
- Health workers without a degree (e.g., street workers; case managers).

The shortage of nurses, social workers, and case managers sometimes results in patients having no one to create and coordinate the implementation of comprehensive care packages for them.

Table 1. Core psychiatry curriculum of postgraduate training in adult psychiatry

	Duration (weeks)
Courses (lectures/tutorials)	
Foundations of psychiatry	1
Forensic psychiatry	2
Sociocultural and rehabilitation psychiatry	1
General clinical psychiatry	1
Foundations of psychotherapy	1
Functioning, disability, and health assessment	0.6
Health promotion and disease prophylaxis	0.4
Review course and assessment before board examinations	1
Grand total duration of theoretical courses	8
Mandatory clinical rotations	
General psychiatry services (core training)	148
Internal medicine	6
Neurology	4
Child and adolescent psychiatry services	8
Neurotic disorders and psychotherapy services	12
Community psychiatric services	12
Addiction and substance misuse services	8
Liaison psychiatry	6
Forensic psychiatry	8
Grand total duration of practical training	212

Trainings in Psychiatry

Undergraduate medical training

The training of undergraduate medical students in psychiatry is based on the national curriculum. But medical schools have certain degrees of freedom adapting the program to the needs and expectations of their students, for example, by offering elective courses or classes.

Postgraduate medical trainings

Adult psychiatry

The postgraduate training in adult psychiatry is a five-year residency program based on the standards of the Section of Psychiatry of the European Union of Medical Specialists. The rotations are dominated by general psychiatry training in the context of in- and outpatient services. The training is complemented by the community, child and adolescent, old age and forensic psychiatry, addiction, liaison, and rehabilitation psychiatry and medical psychotherapy training (Table 1).

Children and adolescents' psychiatry

The postgraduate training in children and adolescents' psychiatry is an independent five-year residency training (Table 2).

State Specialization Examination

To obtain the title of a specialist in psychiatry, the candidates must sit for a centrally organized State Specialization Examination. The passing rate for the State Specialization Examination from 2009 to 2018 was 94.31% in adult and 95.52% in children and adolescent psychiatry, respectively. According to the Chamber of Physicians and Dentists, there are 4,585 and 545 professionally active, board-certified adult and children and adolescent psychiatrists, respectively [21].

Training for Other Health Professionals

Training in psychology

Training in psychology consists of five-year university undergraduate program finished with a degree of Master of Science (M.Sc.). Clinical psychologists receive additional specialty training based on the national curriculum, consisting of core training (2 years) and a subsequent advanced training (2 years) in one of the disciplines: clinical psychology of mental disorders and somatic disorders, clinical neuropsychology, and clinical psychology of children and adolescents. During core training, candidates also acquire the rudimentary knowledge of general psychiatry, neurology, pediatrics, and internal medicine.

Training in psychotherapy

Currently, four-year training in psychotherapy is available for professionals with M.Sc. degree or equivalent such as psychologists, nurses, physicians, and social workers. It is expected to be a subject of change following the new

Table 2. Core curriculum of postgraduate training in children and adolescent psychiatry

	Duration (weeks)
Courses (lectures/tutorials)	
Foundations of children and adolescent's psychiatry	1
Forensic psychiatry	1
Treatment of major psychiatric disorders in children and adolescents	1
Rare diseases: Genetic diagnosis, social, and medical problems	0.4
Psychotherapy in children and adolescents	2
Functioning, disability, and health assessment	0.6
Addiction and substance misuse among children and adolescents	1
Health promotion and disease prophylaxis	0.4
Review course and assessment before board examinations	1
Grand total duration of theoretical courses	8.4
Mandatory clinical rotations	
General children and adolescent's psychiatry services (core training) - inpatient	95
General children and adolescent's psychiatry services (core training) - outpatient	40
General inpatient adult psychiatry services	12
General outpatient adult psychiatry services	4
Pediatric neurology	8
Pediatrics	4
Autism spectrum disorders	8
Community psychiatric services for children and adolescents	24
Community center for children and adolescents mental health support (psychology and psychotherapy)	4
Other diseases/conditions that may require clinical attention	4
Forensics psychiatry	8
Grand total duration of practical training	211

government regulations in 2024. In addition, there is a four-year specialty curriculum in psychotherapy of children and adolescents or substance misuse therapy.

The social workers receive postgraduate training in social services after completing three years undergraduate university program in one of the following fields: pedagogics, special needs pedagogics, political sciences, social sciences, family services, psychology, or sociology.

Organization of Traditional Mental Health-care System in Poland

The information regarding the resources of mental health-care care and the prevalence of mental disorders in Poland used below is provided by information concerning resources of mental health care and the prevalence of mental disorder in Poland for the year 2021, compiled by the Department of Public Health, Ministry of Health and pertain to the year 2021. For more detailed data concerning the type and number of facilities, patient population and the number of consultations provided, number of available beds and/or places please refer to Table 3. First-time patients means that patients were treated in a facility or admitted to the hospital for the first time in their lives during the year 2021.

Ambulatory health care

Patients do not require a formal referral from a primary care physician to access the services of mental health clinics, which represent the predominant form of outpatient care in Poland. The prevalence of mental disorders in outpatient care was 4,697.9/100,000 population, and the incidence was 938.3/100,000.

The four most common groups of diagnoses in *ICD-10* established in outpatient care were neurotic disorders (F40-48) at 35%, followed by mood/affective disorders at 20% (F30-39). Substance use disorders were diagnosed in 11% of treated individuals, with 8% being alcohol use disorders (F10) and 3% involving other psychoactive pharmacologic substances (F11-F19). Organic mental disorders (F00-F09) and schizophrenia, schizotypal, and delusional disorders (F20-F29) made up 10% and 8% of diagnoses, respectively.

Eighty percent of the patient population seen in psychology clinics were residents of urban areas, and 59% were female. The most prevalent age group comprised individuals up to 18 years old (47%), while those above 64 years old constituted the least numerous groups at only 6%. Psychotherapy (individual or group) was provided for 1,446,000 people.

Despite the dynamic development of this form of care in recent years, the scope of services offered to patients varies between facilities. About 50% of clinics provide medical and psychological consultations along with individual psychotherapy sessions, while the remaining clinics offer services limited to basic medical and psychological counseling or only medical consultations. The latter is especially true for clinics operating on a limited-time basis (1–3 days/week), typically located in smaller towns.

Outpatient clinics operating five days a week and offering a comprehensive range of services should serve as the core of the basic model of a MHC in the future. This center would be connected to a community team, providing active care for patients in a specific area and collaborating with day and inpatient care.

Environmental treatment teams

Environmental treatment teams (*Zespoły leczenia środowiskowego*) play a crucial rôle, providing specialized care for chronically ill patients within their environment by the means of frequent home visits and maintaining connections with patients through various activities, such as participation in patient clubs.

The highest number of patients were treated for organic mental disorders (F00-F09): 24%, followed by neurotic disorders (F40-48): 19%, and schizophrenia, schizotypal, and delusional disorders (F20-F29): 18%.

Most patients seen by the members of the environmental treatment teams were inhabitants of the urban areas and females, 74% and 60%, respectively. The most numerous age group consisted of patients aged 30 to 64, comprising 43%, followed by those aged 64 and above at 31%.

Table 3. Resources of mental health care in Poland in the year 2021

Facility type	Number of units	Number of patients seen during the year	Number of consultations/visits provided
Outpatient care			
Outpatient mental health clinics			
Adult	1,439	1,791,507	4.67 million medical and 4 million psychology or other therapeutic consultations
Children and adolescent's	247		
Alcohol addiction/co-addiction therapy	556		
Misuse of psychoactive substances and drug addiction	83		
Adult psychology	813	246,888 including 106,932 first-time patients	1.19 million including 26K medical consultation and 1.16 million psychology consultations
Children and adolescents psychology	257		
Environmental treatment teams	255	76,755	520K visits including 86K home visits and 434K at team's office visits
Day-care units	354 (8,289 beds)	24,532 including 10,802 first-time patients	
Inpatient care (24 h mental health care)			
Total number of hospitalizations	153,586 including 71,748 first-time patients		
Mental health hospitals	59 (17,704 beds)		
Regional forensic mental health centers	4 (282 beds)		
Mental health wards in general hospitals (total: 104 hospitals)	176 wards (5,215 beds)		
	42 detoxification wards (993 beds)		
Alcohol addiction therapy clinics	39 (1,732 beds)		
Drug addiction therapy clinics/centers	2,080 beds		
Hostel wards	35 (506 places)		
Care and treatment facilities and nursing-care facilities	68 (7,921 beds)		
Psychiatric wards for children and adolescents	38		

Source: Information concerning resources of mental health care and the prevalence of mental disorders in Poland for the year 2021

Day-care units

The day-care units (*Oddziały dzienne)* constitute an important environmental form of care, providing medical and rehabilitation services to patients for 8–10 h a day, 5 days a week, in the place of residence. This allows for the preservation of family and social ties.

The prevalence rate was 65.0/100,000 population, and the incidence rate was 28.0/100,000.

The most numerous groups among patients treated in day-care units consisted of individuals diagnosed with disorders caused by alcohol use (F10: 22% and 29% in first-time patients), and anxiety disorders (F40-48: 19% and 25% in first-time patients).

Among the total number of day-care patients, there are a similar proportion of men and women (53% and 47%, respectively), while the majority of those treated were urban residents.

Inpatient care

The largest group of patients in mental health inpatient care consisted of individuals diagnosed with substance use disorders (43%). This group included 34% of all patients with alcohol use disorders (F10) and 9% of patients involving other psychoactive pharmacologic substances (F11-F19). The following groups were patients diagnosed with schizophrenia, schizotypal, and delusional disorders (F20-F29; 18%), organic mental disorders (F00-F09; 11%), and mood/affective disorders (F30-F39; 10%).

Nearly half (48%) of first-time patients were individuals hospitalized due to disorders related to the use of alcohol and other psychoactive substances: 39% due to alcohol use (F10) and 9% due to other psychoactive substances (F11-F19). The following groups included patients diagnosed with neurotic disorders (F40-F48; 13%) and organic mental disorders (F00-F09; 11%). Patients with schizophrenia, schizotypal, and delusional disorders (F20-F29), as well as patients with mood/affective disorders (F30-F39), each constituted 10% of those admitted to hospitals for the first time in their lives.

Among the total number of hospitalized individuals in Poland, 66% are men, and 67% are residents of cities.

The prevalence in 24-h care was 405/100,000, and the incidence rate was 189/100,000 population. The highest prevalence of hospitalization occurred in cases of disorders caused by alcohol use – 139/100,000, schizophrenia

and schizotypal disorders – 74/100000, and organic disorders – 46/100,000. The highest incidence was also observed in cases of disorders caused by alcohol use – 74/100,000.

Hostel wards

Throughout the year, 1,332 individuals used these facilities (81% of males and 72% of urban residents), resulting in a utilization rate of 3.5/100,000 residents. An overwhelming 80% of those staying in hostels were patients with disorders caused by misuse of psychoactive substances. More than half (53%) of all patients had disorders caused using substances other than alcohol, and 27% had disorders caused by alcohol use.

Care and treatment facilities and nursing-care facilities

Care and treatment facilities (*Zakłady Opiekuńczo-Lecznicze - ZOL*) and nursing-care facilities (*Zakłady Pielęgnacyjno-Opiekuńcze - ZPO*) have evolved from former social care facilities and parts of large psychiatric hospitals, where some wards accommodate chronically hospitalized patients, not able to function independently, and who receive no community support.

Alcohol and/or drug addiction treatment

The decision to undergo treatment is voluntary unless compelled by a legal mandate, such as court-ordered treatment for individuals whose alcohol abuse or drug addictions adversely affect family dynamics, obligations, or public order. Similarly, a court of law may conditionally suspend the prison sentence of an addicted individual convicted of a crime related to the use of pharmacologically active substances (e.g., opioids), making participation in treatment a requirement. In these cases, legal obligations intersect with the need for treatment and rehabilitation.

Treatment for alcohol-related disorders or drug addiction is free of charge, extending to both uninsured individuals and, in the case of alcohol, those dealing with coaddiction. Each *voivodeship* is equipped with a *Voivodeship* Center for Alcohol Addiction and Co-addiction Therapy, tasked with overseeing the functionality of alcohol addiction treatment facilities, evaluating service quality, and providing expert opinions on strategies for public health protection. The spectrum of facilities addressing alcohol or drug addictions encompasses various specialized units and clinics, including addiction therapy clinics, daytime addiction treatment units, withdrawal treatment units, centers for the treatment of alcohol abstinence syndromes, hostels, and re-adaptation apartments. Drug addicts may be eligible for substitution treatment, and harm reduction programs (i.e., needle and syringe exchange points) are available. According to the National Bureau for Drug Prevention, there are 25 substitution treatment programs in Poland, with 24 in public and nonpublic health-care facilities and one in a penitentiary.

Future Organization of the Mental Health-care System in Poland in the Context of the Mental Health-care Reform for Adults

The following assumptions were the cornerstones of the mental health-care reform:

- Territorial responsibility: The obligation to care for the local community defined geographically
- One responsible entity to foster cooperation with a possibility to subcontract additional local resources
- Coordination of care and teamwork among MHC staff. The interchangeability of roles and participation of medical and nonmedical personnel, including recovery assistants, are anticipated
- Preventing social isolation or dependence on psychiatric services by early identification of the susceptible life situations and the implementation of early interventions
- Global annual budgeting: A lump sum provided at an annual rate per each inhabitant ≥ 18 years of age.

Mental health-care centers

MHCs are gradually introduced as community-based organization ideally on a county level with catchment area about 100,000-120,000 inhabitants. The MHCs provide comprehensive services, including psychiatric assessment and care, psychological assessments, psychotherapeutic interventions, and socioeconomic support for adult individuals within a specified territorial area (operational zone) (www.czp.org.pl/).

MHCs are divided into two types:

- Type A offers immediate, inpatient, day-care ambulatory, and community-based assistance. Type A MHC has a psychiatric ward integrated into its structure
- Type B is a standalone community center that provides daytime, outpatient, and community-based care. Inpatient treatment is conducted according to general principles in psychiatric wards contracted by the NHF at a standard of 25 beds/100,000 population aged 18 years and above residing in the MHC's operational zone.

At present, there are 94 MHCs (77 type A and 17 type B) in operation covering about 40% of the country's population, which amounts to 12,178,429 adults. Toward the end of 2023, an additional 35 centers are planned to be established, bringing the total to 129 nationwide. They are expected to potentially provide aid to 52.45% of the population aged ≥ 18 years. Patients can access MHCs without the need for a previous referral or an established diagnosis, irrespective of the medical condition, ranging from situational mood disruptions to emergencies.

Each MHC maintains a registration office open from 8: 00 a.m. to 6: 00 p.m., Monday to Friday, ensuring swift, referral-free access. The patient does not need to have an established medical diagnosis to be eligible for the MHC services, and no medical issues are discussed at the registration office.

A mental health coordinator asks the patient to a designated office where an individualized discussion

Table 4. Recommended minimum team headcounts in a mental health center (with catchment area 100,000 population)

Staff function	FTEs
Mandatory number	
Psychiatrists or physicians undergoing specialist training	3.5
Psychotherapist	3
Psychologists, preferably clinical psychologists or trainees	3
Psychotherapist/psychologist	2
Community therapist	2
Occupational therapist	1
Nurse (including psychiatric nurses)	2.5
Receptionist/medical secretary/office support staff	2
Psychotherapist/psychologist/psychiatric nurse – as mental health coordinator	2.5
Social worker	1
Facultative number	
Recovery assistant	1
Addictions psychotherapist	0.5
Job advisor	0.25
Nutritionist	0.5

FTEs, full-time equivalents

takes place, and an action plan is established. The initial health assessment involves, among others a completion of the PHQ-9 questionnaire and, if applicable, the Geriatric Depression Scale. Various aspects of medical support, such as psychiatrist consultations, individual or group psychotherapy, and referrals for hospitalization, are provided based on individual medical needs. Emergency medical cases are dealt with on-site, whereas for cases requiring an urgent medical consultation, an appointment will be scheduled no later than 72 h from the time of the first contact with MHC.

The medical staff at MHCs includes psychiatrists, psychologists, psychotherapists, social workers, rehabilitation specialists, and psychiatric nurses. In addition, two new roles have been introduced: the recovery assistant and the mental health coordinator. A recovery assistant is an individual who has personally experienced serious mental health care issues/crisis and completed appropriate training. The mental health coordinator, appointed from nonmedical staff, plays a pivotal role in coordinating a comprehensive mental health plan for each patient, involving not only medical and psychological treatment but also liaising with the patient's family and overseeing the social aspects of care. The recommended minimum MHC team headcount and the number of full-time equivalents are specified in Table 4. The specification does not include the inpatient unit staff.

MHCs typically operate day-care centers with a diverse range of medical activities, aiming to minimize inpatient hospitalization only for necessary cases. In addition, it is recommended to establish crisis intervention units and crisis hostels within the structures of MHC. Given the scarcity of hospital beds in Poland, this MHC approach benefits not only the patients who can receive localized medical treatment but also the whole health-care system.

Access to mental health care for Ukrainian war refugees

From February 2022, the migration situation in Poland has been dominated by an increased influx of Ukrainian citizens. They constitute the overwhelmingly largest group of foreigners in Poland, accounting for over 80% of all foreigners settling in the country. The number remains in the range of 1–1.4 million people.

Individuals possess the rights to access all medical services under the same conditions as Polish citizens. A children's ombudsman helpline, available in Ukrainian and Russian language, offers free psychological support by phone in collaboration with the Ministry of Health. Furthermore, the Ministry of Health is actively developing solutions to facilitate language communication between health-care providers and patients, aiming to enhance accessibility and support within the health-care system.

Nongovernmental organizations and patient associations

There are several nongovernmental organizations and patient associations involved in providing support for patients or persons undergoing mental health issues. These entities often include not only professionals but also individuals who have personally undergone or are undergoing the recovery process and wish to share their experiences with others.

Research and Publications in Mental Health from Poland

Basic and clinical research in the mental health field in Poland is mostly done at the medical universities, research institutes (e.g., Institute of Psychiatry and Neurology in Warsaw, Institute of Pharmacology of the Polish Academy of Sciences in Cracow). Mental health research is fragmented and mostly opportunistic in nature. But some research teams participate in collaborative projects run by the World Health Organization and the European Union.

Research projects are supported by grants from the national (e.g., National Centre for Research and Development) and international institutions or the industry. From March 2019, the noncommercial clinical trials and research experiments can obtain financial support from the Polish Medical Research Agency. Conventionally, Polish researchers were continually active in the field of pharmaceutical industry-sponsored clinical trials.

Research results are published both nationally and internationally. There are two major Polish journals of psychiatry: *Psychiatria Polska* and *Archives of Psychiatry and Psychotherapy.* Both are international and peer-reviewed journals published by the Polish Psychiatric Association. *Psychiatria Polska* publishes papers in both Polish and English versions (impact factor 1.7).

Conclusion

Poland is currently undergoing a series of significant changes in its mental health care system. As part of an ongoing pilot program, the establishment of new mental health centers (MHCs) is underway. These centers offer accessible, cost-free, individualized care conveniently located near the patient's residence. Effective community mental health care necessitates collaboration across interpersonal, interdisciplinary, and intersectoral domains. Sustained dialog at both local and national levels is crucial, involving the psychiatric care community and policymakers. At present, initiatives are in progress to formulate collaboration principles among diverse entities within the system, focusing on patient and family support alongside the development of diagnostic and therapeutic standards. One of the major systemic challenges is securing a stable, long-term financing system based on the population under care, subject to periodic adjustments to preserve its purchase power.

Data Availability Statement

Data sharing is not available to this article because no datasets were generated or analyzed during the current study.

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Conflicts of Interest

The authors declare no potential conflicts of interest with respect to the authorship, and/or publication of this article.

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