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Psychiatric rehabilitation in Poland. Polish literature review from 1990–2007.

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Summary

Aim. This article provides a concise overview of contemporary psychiatric rehabilitation and community psychiatry tendencies in Poland.

Material and method. On the basis of articles published in the years 1990-2007 in renowned Polish-language journals (Polish Psychiatry, Advances in Psychiatry and Neurology), an attempt was made to establish main directions in the Polish community psychiatry. The authors reviewed data referring to the present situation in mental health care and presented a synthesis of statistical analyses, local experiences and research results concerning psychiatric rehabilitation of patients with long-term mental disorders.

Results and conclusions. Improvement in many areas of provided medical services as well as with respect to an integration process of various community-based psychiatric care forms is needed.

Moreover, it is necessary to create a comprehensive national programme of rehabilitation of the chronically mentally ill, based on resources of individual and community units. The issue of particular importance seems to be a further, in-depth analysis of unfavourable phenomena occurring in the psychiatric care system (marginalization, stigmatization of chronically mentally ill persons, institutionalization or transitutionalization). The above mentioned phenomena show tendencies towards rejection of the de-centralization of mental health service.

chronically mentally ill / psychiatric rehabilitation / community psychiatry / psychiatric care

INTRODUCTION

The interest of authors in rehabilitation of the chronically mentally ill is connected with an international study entitled Development of a European Measure of Best Practice for People with Long Term Mental Illness in Institutional Care (Acronym: DEMoB.inc) coordinated in Poland by the Department and Clinic of Psychiatry at the Wrocław Medical University. Another reason for performing analyses in this field is the wish to get a broader view of the transformation process in Polish psychiatry, this being a reflection of changes taking place in the European mental health care systems. The authors posed questions regarding the direction of changes in psychiatric rehabilitation in Poland, methods and the extent to which they are being monitored and coordinated by suitable institutions, as well as references and applications of the research results in rehabilitation practice. The analysis of the reports from studies and works related to rehabilitation practice in the form of local programmes is based on articles published in journals entitled Polish Psychiatry and Advances in Psychiatry and Neurology in the years 1990-2007.

This article focuses on the synthesis of data taken from the literature related to patients diagnosed with schizophrenia, as the social reha-

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bilitation of this group of patients still poses a challenge of organisational, psychological and economical nature, not only in Poland, but also in countries having a long-established tradition in the community care.

Developing the idea of community psychiatry since the beginning of the 1970's of 20th century resulted in innovative organisational initiatives, which manifested themselves through zoning and sub-zoning of hospitals, measures aimed at preserving continuity of a patient's care, reduction in the number of beds in mental hospitals, developing the network of outpatient health service and psychiatric departments at general hospitals, creating new organisational forms of the community care. The introduced ideas of community psychiatry were legally fixed by the Mental Health Care Act of 19th August 1994 and the subsequent amendments as well as the project of the National Mental Health Care Programme [1, 2, 3].

The subject-matter discussed in the Polish literature devoted to psychiatric rehabilitation of patients suffering from chronic mental disorders basically encompasses four areas:

- study of the patients' quality of life and their satisfaction with the treatment,
- analyses of statistical data with respect to changes in Polish psychiatry,
- introduction of psychiatric rehabilitation projects on the local level,
- comparisons of chosen parameters of the community psychiatry.

STUDY OF THE QUALITY OF LIFE AND SATISFACTION WITH THE TREATMENT

Polish studies [5, 6], similarly to data contained in the world literature, demonstrate that the subjective assessment of the quality of life does not depend on the acuteness of psychopathological symptoms noted by a psychiatrist, and what is more, it does not have a considerable influence on the assessment of a patient's own functioning. Moreover, it was shown, that WTZ's (occupational therapy workshop) participants differ significantly from patients of day care hospitals only with respect to the subjective assessment of their own functioning [6]. This subjective assessment of a patient's own functioning, however, negatively correlates with acuteness of the symptoms of an illness [5]. The assessment of a patient's functioning made by his carer does not significantly influence the subjective assessment of the quality of life of the patient himself [7]. Therefore, it can be concluded that the quality of a patient's life is to a larger extent influenced by other variables, most probably of an intrapsychic and interpersonal character, beyond the assessment of a patient's own functioning or the assessment made by the observer – carer [ibidem].

Opinions of patients regarding conditions and effects of treatment in mental health care units (of inpatient and outpatient mental clinics) [8, 9, 10, 12] were analysed. The following areas of a clinic's functioning need improvement: the therapists' activity (psychologist and occupational therapists), patient's access to formal and medical information as well as conditions of stay related to a clinic's infrastructure [9].

Other reports point to the diverse needs of patients with respect to the conditions of hospitalisation depending on the length of their hospital stay. Relations with hospital staff and other patients were emphasized as the most advantageous elements at the final stage of the stay. Unfavourable elements of the hospital treatment, taking into account the initial estimates were: the very process of treatment, relation with patients, feeling of monotony and idleness, fixed rules of the clinic's functioning, whereas at the end of an inpatient treatment, patients more often found relations with hospital staff unfavourable [12].

Problems with the quality of mental care reported by patients are related to the nature of psychiatry (restricting freedom of patients, aggression, lack of intimacy), conditions of a hospital stay (rules according to which a clinic functions, overcrowding, noise, food and sanitary conditions) as well as hospital staff. Critical comments addressed to hospital staff and connected with a deficit of information concerning treatment and therapy, insufficient interest and scope of the given support, inappropriate behaviour of the auxiliary staff, the lack of respect for sex and intimacy in patient-patient and patient-staff relations. Authors emphasize that the negative assessment of the above mentioned three dimensions of hospitalisation concern these areas of activity of mental health care units, which are directly linked to their proper financing [10].

The study results of satisfaction of patients undergoing treatment in community care forms associated with the Institute of Psychiatry and Neurology indicate the position of a clinic in Warsaw between a traditionally-oriented centre and a centre with long experience in community care [8]. The results of this study encourage reflection about the quality of the offered services and satisfaction with treatment in centres that do not have such comprehensive support of the scientific institution as the clinics taking part in the study.

Analyses of survey results show great dissimilarities among mental health care provided by social assistance homes both with respect to the number and the education of staff, services and the rules regulating care and treatment. Treatment and rehabilitation takes the form of an individualised and multi-directional therapy. Most often mentioned factors, which cause lowering of the quality of mental health care, are lack or insufficient funding (46% of respondents) and the shortage of staff (46%) [11].

ANALYSES OF STATISTICAL DATA

Few publications in this field present changes that occurred over the years in the Polish psychiatric rehabilitation [13, 14, 15]. Załuska points to the phenomenon of a growing number of beds (in total) in psychiatric health care within the time span of 1999 and 2003, as well as creating, since 2001, beds for a long-term care (nursing&care and therapy&care models). The author indicates the necessity of analysing the reasons of such state of affairs in order to find an answer to a question whether the observed increase in the number of beds does not mean resigning from deinstitutionalisation and emergence of a disadvantageous phenomenon of transinstitutionalisation [13].

Analysis of the proliferation of community self-help homes demonstrates that at the end of 2001 as much as 65% of the units took care of both the chronically mentally ill and those intellectually disabled. Such a situation is a major obstacle in creating proper conditions for rehabilitation of the mentally ill. Only 16% of the community self-help homes offered services exclusively for the group of the mentally ill. In 2001, there were 38 sheltered flats having the total of 328 places. In Podlaskie and West Pomeranian Voivodeships there was not a single hostel. The greatest number of hostels was in Silesia – as many as 11. In Greater Poland there were 5, and the remaining voivodeships had from one to four hostels on their territory [14].

On the basis of the quoted data, one can draw a conclusion about considerable limitations resulting from the fact of uneven, and often inadequate to needs, proliferation of community self-help homes and hostels in the framework of community support system for people with mental disorders in Poland.

It is worth noticing that the privatisation process of the national health care also encompassed the outpatient mental health care. In 2001, almost every third outpatient mental health care unit had a status of a non-public clinic. The share of non-public mental health care clinics reached from 10% (in Świętokrzyskie and Subcarpathian Voivodeships) to almost 70% of the outpatient mental health care (over 50% recorded in the Pomeranian, Warmian-Masurian, Greater Poland and West Pomeranian Voivodeships) [15]. The existence of a considerable territorial differentiation with respect to the number of non-public outpatient mental care clinics in Poland can be, inter alia, related to quantitative and qualitative difference in self-governmental policy introducing local conveniences.

LOCAL EXPERIENCES AND PROGRAMMES

Works on the level of local community activities are the example of original, innovative, effective solutions in Polish conditions, as regards psychiatric rehabilitation. They refer to the achievements of global psychiatry and are often formed on the basis of international cooperation [16, 17, 18, 19]. Occupational rehabilitation of patients with schizophrenia, as one of the most crucial elements of social rehabilitation, never saw any comprehensive, effective organisational systems created on the national level. Existing solutions, which include those patients in the system of promoted employment as part of the competitive market, have a very fragmentary and, most of all, local character [4].

Kraków experiences based on activities in the framework of the WTZ, as well as the possibility

of employing the ill in a social enterprise, sheltered work institution, or a free market company, point out the importance of the multi-stage occupational rehabilitation of individuals suffering from schizophrenia within a comprehensive system of rehabilitation [16].

Psychiatric rehabilitation practised in the form of a community model in Białystok, as part of activities of the Psychiatric Rehabilitation Association, includes several environmental initiatives. Dedicated publications emphasise positive influence of the whole environmental care unit on the frequency and length of hospitalisation of those being under care, within the period of 12 months since they were involved in the community treatment. (decrease in the total number of hospitalisations by 15%, decrease in the total time of hospitalisation by over 41%) [17].

Gorzów experiences [18] indicate the following problems noted by workers of 18 community self-help homes: the lack of an established main environmental profile of a self-help home, organising common group activities for the mentally handicapped and chronically mentally ill, no possibility of instant consultation with a psychiatrist and psychologist, considerable overburden of the staff (expressed in the complaints regarding too many working hours, discouragement resulting from the lack of satisfactory effects, lack of professional trainings for the staff). The surveyed environmental self-help homes employ, on average, 3 specialists; the minimal number of patients per one therapist is seven.

Problems connected with enforced changes in the community-profiled institution, being the consequence of the reform of financing medical services, were presented on the example of ZOZ (National Healthcare Institution) in Bielsko Biała [19]. The author stresses the fact that insufficient funds for environmental psychiatry resulted in lowering of the quality and range of the offered services. Financing of the occupational therapy and afternoon club activities was temporarily discontinued, intensity of cooperation with institutions was lessened, the number of admissions was limited, and staff headcount was reduced.

The above mentioned cases provoke a thought on the condition of the rehabilitation of the chronically mentally ill under Polish conditions. Some centres approximate European standards, others function according to rules that are in conflict with the idea of the community psychiatry. Due to very scarce publications in this field, it is hard to assess the scale of each of these phenomena. Locally enforced, unfavourable changes, influencing the offered services, lead to lowering of their quality and do not correspond to nationally developed concepts of community therapy and rehabilitation.

COMPARISON OF THE CHOSEN PARAMETERS OF CARE IN THE FRMEWORK OF COMMUNITY PSYCHIATRY

Studies analysing the influence of the therapeutic management on the social network of patients and burden of their families demonstrated that the burden of patients' families suffering from schizophrenia and treated in the 24-hour system is greater than in case of patients using typical community forms of health care [24, 26]. A significant dependence was statistically observed between indicators of the supporting network of individuals with schizophrenia using an outpatient treatment programme (scope of the network, size of the outside-family network, level of support, type of social support system) and the aims of treatment (insight into the illness and subjective satisfaction from therapy).

The results of Polish studies in this field are consistent with the world reports [29]. Furthermore, it was shown that patients included in the community treatment programme derive more support from their social networks than patients with an individual treatment programme. This allows us to suppose that those social networks of patients using community treatment undergo changes [30].

Prospective studies show that patients undergoing community treatment, as opposed to those treated by means of a programme regarded as traditional (after a stay in an inpatient department they are referred to outpatient clinics) in the 7 year period of illness they had a much lower number of relapses, and also of readmissions (however the difference remains statistically insignificant) [20]. Taking advantage of the offer of occupational therapy workshops, community self-help homes and specialist care services by patients affect the reduction of 24-hour hospitalisations, both with respect to their duration and their number [25].

It should be emphasised that measurable and real effects of therapy in the environmental sys-

tem can be observed only after a longer period of time. According to the so called Hawthorn's effect, it happens that the best, though short-term, effects of treatment are achieved in the first months after creation of a new form of care. The analysis of results of two- and four-year community care of patients with chronic mental disorders clearly demonstrates a tendency towards improvement with respect to social functioning of patients, the increase of satisfaction with services, decrease in the level of troublesome behaviour and burden of families, as well as shortening the period of hospitalisation [22, 23].

Care of the community therapy teams of patients with chronic mental disorders results in considerable improvement in their social functioning, not only in case of patients with a considerable, but also, though to a lesser degree, patients with moderate or even low level of functioning impairment. Thus, it seems purposeful to include patients suffering from less acute functioning disorders in the community treatment programme [24].

Introducing trainings in social and self-service skills into a therapeutic programme gives satisfactory results in the form of, respectively, skills improvement in interpersonal contacts and increased level of knowledge about nourishment and personal hygiene [21, 27, 31]. It is worth noting that participation of patients in the training programme together with pharmacotherapy with an atypical neuroleptic drug (in comparison to antipsychotic treatment with a 1st generation drug) considerably improves social functioning through increasing patients' social knowledge and skills [28].

Due to a narrow scope of research, it is difficult to have a full picture of dependencies between using particular rehabilitation methods and achieved results of the treatment. It seems that raising new research problems in this field and conducting a greater number of studies coordinated with one another, and characterised by a full methodological accuracy, could serve specialists in purposeful planning and managing of rehabilitation addressed to the chronically mentally ill.

DISCUSSION AND CONCLUSIONS

The outcome of studies conducted under Polish conditions in the domain of environmental psychiatry and rehabilitation of patients diagnosed with schizophrenia [32, 33, 34, 35] corresponds with results of foreign reports. It is worth stressing that study results quoted in this publication, which could serve as postulates for mental health care reforms, are hardly reflected in the financial policy of the state. Moreover, it seems that their scope and subject-matter are not coordinated by any subordinate medical structures. As a result, it is hard to present fully the current and actual state of psychiatric rehabilitation of the chronically mentally ill in Poland. It seems that it would be necessary to constantly monitor the development of this sphere, in order to shape local and state policies based on the rules of deinstitutionalisation of psychiatric services. It also seems essential to further observe the scope of unfavourable phenomena occurring in mental health care, such as marginalisation and stigmatisation of the ill as well as institutionalisation and transinstitutionalisation of the health care. Scientific research in this field is indispensable in order to improve treatment conditions of patients suffering from long-term mental disorders.

REFERENCES:

1. Dąbrowski S, Langiewicz W, Żakowska-Dąbrowska T. Przyszłość szpitali psychiatrycznych. Post. Psychiatr. Neurol. 1996; 5: 209–212.
2. Dąbrowski S. Decentralizacja lecznictwa psychiatrycznego. Psychiatr. Pol. 1996; 30 (4): 547–554.
3. Wciórka J. Psychiatria środowiskowa: idea, system, metoda i tło. Post. Psychiatr. Neurol. 2000; 9: 319–337.
4. Kaszyński H. Praca i rehabilitacja zawodowa chorych na schizofrenię: wprowadzenie do modelu „firmy społecznej". Post. Psychiatr. Neurol. 2003; 12 (4): 435–447.
5. Główczak M, Kasperek B, Meder J, Spironow K. Wstępna ocena jakości życia pacjentów przewlekle chorych z rozpoznaniem schizofrenii. Psychiatr. Pol. 1997; 31 (3): 313–332.
6. Spironow K, Kasperek B, Meder J. Jakość życia pacjentów przewlekle chorych z rozpoznaniem schizofrenii. Post. Psychiatr. Neurol. 1997; 6; supl. 2(5): 31–38.
7. Spironow K, Kasperek B, Chądzyńska M. Jakość życia a funkcjonowanie pacjentów chorych na schizofrenię w ocenie pacjentów, ich rodzin i terapeutów. Post. Psychiatr. Neurol. 2003; 12(3): 293–309.
8. Prot K, Pałyska M, Anczewska M, Indulska A, Raduj J. Badanie satysfakcji pacjenta w warunkach opieki

środowiskowej. Post. Psychiatr. Neurol. 2005; 14(4): 299–304.

9. Raduj J, Indulska A, Anczewska M, Lechowicz W, Pałyska M, Prot K. Jakość usług medycznych w opinii pacjentów wybranych oddziałów psychiatrycznych. Post. Psychiatr. Neurol. 2005; 14(4): 293–298.
10. Anczewska M, Indulska A, Raduj J, Pałyska M, Prot K. Analiza jakościowa opinii pacjentów o pobycie w szpitalu psychiatrycznym. Post. Psychiatr. Neurol. 2007; 41(4): 427–434.
11. Kopińska E Jakość opieki psychiatrycznej w domach pomocy społecznej. Psychiatr. Pol. 2006; (5): 855–865 .
12. Zając J, Rymaszewska J, Hadryś T, Adamowski T, Szurmińska M, Kiejna A.Leczenie szpitalne w opinii pacjentów z ostrymi zaburzeniami psychicznymi. Psychiatr. Pol. 2006; 40 (4): 671–681.
13. Załuska M. Środowiskowy model leczenia psychiatrycznego a zmiany w strukturze leczenia w ostatnich latach w Polsce. Post. Psychiatr. Nurol. 2006; 15(4): 277–285.
14. Brodniak WA, Welbel S. Środowiskowe domy samopomocy na tle systemu oparcia społecznego dla osób z zaburzeniami psychicznymi w latach 2000-2002. Post. Psychiatr. Nurol. 2003; 12(4): 393–402.
15. Langiewicz W. Porównanie działalności publicznych i niepublicznych placówek psychiatrycznych lecznictwa ambulatoryjnego w 2001 r. – na podstawie statystyki rutynowej. Post. Psychiatr. Nurol. 2003; 12(4): 383-391.
16. Cechnicki A, Kaszyński H. Programy rehabilitacji zawodowej i pracy dla osób chorych na schizofrenię – rozwiązania krakowskie. Post. Psychiatr. Neurol. 2000; 9: 427–434.
17. Rogowski S. Psychiatria środowiskowa w Białymstoku – od teorii do praktyki. Post. Psychiatr. Neurol. 2000; 9: 389–401.
18. Sterna W. Problemy środowiskowych domów samopomocy. Post. Psychiatr. Neurol. 2000; 9: 435–441.
19. Trembla K. Sytuacja zintegrowanej i zorientowanej środowiskowo jednostki lecznictwa psychiatrycznego w nowych realiach finansowania. Psychiatr. Pol. 2000; 34 (5): 811–817.
20. Cechnicki A. Porospektywne badania przebiegu schizofrenii – nawrót i rehospitalizacja jako kryterium wyników leczenia. Post. Psychiatr. Neurol. 1997; 6, supl. 2 (5): 7–15.
21. Sawicka M, Meder J. Kompleksowa rehabilitacja pacjentów przewlekle chorych na schizofrenię jako źródło zmian w zachowaniu i życiu emocjonalnym – wyniki wstepne. Post. Psychiatr. Neurol. 1996; 5: 393 –399.
22. Słupczyńska-Kossobudzka E, Boguszewska L, Wójtowicz S. Skuteczność zespołów leczenia środowiskowego w czterech ośrodkach – katamneza dwuletnia. Post. Psychiatr. Neurol. 2001; 10: 289–299.
23. Boguszewska L, Słupczyńska-Kossobudzka E, Wójtowicz S. Skuteczność zespołu leczenia środowiskowego w rejonie szpitala „Drewnica" – czteroletnia katamneza. Post. Psychiatr. Neurol. 2001; 10: 301–309.
24. Boguszewska L, Wótowicz S, Słupczyńska-Kossobudzka E. Społeczno-demograficzne i behawioralne predyktory skuteczności działań zespołów leczenia środowiskowego. Post. Psychiatr. Neurol. 2004; 13(2): 105–113.
25. Załuska M, Paszko J. Znaczenie środowiskowych placówek rehabilitacji i oparcia społecznego dla ograniczenia hospitalizacji psychiatrycznych. Psychiatr. Pol. 2002; 36, 6: 953–966.
26. Bury L, Zaborowski B, Konieczyńska Z, Jarema M, Cikowska G, Kunicka A, Bartoszewicz J, Muraszkiewicz L. Brzemię rodziny pacjentów ze schizofrenią objętych różnymi formami opieki psychiatrycznej. Psychiatr. Pol. 1998; 32, 3: 257–286.
27. Meder J, Elbanowski J, Morawiec M, Orzechowska Z, Pakuła Z, Sawicka M, Wachowiak O. Ocena skuteczności treningu prowadzenia rozmowy i rozwiązywanie problemów w kontaktach międzyludzkich u chorych na schizofrenię. Post. Psychiatr. Neurol. 1993; 2: 423–430.
28. Meder J, Kasperek J, Spironow K. Ocena efektów zastosowania treningu „Powrót do społeczeństwa" w rehabilitacji chorych na schizofrenię leczonych lekami przeciwpsychotycznymi I i II generacji. Post. Psychiatr. Neurol. 2003; 12,1: 45–53.
29. Cechnicki A, Wojciechowska A. Zależności pomiędzy właściwościami sieci społecznej a wynikami leczenia osób chorujących na schizofrenię w siedem lat od pierwszej hospitalizacji. Psychiatr. Pol. 2007; 41, 4: 513)525.
30. Walczewski K, Wojciechowska A. Sieci społeczne pacjentów chorych na schizofrenię w trzy lata po pierwszej hospitalizacji. Porównanie grupy objętej programem leczenia środowiskowego z grupą z indywidualnym programem leczenia. Psychiatr. Pol. 1998; 32, 1: 59–68.
31. Sawicka M, Kołaczek A, Bednarek A, Meder J. Uczenie pacjentów chorych na schizofrenię umiejętności samoobsługi. Psychiatr. Pol. 1997; 31, 3: 305–312.
32. Boguszewska L, Słupczyńska-Kossobudzka E. Kierunki i metody badań ewaluacyjnych psychiatrii środowiskowej na świecie w latach 1993-2000. Post. Psychiatr. Neurol. 2002; 11: 187–196.
33. Słupczyńska-Kossobudzka E, Boguszewska L. Główne kierunki i metody badań ewaluacyjnych psychiatrii środowiskowej na świecie. Post. Psychiatr. Neurol. 1997; 6: 381–392.
34. Słupczyńska-Kossobudzka E, Boguszewska L. Koordynacja leczenia – przegląd literatury światowej. Post. Psychiatr. Neurol. 2002; 11: 197–203.
35. Słupczyńska-Kossobudzka E, Boguszewska L. Zakwaterowanie chronione – metaanaliza z literatury. Post. Psychiatr. Neurol. 2000; 9: 415–425.