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An analysis of the functioning of mental healthcare in northwestern Poland

Analiza funkcjonowania opieki psychiatrycznej w północno-zachodniej Polsce*

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ABSTRACT

Introduction: Modern psychiatry faces numerous challenges related with the change of the epidemiology of mental disorders and the development of knowledge in this area of science. An answer to this situation is to be the introduction of community psychiatry. The implementation of this model in Poland was the aim of the National Mental Health Protection Programme. The aim of the study was to analyse the functioning of mental healthcare using the example of the West Pomeranian Province in Poland.

Materials and methods: The analysis relied on a qualitative method. Three group interviews in an interdisciplinary advisory panel were conducted. People representing various areas acting for people with mental disorders participated in each meeting. Based on the conclusions that were drawn, PEST and SWOT analyses of functioning of mental healthcare were performed.

Results: Within the analysis of the macro-environment of mental healthcare, the influence of the following factors was evaluated through PEST analysis: political and legal, economic, socio-cultural, and technological. All of these factors were assessed as negative for the functioning of mental healthcare. Then, a SWOT analysis was performed to indicate the strengths, weaknesses, opportunities, and threats in the functioning of mental healthcare.

Conclusions: 1. Mental healthcare is more influenced by external factors than by internal factors. 2. Macro-environmental factors influence the functioning of mental healthcare in a significantly negative manner. 3. The basic problem in the functioning of mental healthcare is insufficient funding. 4. In order to improve the functioning of mental healthcare, it is necessary to change the funding methods, regulations, the way society perceives mental disorders, and the system of monitoring mental healthcare services.

Keywords: mental health services; healthcare financing; health services accessibility.

ABSTRAKT

Wstęp: Współczesna psychiatria stoi przed licznymi wyzwaniami związanymi ze zmianą epidemiologii zaburzeń psychicznych oraz rozwojem wiedzy w tej dyscyplinie. Odpowiedzią na tę sytuację ma być wprowadzenie środowiskowego modelu opieki psychiatrycznej, który w Polsce miał gwarantować Narodowy Program Ochrony Zdrowia Psychicznego.

Celem pracy było dokonanie analizy funkcjonowania opieki psychiatrycznej na przykładzie województwa zachodniopomorskiego.

Materiały i metody: Wybraną metodą była metoda jakościowa. Przeprowadzono trzy wywiady zbiorowe w interdyscyplinarnym gremium doradczym. W każdy spotkaniu brały udział osoby reprezentujące różne obszary działające na rzecz osób z zaburzeniami psychicznymi. Na podstawie wyciągniętych wniosków wykonano analizę PEST oraz analizę SWOT funkcjonowania opieki psychiatrycznej.

Wyniki: W ramach analizy makrootoczenia opieki psychiatrycznej oceniono za pomocą analizy PEST wpływ czynników polityczno-prawnych, ekonomiczno-gospodarczych, społeczno-kulturowych i technologicznych. Wszystkie te obszary zostały ocenione jako negatywne dla funkcjonowania opieki psychiatrycznej. Następnie podczas analizy SWOT wskazano, jakie są mocne oraz słabe strony, szanse i zagrożenia w funkcjonowaniu opieki psychiatrycznej.

Wnioski: 1. Opieka psychiatryczna w większym stopniu jest kształtowana przez czynniki zewnętrzne niż wewnętrzne. 2. Czynniki zewnętrzne wpływają na funkcjonowanie opieki psychiatrycznej w sposób znacznie negatywny. 3. Podstawowym problemem w funkcjonowaniu opieki psychiatrycznej jest niedobór środków finansowych. 4. W celu poprawy funkcjonowania opieki psychiatrycznej należy dokonać zmian w sposobie jej finansowania, w prawie, w systemie monitorowania świadczeń, a także należy zmienić postrzeganie zaburzeń psychicznych przez społeczeństwo.

Słowa kluczowe: opieka psychiatryczna; finansowanie opieki zdrowotnej; dostępność opieki zdrowotnej.

INTRODUCTION

Modern psychiatry faces numerous challenges related with the change of the epidemiology of mental disorders and the development of knowledge in this area of science. An increase in the number of people treated for mental disorders has been noted, especially in outpatient care [1]. According to the World Health Organization, mental disorders, nervous disorders and

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psycho-social problems concern 450 million people around the world [2]. This generates constantly increasing costs. In Europe, the expenses for mental healthcare are as high as 5.8% of all healthcare expenses [3]. Mental disorders concern approximately 15–25% of Polish people, and their number is increasing. As many as 45% Poles are worried about their own mental health [4].

An answer to this situation is to be the introduction of community psychiatry. Numerous studies have clearly indicated that community psychiatry significantly decreases the number and duration of hospitalization and relieves the families of patients [5, 6, 7, 8, 9]. The implementation of this model in Poland was the aim of the National Mental Health Protection Programme. This programme includes taking up actions leading to promoting mental health and preventing mental disorders. Another goal is to ensure multilateral, integrated and available care. This goal is highly significant, and the issue of increasing the availability of healthcare for all social groups is also one of the purposes of the social policy of the European Union [10]. The National Health Protection Programme also envisages the development of research and information systems within the system of mental health protection [10, 11]. The Regional Mental Health Protection Programme has been launched in northwestern Poland. The programme was designed to implement the above assumptions [12].

The main limitations of the development of mental healthcare are axiological and awareness barriers. They are mostly demonstrated in a distanced attitude towards people with mental disorders. In the face of the stigmatization of people with mental disorders, it is of great importance to provide satisfactory care for patients. Care should support the patient [13], respecting the right to personal freedom, limited only in legally permissible situations [14]. Other barriers to the development of mental healthcare are of a political, legal, economic and organizational nature.

The problem of providing mental health protection is a challenge for public healthcare, requiring mutual efforts from representatives of state authorities, local government institutions, non-governmental organizations, as well as employers and employee associations [15]. It is particularly important to start multidimensional activities in the areas of promoting mental health, preventing mental disorders, and health education. It is also highly significant to increase the availability of services. It is noted that patients with mental disorders sometimes receive psychiatric support even with several years' delay [16].

The aim of the study was to analyse the functioning of mental healthcare, using the example of northwestern Poland. Key factors that influence the functioning of mental healthcare have been identified. The aim of the practical research was to indicate directions of activities leading towards the improvement of the availability and quality of taking care of patients with mental disorders.

MATERIALS AND METHODS

The research material was the conclusions of an interdisciplinary advisory panel regarding organizational issues in the functioning of psychiatry in the West Pomeranian Province in Poland.

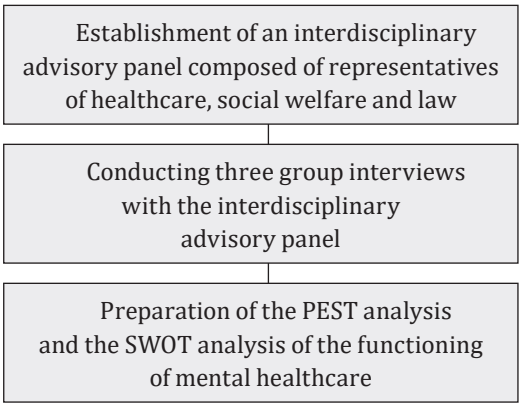

FIGURE 1. Stages of research

The chosen qualitative method was RPAR (Rapid Policy Assessment and Response), serving for quick assessment of regulations and policies. This method is used to evaluate how the rules work in practice. Rapid Policy Assessment and Response includes an analysis of quantitative and qualitative data on the studied phenomenon.

This article concerns the qualitative part of the research (Fig. 1). The study consisted of conducting three group interviews with an interdisciplinary advisory panel. People representing three areas acting for the benefit of people with mental disorders, healthcare, social welfare and law, were invited to the advisory panel.

A psychiatrist, a psychiatric nurse and a psychologist, as representatives of healthcare, attended the interviews. The representatives of social welfare included a director of one of the City Social Welfare Centres, a manager of a community self-help facility for people with mental disorders, and a domestic violence prevention specialist. A lawyer also participated in each meeting. All meetings were recorded and transcribed by an independent observer.

The aim of the first meeting was to identify the main organizational problems of mental healthcare in the West Pomeranian Province. The members of the panel were asked what had the most influence on the functioning of mental healthcare. The second meeting was devoted to the verification and more detailed discussion of factors influencing the functioning of mental healthcare that were identified during the first meeting. A lawyer specializing in procedural matters joined the panel. This allowed the confrontation of claims against the practical functioning of the incapacitation procedure with the knowledge and experience of a lawyer specializing in civil procedures. Moreover, a psychiatrist fulfilling a managerial role in a healthcare institution dealing with inpatient and outpatient mental healthcare joined the panel. This allowed the panel to confront the problems of practitioners – doctors and social welfare workers – with legal regulations currently applicable in Poland.

The third meeting of the panel was devoted to an analysis of the macro-environment of mental healthcare. Attempts were made to indicate which changes are a priority in order to improve the functioning of mental healthcare. PEST analysis was used for that purpose. PEST analysis is a tool used to evaluate the influence of the following factors: political and legal,

economic, socio-cultural, and technological [17]. Before the meeting, all of the previously identified factors influencing the functioning of mental healthcare were grouped into categories (political and legal, economic, socio-cultural and technological). The meeting began with a verification of the presented categorization in a common, interdisciplinary team. Several factors were extended, a few of them were moved to different categories. The next step in the PEST analysis was to discuss the influence of each factor in the functioning of mental healthcare. For that purpose, each factor was ranked on a scale from 1 to 5. Ranks depended on whether a given factor influenced the functioning of mental healthcare in a positive or negative way, and whether that influence was significant or not. Rank 1 meant a significant negative influence, rank 2 a negative influence, rank 3 neutrality, rank 4 a positive influence, rank 5 a significant positive influence. The arithmetic mean of factors from each group was then calculated. The last step was to perform a SWOT analysis of the functioning of mental healthcare in the West Pomeranian Province. This analysis is an overview of internal factors (strengths and weaknesses) and external factors (opportunities and threats) that influence the functioning of mental healthcare.

RESULTS

Among the factors positively affecting mental healthcare was the explanatory memorandum of the act of healthcare provisions financed from public funds. According to the memorandum, the availability of mental healthcare should be as high as possible due to the fact that a person in mental crisis is unable to wait long for care. It is thus a legal justification of providing exceptionally high availability of mental healthcare. Another positive element supporting the functioning of mental healthcare is care for people with mental disorders provided by social welfare.

Many more problems of mental healthcare were indicated. Organizational, financial, legal, and other problems were listed.

Financial problems

Valuation of mental healthcare services has not been changed for several years, which is a source of financial problems. It means that the stay of each patient results in a negative financial balance on psychiatric wards. Members of the panel also noted that it is necessary to increase the number of contracts for mental healthcare services, which will result in an increase of availability. A solution that functions efficiently in Sweden was proposed. The solution consists in training unemployed people, so that they can serve as patient assistants in exchange for wages higher than their unemployment benefits.

Legal problems: lack of the possibility of obligatory treatment at the patient's home

According to members of the panel, Polish law lacks a solution that would allow obligatory treatment in open therapy conditions. In Poland there is a lack of tools to support a patient who is at home and refuses to take medicine. It was proposed to apply the following solution (only in justified situations): the patient has to report to an outpatient clinic once every 2–3 weeks under pain of hospitalization. Members of the panel also suggested that the procedure of treatment on the basis of a motion should be shortened. Currently, the decision process lasts a few months. It should be shortened to several weeks. On the other hand, society should be educated about the possibilities of the patient's family applying for such treatment. It was suggested that primary care doctors should conduct such education.

Legal problems: the duration of the incapacitation procedure

Members of the panel mutually agreed that the incapacitation procedure should be used only for the benefit of the patient. The purpose of incapacitation is not to protect the environment of the patient, or the patient's wealth. At the same time, the procedure of incapacitation should only be used as the last resort, when other legal solutions are ineffective. Members of the panel noted that there are situations when a patient with mental disorders should be incapacitated but that does not occur. The reasons for this come from economic factors. Incapacitation results in losing certain rights, for example building qualifications, which causes immediate loss of employment of the person placed under incapacitation, and in consequence – loss of means of survival for their family. For that reason, families do not apply for incapacitation, even though this legal institution should be used. Another issue related with this procedure is its negative perception in society. During the meeting doctors and social welfare workers emphasized that many people consider the incapacitation of a member of their family as hurting that person. Simultaneously, people with mental disorders who do not feel mentally ill do not see the need to be incapacitated either. They are also afraid of being deceived by their relatives.

During the first meeting of the panel it was claimed that the incapacitation procedure is too lengthy, as it lasts approximately 5 months. However, in the course of a second discussion the conclusion was drawn that this time should not be shortened. The institution of incapacitation interferes with the life of a person to such an extent that no decision in such cases should be made hastily. During the meeting it was also emphasized that the procedure of incapacitation should be used only after taking into consideration the overall clinical state of a person, instead of a single episode. Moreover, people placed under incapacitation should be granted the right to appeal against the decision of being incapacitated.

Among other problems related with the incapacitation procedure, it was indicated that there is a lack of people willing to take on the function of legal guardian of an incapacitated person. One of the reasons for that is the great responsibility of legal guardians combined with low remuneration. Another issue concerns procedural matters. A legal guardian or a probation officer is never established in the course of the same procedure during which the decision of incapacitation is made. This is the result of the different competencies of courts. The appropriate court for incapacitation procedures is the regional

court, and for procedures of establishing a legal guardian it is the district court. Such separation of procedures creates situations when a person is already incapacitated but has no legal guardian or probation officer.

The lawyer present at the meeting emphasized that incapacitation is a legal institution with the most far-reaching consequences. He also noted that Polish law has other viable institutions protecting people unable to make independent decisions as a result of mental disorders. Such institutions are: defects in consent towards single legal acts, establishing a temporary advisor acting as legal representative during the incapacitation procedure, granting a probation officer for a disabled person, and hospitalization on the basis of a motion. The necessity of legal education for the entire society with respect to the above-mentioned institutions was also underlined.

Organizational problems: lack of information flow between institutions dealing with mental healthcare

The interdisciplinary character of the panel created an opportunity to discuss the issue of information flow between social welfare and medical care. It was noted that doctors do not inform patients about available means of support, such as community self-help homes for people with mental disorders. Social awareness regarding various forms of help should also be increased. It was emphasized that numerous people live without having any mental health support system. In order to have information about the existence of those people and give them necessary information, it is indispensable for four institutions to cooperate: social welfare, medical care, the police, as well as facility administrators. Information flow between the institutions mentioned above should not be automatic and top-down, but needs to be adjusted to the individual needs of people with mental disorders.

PEST and SWOT analysis

According to the results of the PEST analysis, all of the areas: political and legal, economic, socio-cultural, and technological, were evaluated as negative for the functioning of mental healthcare. The results of the analysis are presented in Table 1. In all areas, of the total 26 factors influencing mental

TABLE 1. PEST analysis

Political and legal environment	Pts.	Economic environment	Pts.
Lack of the possibility of obligatory treatment in open therapy conditions	2	Few contracts for psychiatric services with the NFZ (National Health Fund), especially community mental healthcare	1
Lack of public nursing and care insurance	2	Unfavourable valuation of points	1
Lack of social education regarding legal institutions to protect the welfare of the patient	2	Lack of sufficient financing of patient assistant services, or someone who would supervise medicine intake in the patient's environment	1
Long duration of procedures concerning people with mental disorders	1	Low availability of social welfare homes for people with chronic mental illnesses	1
Organizational regulations of the World Health Organization (especially the development of community mental healthcare)	4	Inability to fulfil the provisions of the NMHPP (incoherence of regulations, lack of financing)	1
Possibility to provide care services for people with mental disorders by social welfare	5	Financial possibilities of patients	1
Lack of personnel necessary to introduce organizational changes	1	Unfavourable conditions of hiring people engaged in multidimensional care (too few jobs, too low salaries)	1
Lack of noticing people with mental disorders as a disfavoured group by national policies	1	Possibility of financing research in psychiatry	2
–	–	Lack of financial resources necessary to introduce organizational changes	1
Average	2.25	Average	1.11
Social and cultural environment	**Pts.**	**Technological environment**	**Pts.**
Stigmatization of people with mental disorders	1	Lack of statistics regarding the demand for mental healthcare services, which causes inadequacy of spending in comparison with existing needs	1
Increasing number of people treated for mental disorders	2	Lack of the possibility to monitor the patients (in justified cases)	2
Lack of sufficient social awareness regarding threats against mental health, and lack of responsibility for one's own mental health	1	–	
Information flow between institutions supporting people with mental disorders	1	–	
Insufficient role of primary care doctors in preliminary recognition and ordering psychiatric diagnosis	2	–	
Too low competencies of primary care doctors with regard to psychiatry, due to a lack of training	2	–	
Psychiatry as a reluctantly chosen specialization	2	–	
Average	1.57	Average	1.50

1 – significant negative influence; 2 – negative influence; 3 – neutrality; 4 – positive influence; 5 – significant positive influence

healthcare, only two were evaluated as positive. These two factors were: regulations of the World Health Organization (WHO) regarding the organization of mental healthcare, and the functioning of care services for people with mental disorders provided by social welfare.

The lowest evaluated was the economic area. It was ranked at 1.11 points (with 5.0 as the maximum). All of the factors in this area, except for one, were ranked 1, which stands for significant negative influence. In this area, there were factors such as too low a number of contracts for mental healthcare services, especially community care, low availability of various forms of help, and too low a number of jobs combined with low salaries of people engaged in multidimensional support for people with mental disorders.

The second lowest ranked area (1.50 points out of 5.0) was the technological environment, with the following problems: lack of statistics regarding the demand for mental healthcare services, and lack of the possibility to monitor the patients (in justified cases), which – according to members of the panel – could help to prevent the social exclusion of people with mental disorders.

According to the conclusions drawn during the discussion, mental healthcare is not supported by the socio-cultural environment either, with the influence of this environment even being negative. People with mental disorders are still stigmatized by society, which often makes them unable to rely on the proper support of the environment. An increase in the number of people treated for mental disorders was also noted; it was, however, emphasized that although this situation is negative from the point of view of public health, a properly functioning mental healthcare system should be able to cope with this challenge. In relation to this, it was noted that the negative influence of this factor on the functioning of mental healthcare is not significant.

Another disturbing phenomenon related with an increase in the occurrence of mental disorders is the lack of sufficient social awareness regarding threats against mental health, and lack of responsibility for one's own mental health. The role of primary care doctors in preliminary recognition and ordering psychiatric diagnosis is too small. This is mostly caused by the inadequate competencies of primary care doctors with regard to psychiatry, due to a lack of training.

The highest rated environment of mental healthcare is the group of political and legal factors. Although this group was rated the highest, the evaluation remains negative, and is as low as 2.25 out of 5.0 points. This group of factors included such problems as the lack of the possibility of obligatory treatment in the patient's home, no discerning of the problems of people with mental disorders in state policy, and the lack of public nursing and care insurance. This was also the only group where two factors were evaluated positively: organizational regulations of the WHO (especially the development of community mental healthcare), and the possibility to provide care services for people with mental disorders by social welfare.

On the basis of the obtained results, a SWOT analysis of the functioning of mental healthcare in northwestern Poland was performed (Table 2).

TABLE 2. SWOT analysis of the functioning of mental healthcare

Strengths	Weaknesses
Care services of social welfare provided for people with mental disorders.	Lack of information flow between institutions supporting people with mental disorders
Opportunities	**Threats**
Increasing the role of primary care doctors in mental healthcare (training of primary care doctors in psychiatry).	Epidemiological prognoses • an increasing number of people with mental disorders, • mental disorders as one of the main causes of inability to work
Introduction of public nursing and care insurance.	Lack of statistics regarding the demand for mental healthcare services
Establishing information points in hospitals, providing patients with information about available medical care and social welfare services.	Psychiatry, especially child and adolescent psychiatry, is a specialization reluctantly chosen by students – lack of development and financial prospects
Implementation of the Swedish solution: training unemployed people so that they can serve as patient assistants in exchange for wages higher than their unemployment benefits.	Very long waiting time for a place in a social welfare home for people with chronic mental disorders
New contracts for community mental healthcare services.	Lack of sufficient financing of patient assistant services, or someone who would supervise medicine intake in the patient's environment
Introduction of obligatory treatment in open therapy conditions.	Primary care doctors do not serve as first line psychiatrists
There is a legal basis for providing high availability of mental healthcare – explanatory memorandum of the act of healthcare provisions financed from public funds (a person in crisis is unable to wait long for care).	The market of medical services: • unfavourable valuation of points, • low number of contracted mental healthcare provisions (mainly environmental care), • unfavourable employment conditions of doctors in hospitals (lack of norms)
–	Legal regulations: • the incapacitation procedure – stigmatization, duration, the procedure is prohibited by international law, • lack of the possibility to treat a patient without their consent (apart from exceptional cases)

DISCUSSION

Healthcare is determined by many factors. These are the legal conditions, organization of providing health services, cooperation with social welfare, and local conditions. Members of each of these areas may have different opinions on the functioning of the system. They may also have a mistaken belief about the functioning of other areas because of incorrect information flow. The chosen method allowed for the confrontation of different points of view. The interdisciplinary advisory panel provided an opportunity for a quick exchange of experiences. Furthermore, if the SWOT analysis and PEST analysis is developed by several specialists, it is more objective than by one. For this reason, the RPAR method was chosen.

As Samochowiec and Samochowiec [1] point out, the need for changes in the functioning of mental healthcare were discussed as early as in the 1970s. However, those changes were never introduced, mostly due to the opportunistic attitudes of authorities of the day and the lack of people responsible for health policies. Also, the assumptions of the latest edition of the National Mental Health Programme have not been realized [18].

Studies have shown that the problem of mental healthcare is the insufficient development of community psychiatry. Meanwhile, this model is recommended by the WHO [2, 19, 20, 21]. It has been proved that this model is more effective and cheaper than the traditional one [22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42].

Dlouhy found that Poland and other countries in western Europe are suffering the consequences of the totalitarianism of the twentieth century. This system enables the development of civil society, decentralization, and non-governmental organizations. This delayed the development of community care [43].

In other countries of Europe one universal model of psychiatric care does not apply. In Australia hospital care prevails. In Greece, the objective is closing psychiatric hospitals and opening psychiatric wards in general hospitals. In Italy they have developed mental health centres. In the Netherlands, psychiatric care is provided in close cooperation with GPs and social welfare staff [44, 45]. In UK, the basis for mental healthcare is Community Mental Health Teams [44, 46].

The panel pointed out that one of the problems of mental healthcare is inadequate funding. Countries with higher average incomes, which include Poland, spent 4.27% of their healthcare spending on mental health. In Poland it is 3.5%. For comparison, in countries with low national incomes this percentage is 2.6%, and in countries with a high income 6.88% [47]. Also, the employment rate of medical personnel in Poland is unsatisfactory. The latest available data indicate that the number of psychiatrists per 10,000 people in Poland is 6.0 [48]. Meanwhile, the average for Europe in 2014 was 7.43 per 10,000 people [49]. It is pointed out that patients with mental disorders are discriminated against in comparison with other patients [1]. Such a state of affairs increases the stigmatization of visiting a psychiatrist [1, 50]. According to the report "Epidemiology of mental disorders and access to mental healthcare", a person with mental disorders is treated with significant distance by society. Moreover, the level of acceptance of people with mental disorders in 2010 was lower than the level declared in previous research, conducted in the years 1995, 1996, 2008. The results of this study also show that mental illnesses are the fourth group of illnesses (after cancer, heart diseases, and AIDS) that respondents were most afraid of. Additionally, this research shows that 38.9% of respondents would protest against the establishment of a psychiatric hospital in their neighbourhood; in the case of mental health clinics the percentage was 32.7%, and in the case of outpatient clinics 31.9% [15]. Psychiatrists are not trusted by society, either [51]. In the opinion of respondents, both the availability and the quality of local mental healthcare was rated lower than in the case of the overall evaluation of healthcare [15]. Other researchers also point out problems such as the particularly difficult situation of people with addictions, for whom access to medical care is often limited, for example by the negative attitudes of medical personnel [52]. Similar conclusions were drawn during research on community psychiatry performed in the Pomeranian Province [53].

At an earlier stage of research, in order to obtain a full image of the functioning of mental healthcare in northwestern Poland, a diagnostic survey among mental healthcare providers was conducted. This allowed the researchers to learn the opinions of a wider group of specialists-practitioners on the functioning of psychiatry [54, 55]. The last stage of the research was to conduct a diagnostic survey among patients of various forms of mental healthcare. This allowed researchers to learn their opinion of mental healthcare.

The research performed only concerns northwestern Poland, which means that its extent is limited. On the one hand, it is an advantage of the research, as it has allowed the identification of barriers to mental healthcare specific for the region. On the other hand, the results of the research have shown that they are external barriers on a national scale, which means that their deeper analysis cannot be limited to only one single region of Poland.

CONCLUSIONS

1. Mental healthcare is more influenced by external factors than by internal factors.
2. Macro-environmental factors influence the functioning of mental healthcare in a significantly negative manner.
3. The basic problem in the functioning of mental healthcare is insufficient funding.
4. In order to improve the functioning of mental healthcare, it is necessary to change the funding methods, the legal regulations, the way society perceives mental disorders, and the system of monitoring mental healthcare services.

REFERENCES

1. Samochowiec A, Samochowiec J. Expectations and challenges of modern psychiatry. Terapia 2009;17(11/12):8-11.
2. Mental Health Report 2001. Mental Health: new understanding, new hope. Geneva: World Health Organization; 2001.

3. Herczyńska G, Czabała C, Namysłowska I. Facing the challenges, building solution – European governments focus on mental health. Post Psychiatr Neurol 2005;14(3):259-66.
4. Wciórka B, Wciórka J. An opinion poll – are Poles anxious about their mental health? Post Psychiatr Neurol 2005;14(4):305-17.
5. Słupczyńska-Kossobudzka E, Boguszewska L, Szirkowiec W. Territorial differentiation of hospital admissions of patients with schizophrenia in Poland in the years 1999 and 2003. Post Psychiatr Neurol 2007;16(2):123-32.
6. Słupczyńska-Kossobudzka E, Wciórka J. Psychiatria środowiskowa. In: Bilikiewicz A, Pużyński S, Rybakowski J, Wciórka J, editors. Psychiatria. Wrocław: PZWL; 2003. pp. 507-25.
7. Słupczyńska-Kossobudzka E, Boguszewska L. Community treatment teams: meta-analysis of information from subject matter literature. Post Psychiatr Neurol 1998;7(4):387-98.
8. Boguszewska L, Słupczyńska-Kossobudzka E, Wójtowicz S. Community team efficacy in the „Drewnica" hospital catchment area. Post Psychiatr Neurol 2001;10:301-9.
9. Boguszewska L, Słupczyńska-Kossobudzka E. Community team efficacy in the "Drewnica" hospital catchment area – the effect on the family burden. Post Psychiatr Neurol 1999;8:357-64.
10. Bujalski M. Barriers to access to treatment for people with alcohol- and drug-related problems. Alkoh Narkom 2008;21(4):277-85.
11. Ordinance of the Council of Ministers of 28 December 2010 on the National Mental Health Protection Program. J Laws 2011;24(128).
12. Regional Mental Health Protection Program for the West Pomeranian Voivodship for the years 2011–2015 (appendix to the resolution of the West Pomeranian Voivodship Board, No. 2147/11 of the 22 December 2011).
13. Zarzeczna-Baran M, Bandurska E, Nowalińska M, Daniluk R. Quality evaluation of nursing and treatment services made by patients of psychiatric hospitals. Ann Acad Med Gedan 2012;42:41-52.
14. Radlińska I, Bażydło M, Karakiewicz B. Prawa osób niepełnosprawnych intelektualnie w prawie międzynarodowym. Med Health Sci Rev 2015;1(3):52-63.
15. Moskalewicz J, Kiejna A, Wojtyniak B, editors. Kondycja psychiczna mieszkańców Polski. Epidemiologia zaburzeń psychiatrycznych i dostęp do psychiatrycznej opieki zdrowotnej – EZOP Poland. Warszawa: Instytut Psychiatri i Neurologii; 2012. pp. 270-7.
16. Munoz R. The golden years of psychiatry are in the future. Post Psychiatr Neurol 2010;19(2):101-2.
17. Klich J, Kautsch M. Narzędzia do określania położenia organizacji względem najważniejszych interesariuszy. In: Kautsch M, editor. Zarządzanie w opiece zdrowotnej. Nowe wyzwania. Warszawa: Wolter Kluwer; 2010.
18. Bażydło M, Karakiewicz B. Realizacja Narodowego Programu Ochrony Zdrowia Psychicznego a dostępność opieki psychiatrycznej. Fam Med Primary Care Rev 2015;17(3):175–9.
19. Mental Health Declaration for Europe. Facing the Challenges, Building Solutions. European Ministerial Conference on Mental Health. Helsinki: World Health Organization; 2005.
20. Mental Health Action plane for Europe. Facing the Challenges, Building Solutions. European Ministerial Conference on Mental Health. Helsinki: World Health Organization; 2005.
21. What are the arguments for community-based mental health care. Copenhagen: World Health Organization; 2003.
22. Füredi J, Mohr P, Swingler D, Bitter I, Gheorghe MD, Hotujac L, et al. Psychiatry in selected countries of Central and Eastern Europe: an overview of the current situation. Acta Psychiatr Scand 2006;114(4):223-31.
23. Załuska M. Środowiskowy model leczenia psychiatrycznego a zmiany w strukturze lecznictwa w ostatnich latach w Polsce. Post Psychiatr Neurol 2006;15(4):277-85.
24. Creed F, Anthony P, Godbert K, Huxley P. Treatment of severe psychiatric illness in a day hospital. Br J Psychiatry 1989;154(3):341-7.
25. Creed F, Black D, Anthony P, Osborn M, Thomas P, Franks D, et al. Randomised controlled trial of day and in-patient psychiatric treatment. 2: Comparison of two hospitals. Br J Psychiatry 1991;158(2):183-9.
26. Creed F, Black D, Anthony P, Osborn M, Thomas P, Tomenson B. Randomised controlled trial of day patient versus inpatient psychiatric treatment. BMJ 1990;300(6731):1033-7.
27. Middelboe T. Prospective study of clinical and social outcome of stay in small group homes for people with mental illness. Br J Psychiatry 1997;171:251-5.
28. Fenton WS, Mosher LR, Herrell JM, Blyler CR. Randomized trial of general hospital and residential alternative care for patients with severe and persistent mental illness. Am J Psychiatry 1998;155(4):516-22.
29. Dayson D, Lee-Jones R, Chahaj KK, Leff J. The TAPS Project 32: social networks of two groups homes 5 years on. Soc Psychiatry Psychiatr Epidemiol 1998;33(9):438-44.
30. Boguszewska L, Słupczyńska-Kossobudzka E, Szirkowiec W. Przewlekle chorzy w psychiatrycznych placówkach leczniczych i opiekuńczych w latach 1992–2005. Post Psychiatr Neurol 2008;17(4):337-46.
31. Kallert TW, Priebe S, McCabe R, Kiejna A, Rymaszewska J, Nawka P, et al. Are day hospitals effective for acutely ill psychiatric patients? A European multicenter randomized controlled trial. J Clin Psychiatry 2007;68(2): 278-87.
32. Marshall M, Crowther R, Sledge WH, Rathbone J, Soares-Weiser K. Day hospital versus admission for acute psychiatric disorders. Cochrane Database Syst Rev 2011;12:CD004026. doi: 10.1002/14651858.CD004026.pub2.
33. Marshall M. Acute psychiatric day hospitals. BMJ 2003;327:116-7.
34. Horvitz-Lennon M, Normand SL, Gaccione P, Frank RG. Partial versus full hospitalization for adults in psychiatric distress: A systematic review of the published literature (1957–1997). Am J Psychiatry 2001;158(5):676-85.
35. Marshall M, Crowther R, Almaraz-Serrano A, Creed F, Sledge W, Kluiter H, et al. Systematic reviews of the effectiveness of day care for people with severe mental disorders: (1) acute day hospital versus admission; (2) vocational rehabilitation; (3) day hospital versus outpatient care. Health Technol Assess 2001;5(21):1-75.
36. Priebe S, Jones G, McCabe R, Briscoe J, Wright D, Sleed M, et al. Effectiveness and costs of acute day hospital treatment compared with conventional inpatient care: randomised controlled trial. Br J Psychiatry 2006;188:243-9.
37. Larivi Ère N, Desrosiers J, Tousignant M, Boyer R. Multifaceted impact evaluation of a day hospital compared to hospitalization on symptoms, social participation, service satisfaction and costs associated to service use. Int J Psychiatry Clin Pract 2011;15(3):228-40.
38. Creed F, Mbaya P, Lancashire S, Tomenson B, Williams B, Holme S. Cost effectiveness of day and inpatient psychiatric treatment: results of a randomised controlled trial. BMJ 1997;314(7091):1381-5.
39. Piotrowski P, Kiejna A. Czy system oddziałów dziennych może być szansą redukcji kosztów leczenia psychiatrycznego? Psychiatr Pol 2005;39(6):1067-75.
40. Cechnicki A. Towards psychotherapy – oriented community psychiatry – 30 years of experiences in Kraków. Arch Psychiatry Psychother 2011;1:71-80.
41. Cechnicki A. W stronę psychoterapeutycznie zorientowanej psychiatrii środowiskowej – 30 lat doświadczeń krakowskich. Psychoterapia 2009;3(150):43-55.
42. Koczorowski R, Jundziłł-Bieniek E. Środowiskowe uwarunkowania zaburzeń psychopatologicznych u osób powyżej 65. roku. Protet Stomatol 2010;60(3):162-9.
43. Dlouhy M. Mental health policy in Eastern Europe: a comparative analysis of seven mental health systems. BMC Health Serv Res 2014;14:42. doi: 10.1186/1472-6963-14-42.
44. Meder J, Jarema M, Araszkiewicz A. Psychiatryczna opieka środowiskowa w Polsce. Raport. Warszawa: Instytut Praw Pacjenta i Edukacji Zdrowotnej; 2008.
45. Amaddeo F, Becker T, Fioritti A, Burti L, Tansella M. Mental Health Policy and Practice across Europe. The future direction of mental health care: Reforms in community care: the balance between hospital and community-based mental health care. Geneva: World Health Organization; 2007. p. 236-9.
46. Boardman J, Parsonage M. Delivering the Government's Mental Health Policies. Services, staffing and costs: Community-based teams. The Sainsbury Centre for Mental Health; 2007.
47. Jacob KS, Sharan P, Mirza I, Garrido-Cumbrera M, Seedat S, Mari JJ, et al. Mental health systems in countries: where are we now? Lancet 2007;370(9592):1061-77.
48. Zdrowie i ochrona zdrowia w 2013 r. Warszawa: Główny Urząd Statystyczny; 2014.
49. Mental Health Atlas 2014. Geneva: World Health Organization; 2015.
50. Koszewska I, Boguszewska L. Psychiatric-sociological diagnosis of the Tatra county. Characterization of its regional specificity prior to implementation of a depression and suicide prevention program. Suicydologia 2009/2010;5(6):5-63.

51. Ikkos G, Bouras N, McQueen D, John-Smith P. Medicine, affect and mental health services. Post Psychiatr Neurol 2010;19 (2):106-7.
52. Bujalski M. Barriers to access to treatment for people with alcohol- and drug-related problems. Note from the Polish part of the IATPAD study. Alkoh Narkom 2008;21(4):461-4.
53. Wojtecka A. Environmental psychiatry in the Pomeranian Voivodship – selected aspects. Polish Association of Health Care Programs. Gdańsk; 2011. http://ptpz.pl/images/stories/publikacje1/psychiatria%20srodowiskowa%20w%20wojewodztwie%20pomorskim.pdf (20.12.2014).
54. Bażydło M, Karakiewicz B. Quality and availability of care for people with mental disorders – assessment of health care providers. Pomeranian J Life Sci 2016;62(1):72-7.
55. Bażydło M, Karakiewicz B. Assessment of the availability of mental health services. Pomeranian J Life Sci 2015;61(2):228-31.