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Operation of Mental Health Centres (CZP) in Poland during the SARS-CoV-2 pandemic

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Summary

The paper concerns the community-based model of psychiatric care implemented within the pilot programme in Mental Health Centres (CZP) during the SARS-CoV-2 pandemic.

The aim of the study is to characterise the changes in the operation of Mental Health Centres (CZPs) in Poland during the COVID-19 pandemic. The change in the concept of psychiatric care and the shift towards a community-based model within CZPs meant, among other things, that providers did not have to present and implement strictly defined schedules, which made it possible to respond to the current needs of patients and made it possible to adapt the conditions and ways of providing psychiatric care in Poland during the pandemic.

On the basis of the experience during the pandemic, recommendations were made to improve the organisation of CZPs in Poland.

Key words: SARS-CoV-2 pandemic, Mental Health Centres

Introduction

Mental health, including mental disorders and diseases, and mental health protection are those areas/spheres of social life and public activity in which many prejudices and barriers exist [1]. In Poland, for many years, changes aimed at improving the existing mental healthcare system on such a large scale as the ones taking place at present had not been introduced [2]. The pilot programme implemented in Mental Health Centres (Pol. = CZP) is an attempt to test the community model of psychiatric care in the Polish healthcare system. In its assumptions, the pilot project aims to check whether the community care will have an effect on:

- the operation of the mental healthcare system,
- cost-effectiveness, quality, and availability of services,
- the structure of psychiatric diagnoses,
- reducing public health problems, including the number of suicides,
- improving access to care for people suffering from a mental crisis.

The community model fosters better results in the recovery process, stimulates the return of people who have experienced a mental crisis and their families to participate in social life, and counteracts the stigmatisation phenomenon [3, 4]. The abandonment of the inpatient treatment model based on large psychiatric hospitals and the deinstitutionalisation of psychiatric care are the directions of changes postulated by international organisations which create the health policy on the basis of scientific knowledge [5, 6].

The community model of psychiatric care assumes collaboration of the Mental Health Centres (CZPs) with local self-government administration. The CZP is run as within a therapeutic entity, the task of which is to provide comprehensive healthcare for people with mental disorders aged more than 18 years in a specific territorial area. For the implementation of the task, the entity running the CZP receives a lump sum per population, which is the product of the rate per capita and the number of adult residents in the area of operation in which the entity is responsible for the implementation of psychiatric care. The funds received by the entity operating the CZP may be used exclusively to cover the current costs of functioning of the CZP's operation connected with the provision of mental care services to the population covered by the pilot programme and ensuring readiness to provide them for this population. In each CZP, as part of the mental health clinic, there is a Reporting and Coordination Centre (Pol. = PZK), the tasks of which include, inter alia: providing information about the scope of the centre's operation and the possibility of obtaining health services, conducting an initial assessment of needs, agreeing an initial treatment plan, agreeing the date of admission and indication of the place of obtaining the necessary psychiatric and social welfare benefits, and providing healthcare services [5].

On 27 April 2018, the Minister of Health issued a regulation [7] on a pilot programme in health centres. This programme covers the period starting from 1 July 2018 to 31 December 2022 [8]. Contracts for the implementation of the pilot programme were concluded by healthcare entities as of 1 July 2018 to 1 December 2018, thus a large number of entities tested the project in 2019. This time allowed for the reorganisation of work and focusing on expanding community care for the populations covered by the programme, but it was too short to implement the community care model to a full extent.

The concept of changing the model of psychiatric care, i.e. the transition to the community model (including: flexible adaptation of the concept of this model of psychiatric care along with the changing conditions during the pandemic) and the lack of the need to present and implement strictly defined schedules by service providers allows responding to the needs of patients and allows for adaptation of the conditions and methods of providing services in the field of psychiatric care.

Health services in the field of psychiatric care in the Mental Health Centres in Poland are provided in the following conditions:

(1) stationary:
   (a) psychiatric,
   (b) at the place of providing emergency aid (i.e. in emergency and urgent cases, e.g. psychiatric emergency room or psychiatric admissions department in a general hospital);
(2) daytime psychiatric;
(3) outpatient – psychiatric and community (home) treatment [9].

While testing the community model of psychiatric care under the CZP, the implementers adapted the solutions to the innovations arising from the project assumptions. However, the time to implement the psychiatric care reform proved to be insufficient and the onset of the COVID-19 pandemic revealed several systemic and organisational problems [10-12].

The aim of this article is to characterise the changes in the operation of the CZPs in Poland during the pandemic caused by the SARS-CoV-2 virus.

Material and method

The experiences from 2019 show that where the Mental Health Centres started their activities, they gained recognition and support from local authorities. In some of the areas covered by the pilot programme under the CZP, there is a sound collaboration between the leading entity and, for example, the Social Welfare Centres (OPS), or basic healthcare (POZ) clinics. The above-mentioned authorities can thus create better conditions of care for the population in a given area. The CZPs can support the OPSs and POZs in particularly difficult work in the case of caring for people suffering from mental disorders and diseases, while the OPSs and POZs can support or mediate in assistance in building a support network and reaching those patients who, due to social exclusion [13, 14], would not be able to benefit from the assistance offered under the CZP without such actions.

According to the announcement of the National Health Fund Headquarters of 15 March 2020 on the implementation and settlement of services such as psychiatric care and addiction treatment in connection with the prevention, counteraction, and combating of COVID-19, one points to the possibility of performing and accounting for medical consultations provided under contracts for providing healthcare services, such as psychiatric care and addiction treatment, and a pilot programme in Mental Health Centres with the use of Information and Communications Technology (ICT) systems or other communication systems.[1] The data presented in the article were developed based on information collected by the National Mental Health Protection

[1] The entities used generally available forms of communication, i.e. telephone calls with patients, e-mail correspondence, instant messaging and platforms enabling audio and video connections, e.g. Microsoft Teams, Zoom and Google Meet, WhatsApp, Signal, and Facebook Messenger.

Programme Pilot Office in April 2020 from the implementers of the pilot programme at the CZPs.

On 5 April 2020, the National Mental Health Programme's Pilot Office asked the managers and coordinators of 35 centres (29 operating and 6 planning to start operations) to present the then current situation in institutions and local psychiatric care, existing issues and ways of solving them, and information on how the CZP and PZK models work in the conditions of the SARS-CoV-2 pandemic. The questions were open-ended. The information obtained allowed for the development of a general assessment of the situation present in the CZPs, as well as the identification of problems requiring action at the central level. The results were divided into the following 6 categories:

(1) general information (including day wards and Reporting and Coordination Centres);
(2) stationary benefits;
(3) outpatient and community services;
(4) issues and other information related to the pandemic;
(5) the entity's postulates and expectations;
(6) decisions of the provincial governor imposing obligations in association with the pandemic.

The responses sent by the CZPs, broken down by province, are shown in Table 1. The responses were sent by 33 entities, including 6 establishments, which planned to start operations, having no previous experiences in the implementation of tasks arising from the regulation on the pilot programme in the CZPs.

Table 1. **Number of responses received from the CZPs, broken down by province**

Item no.	Province name	Number of replies received
1	Lower Silesia	2
2	Kuyavia-Pomerania	1
3	Lublin	2
4	Lubusz	1
5	Łódź	3
6	Lesser Poland	4
7	Masovia	4
8	Opole	0
9	Subcarpathia	2
10	Podlaskie	4
11	Pomerania	2
12	Silesia	2
13	Holy Cross	2
14	Warmia-Masuria	2

table continued on the next page

15	Greater Poland	1
16	West Pomerania	1

Source: own study based on data collected by the Pilot Office as part of the monitoring of CZP continuity.

The number of responses received is strictly related to the number of Mental Health Centres operating in Poland. Most responses were received from the Lesser Poland, Masovia, and Podlaskie provinces (four responses from each province). Three responses were received from the Łódź Province. Two responses were received by the Pilot Office from each of the following provinces: Lower Silesia, Lublin, Subcarpathian, Pomerania, Silesia, Holy Cross, and Warmia-Masuria. One response was received from the following provinces: Lubusz, Kuyavia-Pomerania, Greater Poland, and West Pomerania. No response was received from the Opole province due to the fact that no CZPs existed in its territory.

Results

From the collected information, it appears that the provinces which imposed the obligations connected with the pandemic on the psychiatric wards included in the CZPs (e.g. those that are part of dedicated isolation hospitals) did not indicate at the same time other psychiatric wards that would take over the existing tasks of pandemic wards. This caused local difficulties in the coordination of psychiatric care. The CZPs introduced organisational changes connected with the pandemic depending on local conditions. In several entities, the principle of functioning in two or three permanent, separate teams, exchanging tasks alternately, was introduced. Many CZPs have implemented safe procedures for admitting patients in case of the necessity of personal contact and employees have been trained. In some of them, a decision was made to reorganise the location or reconstruction to this end. [2]

The reported postulates and proposals collected from the CZPs during the pandemic cover the following issues that were signalled by the respondents to be implemented during and after the period of risk of contracting the SARS-CoV-2 virus in Poland:

- the possibility of current supply of personal protective equipment;
- the expectation of consulting the provincial governors' decisions on psychiatric care with provincial consultants and interested institutions;
- introducing solutions (at the provincial level) establishing the rules for providing residential care for residents of the CZP's area of operation, if the CZP's psychiatric ward has been transformed into an "isolation" ward for the province's inhabitants;
- development of national guidelines for advice/home/community visits in conditions of the pandemic;

[2] The information comes from a memo prepared by the Pilot Office for the Ministry of Health.

- development of national guidelines for the functioning of "isolation" psychiatric wards (in particular in dedicated COVID-19 hospitals) and general psychiatric wards in specialist hospitals not transformed into dedicated COVID-19 hospitals;
- standardisation of procedures ensuring the safety of staff in psychiatric care facilities and the performance of diagnostic tests for patients and staff of inpatient care units, including emergency rooms;
- abolishing referrals to a psychologist, thereby increasing access to mental health-ensuring services.

Summing up the results of the study, it can be stated that: in the first phase of the pandemic, the focus was on tracking new cases of COVID-19. The second phase of the pandemic was a series of preparatory activities, including the reorganisation of systems in terms of the treatment of "positive" patients, that consisted in, inter alia, setting up special zones for people diagnosed with the coronavirus. Some reports on the activities of the CZPs during the pandemic, collected by the National Mental Health Protection Programme Pilot Office, mention the reorganisation of the system of admitting patients to psychiatric wards with a separate path for people suspected of being infected and ensuring appropriate forms of isolation in the ward and outside wards in dedicated COVID-19 hospitals. The third phase is a period in the pandemic that should be focused on the comprehensive treatment of patients and the re-coordination of the entire system of treating mentally ill patients who are not suspected of being infected with the coronavirus as part of the CZPs.

During the pandemic, the entities implementing the pilot programme, while waiting for the guidelines and positions of the Ministry of Health, the National Health Fund, and the State Sanitary Inspection, carried out their activities based on the skills and experience of physicians and the clinical situation (without sufficient data coming from scientific research); hence, only some of the postulated and reported problems were solved in a systemic way.

Based on the experience of the SARS-CoV-2 pandemic, it is important as part of the CZPs' work organisation in Poland that [3]:

– Patients know where and how to report their ailments: in all CZPs the work of Reporting and Coordination Centres (PZK) is currently being continued. They provide a type of readily available help, especially expected in the conditions of a pandemic, quickly providing basic information and thus eliminating helplessness and insecurity and fear for oneself or one's loved ones. The PZKs quickly developed the principles of using ICT systems to inform, offer initial support, and coordinate further assistance, while maintaining the possibility of direct contact in urgent cases or in cases of inability to use remote forms of contact.
– New work organisation procedures were implemented in selected forms of psychiatric care, including:

[3] Developed on the basis of the data collected by the Pilot Office as part of monitoring CZPs' continuity.

- 24/7 wards, including through organising separate rooms or parts of wards where patients suffering from COVID or suspected of being infected by the SARS-CoV-2 virus infection were present (from the time of their admission to obtaining the SARS-CoV-2 test result);
- day wards, in which during the pandemic, the activity of these wards was temporarily suspended in all CZPs, which was, among others, the procedure recommended by the National Health Fund. Patients of the days wards were mostly provided with the maintenance of contact with the CZP and the necessary support as part of outpatient services, most often offered in the form of online consultation, which, depending on the needs and individual preferences of the patient, should be continued or implemented in a mixed form (stationary meetings and online consultation);
- mental health clinics (PZP), which maintained the continuity of care in most Mental Health Centres – mainly through ICT systems. Any deviations from this rule were made mainly in relation to first-time patients or patients who signalled particularly serious difficulties, or who required the administration of drugs in depot form. The possibility of using e-prescriptions and e-medical certificates was an important facilitation. At present, there is a need to develop a flexible system of work in clinics, i.e. one that meets the patient's needs;
- community treatment teams (ZLŚ), where the service of care is provided in a similar way to the one described above. The active nature of the care provided by the ZLŚ requires more frequent and regular contact with the patients, currently implemented chiefly through ICT systems. The exceptions are mainly associated with the need to administer long-acting drugs [15].

Conclusions and recommendations

1. A new map of mental health services' organisation following the peak of the pandemic in Poland is urgently needed. The map with a new division of tasks is to provide patients with mental health problems with the knowledge of a quick access path to physicians in their area. In the first and second phase of the pandemic, patients not infected with SARS-CoV-2 had problems with access to inpatient forms of psychiatric care; therefore, now, due to the experiences from the pandemic, it is necessary to develop for the future:
   – national guidelines for the operation of "isolation" psychiatric wards (in particular in dedicated COVID-19 hospitals) and general psychiatric wards in specialist hospitals not transformed into dedicated COVID-19 hospitals;
   – solutions (at the provincial level) setting out the rules for providing residential care for residents of the CZP area of operation in the event that a psychiatric ward of the CZP is transformed into an "isolation" or other ward for the needs of the province's residents.

2. Well-functioning community care fosters good understanding of patients' needs and their living conditions, which means that even in a situation of, for instance, a pandemic, there is no element of surprise and there are known channels and methods of reacting to an emergency situation (in areas related to, inter alia, risk assessment or management of change). In the situation of the pandemic, the pilot CZPs quickly and easily adapted their response methods to the changing or new needs/new circumstances. This "ease of fast adaptation of the way of responding to the changing or new needs/new circumstances" is the capabilitythat distinguishes the functioning of the CZPs, which have become achievable owing to flexible schedules and conditions for providing services under traditional systemic solutions. A new method of financing the pilot CZPs played a significant role here – in the form of a lump sum per population, which ensured "flexible financial stability" of the CZPs and allowed for focusing efforts on searching for adequate solutions in response to the challenges associated with the pandemic.
3. As part of the activities in the field of psychiatric care reforms in Poland, it seems appropriate, at the present stage, to use all observations and information on the operation and organisation of work of entities that were included during the COVID-19 pandemic in the CZP pilot programme in order to continuously improve the functioning of a new model of mental healthcare that is based on community care. The knowledge and experience gained during the pandemic should be used to develop a diagnostic and therapeutic standard in CZPs, which should take into account, inter alia, patient management during a pandemic.

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