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Mental Health Centers. Preliminary evaluation of the pilot program implementation process

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Summary

Aim. The aim of the presented research is to characterize the operating Mental Health Centers (MHCs) and to provide a preliminary assessment of the implementation process of the pilot program model in the area of psychiatric care in Poland.

Method. The study uses the Polish version of the German questionnaire, which covers four areas: (1) basic conditions of the model project/pilot program; (2) characteristics of the organizational structure of the treatment entity; (3) statistical characteristics of the services provided; (4) specific features of the psychiatric care system in model regions/pilot program Mental Health Centers.

Results. Nineteen of the 27 Mental Health Centers completed the survey. The centers have 428 beds in day units and 1,971 beds in inpatient units. Most of the centers (15 of 19) work with subcontractors and all are publicly funded. Eight centers were established by psychiatric hospitals and 11 centers were constituted at psychiatric wards within multi-specialist hospitals. The medical services provided by the centers mainly include psychiatry and psychotherapy. In 2019, the centers provided medical services to a total of 65,614 patients; 8,432 patients received at least three forms of treatment.

Conclusions. The first full year of MHC operation in the pilot program indicates the expected direction of change in psychiatric care – achieving a significant level of implementation of community care standards. The survey needs to be repeated to verify this direction. A limitation of the study was the lack of survey responses from 30% of MHCs. In the future, we should aim for at least 90% of completed surveys.

Key words: pilot program, Mental Health Centers, community psychiatry

Introduction

The aim of community psychiatry is to enhance the mental health capacity available in the community by addressing various aspects of mental health (promotion, prevention, healthy functioning and its disorders) rather than just the problems of mental disorders. In practice, however, such a far-reaching understanding of the scope of community psychiatry has not been more widely realized and generally focuses on addressing issues related to the presence and treatment of people with mental illness. When looking at the contexts in which the term 'community psychiatry' appears, there are at least four major ones. Community psychiatry can be regarded (1) as a certain idea which is a kind of moral message of psychiatric practice, (2) as a certain system of organization of psychiatric health care, (3) as a certain method of treatment, and 4) as a certain way of setting, context or background of psychiatry [1]. This text uses the second understanding of the term.

The community-based model of psychiatric treatment has been implemented in Poland since the 1970s in parallel with the reform of all psychiatric care towards deinstitutionalization [2, 3]. During this period, the number of mental health outpatient clinics, community treatment teams, psychiatric wards at general hospitals, and day wards increased, and community-based social support facilities for the mentally ill were established as part of social welfare. In psychiatric hospitals, wards with specific profiles related to the diagnosis, age of patients or forensic psychiatry were established. According to statistical data, in 2018, in Poland, more than one million six hundred thousand people with mental disorders were treated in psychiatric outpatient care [4]. The most common problems reported are stress-related neurotic disorders and mood disorders, which indicates the need for cooperation between primary care medical professionals, psychiatrists, psychologists or social workers. Such coordination of activities and integration of treatment of people with mental disorders is possible within a Mental Health Center.

In Poland, Mental Health Centers (MHCs) were established thanks to the National Mental Health Protection Program. They operate under a pilot program of Mental Health Centers established and supervised by the Minister of Health and funded by the National Health Fund. Its implementation began in mid-2018 [5, 6]. Currently, 33 Mental Health Centers are already operating. The pilot program of community psychiatry is to be implemented by the end of 2022 so as to prepare a systemic reform to provide all Polish residents with the health care of MHCs. By the end of 2027, at least one Mental Health Center is to operate in every county, in every district of large cities.

The reform of psychiatric care is taking place not only in Poland but also in other European countries. The theoretical assumptions of the changes are known, but the question of whether the new models of care are more effective than the standard one still requires a number of studies. Researchers from Germany conducted a multi-stage iterative research process based on Grounded Theory Methodology (GTM) to identify and operationalize model components. A complex algorithm and expert interviews were

used to quantify the relative importance of each component and develop a summary score. Face and content validity were examined, and internal consistency was tested using the Cronbach's α coefficient. As a result, ten of the eleven FIT (Flexible and Integrative Treatment) components could be operationalized, quantified and combined into an overall score [7].

For reasons of scientific utility, components allow for an integrated process of collecting, analyzing and interpreting both qualitative and quantitative data sets. In this way, they can help overcome the widely recognized challenges of using mixed methods in health services research. They can also serve as a theoretical basis for constructing accuracy tools and research guides to evaluate the processes and outcomes of FIT models. They can serve as a target figure for implementing and/or monitoring FIT projects. By helping to keep in mind the various components of treatment, they pave the way for purposeful strategies for establishing or developing FIT models (described in the further part of the article).

The implementation of the FIT model in Germany, for example, allowed to reduce the time of hospitalization of patients aged 65 and older: in centers with exclusive implementation of the so-called FIT64b model, the time of hospitalization was on average 3.2 days compared to 8.4 days in centers with standard care [8]. A comprehensive evaluation of the implementation of the FIT model in 12 psychiatric inpatient units in Germany indicates a relatively stable style of structural and processual change and a shift of rigid forms of inpatient care towards flexible and integrative forms of outpatient care [9].

Due to the importance of these issues, a Polish-German research group was established in 2017, whose members on the Polish side are the authors of this paper and on the German side are Julian Schwarz, Sebastian von Peter and Martin Heinze. Using the dimensions proposed in the German model, a questionnaire was developed to describe one full year of functioning of the pilot program MHCs in Poland. The functioning of MHCs in 2019 was evaluated. The aim of this article is to present the results of the survey and a preliminary assessment of the implementation process of the capitation model in the area of psychiatric care in Poland.

Material and methods

The study used the Polish version of a survey developed by a team of German researchers led by Arno Deister and Martin Heinze. The survey is divided into four areas: (1) basic conditions of the model project/pilot program; (2) characteristics of the organizational structure of the treatment entity; (3) statistical characteristics of the services provided; (4) specific features of the psychiatric care system in model regions/pilot program Mental Health Centers.

The first area includes background information on the duration of the model project/pilot program, the contract with the NHF/health insurance funds, the percentage of budget share, and the cooperation of the pilot program MHC with subcontractors.

Structural characteristics include the type of treatment entity (specialist hospital, psychiatric unit in a general hospital, university clinic), the size of the region covered by medical care, the financing structure (non-profit, public, private), and medical services. This section also includes questions about, among other things, the number of inpatient wards, day wards and outpatient clinics that are spatially and structurally integrated into a single institution, the number of inpatient wards with outpatient and partial-inpatient (day) care offers, the total number of beds in the clinic, the number of psychiatric beds liquidated during the study period, and the number of places in psychiatric day wards.

The statistical characteristics of the services provided include numerical values for the number of inpatients, number of cases, average duration of an inpatient episode, average duration of cumulative periods of stay by inpatient, partial-inpatient (day), outpatient, patients treated under a Community Mental Health Team (CMHT), and number of passes.

The final area of the survey measures how well the 11 dimensions of the FIT models are met: (1) shifting into outpatient setting (annual comparisons omitted in Polish questionnaire due to survey conducted at one point in time); (2) flexible shift of settings; (3) continuity of treatment team; (4) multi-professional cooperation; (5) therapeutic group sessions across all settings; (6) outreach home care; (7) systematic involvement of informal caregivers; (8) accessibility of services; (9) sovereign steering of services; (10) cross-sectoral cooperation; (11) expansion of professional expertise.

The Polish version of the survey was developed in the following steps: translation, pilot study of the survey in selected MHCs and sending out the final version of the survey to all operating MHCs. The survey was conducted from July 28 to the end of December 2020. The questionnaires were sent electronically to the managers of the treatment entities running the Mental Health Centers and to the managers of the centers with the request to fill in the data for 2019 and send it back. Questionnaires were sent to 27 centers, and completed surveys were received from 19 centers (70%). During the last two stages there were questions requiring the creation of a glossary with explanations of some entries resulting from the divergence of the German and Polish systems. Then the obtained information was verified individually (by phone and/or e-mail) for each questionnaire.

The obtained data were analyzed using descriptive statistics by calculating mean values, minimum values, maximum values, and standard deviations. At several points, a wide range of reported values or a small number of responses was obtained, and quantitative analysis was not possible. The degree to which the dimensions of the FIT models were met was given as a percentage.

Results

The first area of the survey focused on the characteristics of the pilot program model. The average implementation time of the pilot program model in the surveyed

MHCs was 15.9 months (min. 13 – max. 18; *SD* = 1.52). The average share of funding from the NHF covered 73% of the MHC budget (min. 5.1% – max. 100%). 15 centers worked with subcontractors, including 7 centers with 1 subcontractor, 5 centers with 2 subcontractors, 2 centers with 3 subcontractors, 1 center with 6 subcontractors.

The second area of the survey concerned the characteristics of the organizational structure of the treatment entity (Table 1).

Table 1. **Characteristics of the organizational structure of the treatment entity**

Organizational structure of the MHC	Mean	SD
Size of catchment area (population)	100,355 (min. 38,947 – max. 184,000)	40,096.22
Number of inpatient units, day wards, outpatient clinics that are spatially and structurally integrated into a single institution	6.7 (min. 3 – max. 19)	4.23
Number of inpatient units with outpatient and partial-inpatient (day) care offer	1.4 (min. 0– max. 8)	1.77
Number of day wards with integrated outpatient care offer	1.2 (min.0 – max.4)	0.85
Total number of clinic beds 2019 (bed plan)	103.7 (min. 20 – max. 502)	138.60
Psychiatric beds liquidated in 2019	16.4 (min. 5 – max. 39)	15.29
Number of places in psychiatric day wards in 2019	22.5 (min. 8 – max. 49)	11.88

Eight MHCs operate within specialized (psychiatric) hospitals, and eleven were established at psychiatric wards in multi-specialist hospitals (including one university clinic). The 19 examined MHCs provide care to a total of 1,806,384 adult residents of Poland.

All MHCs in Poland are publicly funded. Psychiatry and psychotherapy are provided in 19 centers, psychosomatics and psychotherapy in 9 centers, child and adolescent psychiatry in 4 centers. Two centers provide three types of services, 9 centers – two types of services, 8 centers – one type of services. In total, the surveyed centers have 127 inpatient units, day wards, outpatient clinics which are spatially and structurally integrated in one institution. Regarding inpatient units with outpatient and partial-outpatient (day care) services, there are no such units in 3 centers, in the remaining 16 centers the total is 27.

Regarding day wards with integrated outpatient care, 1 center does not have such a form, while the remaining 18 centers have a total of 23 such wards. The total number of inpatient beds in all centers is 1,971. A total of 82 beds were liquidated in 5 of the 19 MHCs in the surveyed period. The total number of beds in day wards in all MHCs is 428.

Detailed information about the staff working in the surveyed centers is provided in Table 2. The average number of all employees in each center is more than 76. The centers have the highest number of nurses (32 people per center on average), doctors (15 people on average), psychologists and psychotherapists (14 people on

average), and the lowest number of recovery assistants – in total only eight assistants in eight centers (out of 19 surveyed).

Table 2. **Full-time staff by occupational group**

Staff	Number of MHCs	Mean	Min. – max.	SD
Total Staff	19	76.3	28.15 – 161.46	32.93
Doctors	19	15.1	5.05 – 246	6.77
Psychologists and psychotherapists	19	13.9	3.95 – 40	9.97
Nurses	19	32.0	3.5 – 125.3	25.03
Community-based therapists	13	2.6	0.11 – 9.05	2.64
Occupational therapists	17	3.2	1 – 8	1.63
Social workers	11	1.9	0.03 – 10	2.74
Recovery assistants	8	1.2	0.11 – 2	1.04
Other staff (including paramedics, medical supervisors, medical assistants)	11	13.3	2 – 26	7.28

The third area of the survey includes statistical characteristics of the medical services provided (Table 3).

Table 3. **Statistical characteristics of services provided**

	Mean	SD
Total number (all patients: all units)	3,860 (min. 1,087 – max. 9,960)	2,241
Patients in inpatient care	394 (min. 132 – max. 1,106)	251
Patients in partial-inpatient care/day ward	82 (min. 20 – max.171)	52
Patients in outpatient care	2,819 (min. 1,071 – max. 6,929)	1,650
Patients under Community Mental Health Team care	181 (min. 31 – max. 486)	145
Number of inpatients/outpatients receiving partial-inpatient and outpatient care	682 (min. 15 – max. 4,006)	1,214
Number of patients who received at least three forms of treatment	527 (min. 3 – max. 4,164)	1,272
Number of cases (= treatment episodes):	15,301 (min. 3,847 – max. 33,270)	10,901
Inpatient	1,425 (min. 107 – max. 8,165)	2,583
Partial-inpatient/day ward	496 (min. 8– max. 3,216)	1,012
Outpatient	11,247 (min. 234 – max. 30,627)	7,718
Community Mental Health Teams	1,987 (min. 35 – max. 5,999)	1,724

The total number of patients in all forms of treatment is 65,614, in inpatient care – 6,296, in day wards –1,313, in outpatient care – 45,103, patients under care of a CMHT – 2,890. The number of patients receiving partial-inpatient and outpatient

care is 10,914, and the number of patients who received at least three forms of treatment (inpatient, partial-inpatient, outpatient, home care) is 8,432.

The total number of cases (treatment episodes) across all hospital sectors/units is 229,508, in inpatient care in 2019 is 22,801, in partial-inpatient/day care it is 7,932, in outpatient care – 179,954, and under care of Community Mental Health Teams the total number of cases is 31,784.

Average duration of treatment episode (in days) in 2019 (= average length of stay) across all hospital sectors/units is 26 days (min. 1.93 – max. 103.5; *SD* = 28). The average duration of a treatment episode in inpatient care is 28 days (min. 13 – max. 45; *SD* = 13). In day units, the average duration of a treatment episode is 58 days (min. 10 – max. 171; *SD* = 39).

The question about the average number of service days per outpatient quarter covered 3 months. The range of reported values went beyond the definition proposed in the survey (outpatient quarter): the average duration of an inpatient episode was 402 days (min 1 – max 4,805). In community treatment teams, the range of reported values also exceeded the definition proposed in the survey (outpatient quarter): the mean duration of an inpatient episode was 97 days (min 1 – max 436).

The average duration of cumulative periods of stay in all hospital sectors/units is 23 days (min. 6.6 –max. 48.88; *SD* = 16). The average duration of cumulative periods of stay in inpatient wards is 29 days (min. 18.41 – max. 48; *SD* = 11), in partial-inpatient units – 54 (min. 28 – max. 83; *SD* = 24).

Values reported for the average duration of cumulative length of stay in outpatient care were not within the intended definition – the mean was 5 days (min. 0.75 – max. 5.16). Values reported by Community Mental Health Teams were not within the intended definition – average duration of cumulative length of stay was 14 days (min. 0.74 – max. 60).

The number of treatment episodes with at least a day pass was 1,670, mean 111 (min. 9 – max. 389; *SD* = 106). The number of treatment episodes with at least a day pass in inpatient units was 40, mean 3 (min. 1.7 – max. 6; *SD* = 1).

When asked about the number of patients who received inpatient services from mental health professionals in 2019 that lasted at least 7 days or more continuously, only 6 MHCs provided information, with a range of results from 1 to 826.

The final, fourth area includes a description of the features of the psychiatric care model (FIT) and quantifies the degree to which community-based psychiatric care solutions were implemented at each MHC. Aggregate scores for individual Centers ranged from 17 to 51 points (out of possible 60). The average score was 33 points, which is 55% implementation of community-based care solutions and dimensions, compared to a situation where all MHCs would have full, multidimensional, multiprofessional and inter-sectoral community-based care in place, where all components would be 100% implemented.

Of the nine assessed dimensions: (1) cooperation involving all professional groups achieved an implementation rate of 70%, (2) sovereign steering of therapeutic activities

– 69%, (3) cross-sectoral group therapeutic offers – 65%, (4) accessibility of services – 61%, (5) flexible shift of settings – 60%, (6) cross-sectoral cooperation – 56%, (7) expansion of professional expertise – 54%, (8) continuity of treatment team – 47%, and (9) Community Mental Health Teams having their own vehicles – 46%.

For 100% of the Centers, all services are available within a maximum of 1 hour by car. In 83%, patients under inpatient or partial-inpatient care, and patients under outpatient care are treated in the same institutions located in the same area. The number of inter-professional meetings per week has reached an implementation rate of 80%.

After analyzing the responses, it became apparent that the following components were the most difficult for entities to implement in the pilot program: multi-specialist collaboration, treatment groups involving all MHC members, outreach home care – multi-specialist treatment in the patient's home, participation of informal caregivers, accessibility of services, patient autonomy in service steering, and cross-sectoral cooperation.

Discussion of results

The results presented here describe the organizational structure and characteristics of the services provided by the pilot program Mental Health Centers in Poland. A 70% response rate was achieved, and a minimum of 90% of completed surveys should be sought in the next survey.

The centers participating in the survey provide psychiatric care to about 1.8 million people in Poland. The centers have 428 places in day units and 1,971 beds in inpatient units. Most centers (15 out of 19) work with subcontractors and all are publicly funded. In terms of organizational structure, 8 centers were established by a psychiatric hospital and 11 centers at psychiatric wards of multi-specialist hospitals. The medical services provided by the centers mainly include psychiatry and psychotherapy. In 2019, the centers provided medical services to a total of 65,614 patients, including 6,296 patients in inpatient care, 1,313 patients in day wards, 45,103 patients in outpatient care, and 2,890 patients in Community Mental Health Teams. 8,432 patients received at least three forms of treatment. The average length of patient stay in all hospital sectors/units was 26 days, in inpatient care it was 28 days, in day units – 58 days.

Within the MHC workforce, nurses make up the largest group, followed by doctors and psychologists and psychotherapists. The advantage in employing doctors may result from the regulation on MHC pilot program making the conditions for the provision of services dependent on the number of doctors [5]. Community-based therapists are not well represented despite being professionally qualified to work in community care. Assistants in recovery are also a small group.

The wide range of results in terms of the number of patients who received treatment services from professionals from different professional groups in the field of psychiatry, lasting continuously for at least 7 days and more, and the service provision in only 6 MHCs, may indicate the variation of comprehensive patient care in different

MHCs – from its absence to a high degree of cooperation between professionals from different professional groups.

The limitation of our study is the lack of validation of the questionnaire translated into Polish. Also a limitation of the questionnaire were the questions about the average and cumulative number of days of stay in the outpatient clinic and under care of a Community Mental Health Team, which is related to different ways of recording these medical services in Germany and Poland, as in our country we use the term 'visit' rather than the number of days to account for outpatient services.

Among the most important differences between the model care in Germany and the pilot MHCs is that in Poland, the way of financing is a lump sum per population – the capitation budget per adult inhabitant of the area covered by a Mental Health Center, whereas in Germany, there is a budget per patient. Also, the financing structure is different: in Poland, the National Health Fund is the only financing body, in Germany, there are 16 Health Insurance Funds (*Krankenkassen*). In Poland, there are CMHTs, which provide both continuous care and an alternative to hospitalization [10], whereas in Germany, there are no CMHTs, due to a separate and difficult financing by the German health insurance funds. In Poland, Mental Health Centers cooperate with subcontractors, while in German model care regions, no such cooperation exists. In the Polish MHCs, the therapy is supposed to start quickly and according to need in a directly accessible way, therefore waiting lists have been eliminated and everyone is admitted on an ongoing basis. In Germany, the accepted solution is the use of waiting lists: the admission center in a model clinic maintains a list where all patients who would like to be treated are admitted according to the severity of the condition and health needs.

Regarding the necessary minimum for a MHC in Poland or a model clinic in Germany –in our country four treatment structures are needed: a hospital unit, a day-care unit, a community-based unit, and an outpatient unit. In Germany, there is only one clinic providing care in the model region. On the other hand, in both countries, an important role is attributed to the inclusion of assistants in recovery (Ex-In) in the treatment program [11].

In the work of Thornicroft and Tansella [12], the main conclusion was that both community-based and hospital services are needed in all areas (countries and regions), regardless of resource level. The evidence in this study argued for a balanced approach that included both community and hospital services. Areas with low resource levels can focus on improving primary health care, with specialist facilities. Medium-resource areas can additionally provide outpatient clinics, community mental health teams (CMHTs), acute inpatient care, community home care, and employment and work formats. High-resource areas may provide all of the above services, along with more specialized services such as specialized outpatient clinics and CMHTs, assertive community treatment teams, early intervention teams, alternatives to acute inpatient care, alternative types of community-based 24-hour care, and alternative forms of employment and rehabilitation.

Forty-four studies were analyzed in a meta-analysis by Ziguras and Stuart [13]; 35 compared assertive community treatment or clinical case management with treatment as usual, and nine directly compared assertive community treatment with clinical case management. Both types of case management were more effective than treatment as usual in three outcome domains: family burden, family satisfaction with services, and cost of care. Total number of admissions and percentage of hospitalized clients were reduced in assertive community treatment programs and increased in clinical case management programs. The number of days spent in the hospital was reduced in both programs, but assertive community treatment was significantly more effective. Although clients in clinical case management had more admissions than those in usual care, the admissions were shorter, reducing the total number of hospital days. Both types of case management were equally effective in reducing symptoms, increasing patients' contact with services, reducing dropout rates, improving social functioning, and increasing patient satisfaction.

The extent to which the dimensions of the FIT models were met in our survey shows that the pilot program MHCs in Poland achieved a significant level of implementation of community care standards within a year and a half. The implementation of the above components is significantly linked to the method of financing – a lump sum per population. Only if this mode of financing is maintained will a full, multi-dimensional, multi-professional and inter-sectoral community care service be possible.

In a (qualitative) survey conducted by the Patient Ombudsman in relation to Mental Health Centers in June 2020, the authors of the survey obtained a number of conclusions – partly overlapping and partly differing from the conclusions of the pilot program MHC survey conducted by the authors of this study [14]. The survey of the Patient Ombudsman describes the following dimensions of cooperation with other entities as good: cooperation with subcontractors and cooperation with social welfare centers, and as requiring further development: cooperation with primary care centers, night shelters and hostels, care and treatment institutions and social welfare homes, and cooperation with local governments. Our survey shows a high participation of subcontractors in the provision of care, but their low participation in the "life" of the MHCs (e.g., in meetings).

There is agreement with the conclusion that the strengths of the care provided by MHCs are: immediate comprehensive psychiatric care, reduced hospitalizations (reduction of hospital beds), development of community psychiatry (high degree of fulfillment of the dimensions of FIT models). Areas for further work identified in both surveys are: admission of patients from outside the territory, lack of training in community psychiatry, difference in costs of maintaining centers in communal and urban areas, difficulties in staffing and premises. As far as proposals for legislative changes in Poland are concerned, there is one conclusion from both surveys – there is a need for an amendment to the Mental Health Act, as well as the establishment of a separate institution evaluating, for example, uniform medical records and the regulation of unused funds in the next settlement period.

Conclusions

1. The first full year of MHC operation in the pilot program indicates that the expected direction of change in psychiatric care is to achieve a significant level of implementation of community care standards.
2. In order to observe the above process toward full implementation of multidimensional, multi-professional and inter-sectoral community care, the study needs to be repeated after at least 3 years of MHC operation.
3. Areas that require special attention in the establishment and development of Mental Health Centers in Poland include multi-specialist cooperation, treatment groups with the participation of all MHC members, outpatient home care – multi-specialist treatment at home, participation of informal caregivers, accessibility of services, patient autonomy in steering the services, and inter-sectoral cooperation.

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