

Satisfaction with mental health care and subjective well-being of patients with schizophrenia receiving community psychiatric care – a preliminary report

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Abstract

Schizophrenia is a chronic mental disorder whose course is associated with a substantial reduction in quality of life. An important aspect of psychiatric treatment is adapting care to patients' needs within their living environment. Poland is currently undergoing a reform introducing a community-based care model. Elements of this model had already been implemented in some areas, allowing the authors to compare selected aspects of quality of life among patients diagnosed with schizophrenia in Krapkowie County (where a mental health outpatient clinic, a community treatment team, and a psychiatric day hospital were available) and Strzelce County (where only a mental health outpatient clinic was available). These aspects included subjective well-being and satisfaction with the care received. The analysis included both pooled data on patients' social and occupational circumstances and a comparison of treatment assessments and well-being between the two counties. Patients receiving community-based psychiatric care reported greater treatment satisfaction, a stronger sense of security, and greater engagement in treatment. Differences in the availability of psychiatric care between regions were accompanied by differences in treatment experiences and perceived support. Establishing Type B Mental Health Centers in regions previously lacking comprehensive psychiatric care may improve selected aspects of patients' quality of life and reduce the risk of marginalization among people diagnosed with schizophrenia. These preliminary findings suggest advantages of the community-based care model in the areas studied and provide a basis for further research.

schizophrenia, community care, mental health centers

INTRODUCTION

Schizophrenia is a chronic mental disorder affecting approximately 1% of the population, which corresponds to over 26 million people worldwide [1]. The disorder is associated with a substantial reduction in quality of life, repeated hospitalizations, the need for treatment modifications, re-

duced life expectancy, and an increased risk of suicide [2, 3]. Recurrent episodes often result in social isolation, institutionalization, and difficulties in social readjustment [4, 5, 6].

The quality of life of patients with schizophrenia has been examined in numerous clinical and community-based studies [7, 8, 9, 10]. Velligan and colleagues showed that environmental support can improve psychosocial functioning when it is tailored to individual needs and everyday circumstances [1]. In Poland, research on this subject has been conducted by Jarema and colleagues [12, 13].

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In recent decades, psychiatric care worldwide has shifted from an institutional model toward a community-based approach focused on supporting patients in their everyday environment. Deinstitutionalization has been implemented in many countries, including Denmark, Italy, and Australia [13, 14, 15, 16]. In Poland, this model is being introduced as part of the adult psychiatric care reform that has been underway since 2018. One of its main elements is the development of Mental Health Centers (Centra Zdrowia Psychicznego, CZP) [17, 18, 19].

The Mental Health Center model is based on the principle that treatment for people with mental disorders should take place as close to their place of residence as possible, using local, integrated forms of support [16–19]. These centers serve clearly defined catchment areas, usually a single county or several municipalities, and provide comprehensive psychiatric care tailored to patients' individual needs and current health status. Depending on the type of facility, patients can access outpatient, community-based, day, and inpatient care without a referral. This approach supports continuity of treatment and rapid intervention during crises, forming the foundation of community-based psychiatric care in Poland [18, 19].

Two types of Mental Health Centers operate in Poland:

- Type A: emergency, inpatient, day, outpatient, and community-based care;
- Type B: emergency, outpatient, and community-based care, without an inpatient ward [18].

Study objectives

The general objective of this study was to assess selected aspects of quality of life, namely satisfaction with psychiatric treatment and subjective well-being, among patients with schizophrenia in two counties of the Opole Voivodeship, Krapkowice and Strzelce, before the introduction of a Type B Mental Health Center. This preliminary study provides a basis for a subsequent, in-depth comparison of care following the introduction of the Mental Health Center in these counties.

The specific objectives were to assess the experiences of patients with schizophrenia in the following areas:

- social and occupational functioning;
- access to different forms of psychiatric treatment, including inpatient, day, and community-based care;
- satisfaction with treatment and relationships with medical staff;
- subjective well-being;
- the need for further psychological and social support.

MATERIALS AND METHODS

The study included 108 individuals diagnosed with schizophrenia who received regular psychiatric care in two counties of the Opole Voivodeship: Krapkowice ($n = 56$) and Strzelce ($n = 52$). Data were collected using a questionnaire developed by the authors. The data presented in this article were obtained through research conducted at the CZP in Krapkowice and Strzelce Opolskie. The survey was administered during patients' second or subsequent visit to the mental health outpatient clinic (Poradnia Zdrowia Psychicznego, PZP) or in their homes during a visit by the community treatment team (Zespół Lecznictwa Środowiskowego, ZLŚ).

The two counties were selected because they differed substantially in the range of psychiatric services available. Krapkowice County had a mental health outpatient clinic, a community treatment team, and a psychiatric day hospital, whereas Strzelce County had only a mental health outpatient clinic. Both counties are small administrative units with a mixed urban–rural structure. Respondents were therefore not stratified by urban or rural residence.

It was assumed that the availability of treatment options and the quality of psychiatric care could influence satisfaction with care and subjective well-being, both of which are aspects of quality of life. The analysis included pooled data on patients' social and occupational circumstances and a comparison of treatment assessments and well-being between the two counties.

Purposive sampling was used to recruit patients receiving the selected forms of psychiatric treatment. The number of respondents was

similar in the two counties, allowing comparisons between them.

Inclusion criteria

- age of at least 18 years;
- a diagnosis of schizophrenia according to ICD-10 (F20–F20.9);
- illness duration of at least 12 months;
- written consent to participate in the study.

The exclusion criterion was refusal to provide consent. The study was anonymous and conducted in accordance with the principles of research ethics, including regulations on personal data protection and respect for patients’ rights. Before data collection began, the study protocol was reviewed by the Bioethics Committee at the Medical University of Lodz (Opinion No. RNN/212/24/KE, dated September 10, 2024).

The questionnaire developed by the authors consisted of 99 closed – and open-ended questions. It addressed patients’ current and retrospective assessments of their social and occupational circumstances; access to and assessment of psychiatric treatment, including inpatient care, day care, community-based treatment, and pharmacotherapy; relationships with medical staff; contact with the community treatment team; life satisfaction and subjective well-being; psychological needs; and social relationships.

Survey data were selected for analysis according to the study objectives. The analysis included quantitative data, expressed as percentages and mean ratings on a scale from 1 to 10, and qualitative data from patients’ open-ended responses. Results concerning social and occupational circumstances were pooled across the two counties (Part 1). Treatment assessments and well-being were compared between Krapkowice and Strzelce counties (Part 2).

RESULTS

1A. Social circumstances of patients with schizophrenia (pooled data)

Table 1 presents the respondents’ social circumstances.

Table 1. Social circumstances of patients with schizophrenia (N = 108)

Characteristic	Percentage
Gender	Female: 52%; male: 48%
In a relationship	28%
Having children	41%
Experiencing loneliness	34%
Living with family, most often parents	74%
Maintaining good relationships with family	81%
Contact with people outside the family	68%
Rating family relationships or friendships as supportive	77%

The data indicate that respondents’ social lives were centered primarily on their immediate environment, particularly their families. Although most reported good relationships with relatives and perceived their surroundings as supportive, approximately one-third experienced loneliness. This may reflect unmet needs in interpersonal relationships.

Family remained the main source of support, although family presence alone may not meet all emotional needs. Most respondents lived with family (74%), and 72% were not in a relationship. These findings may indicate limited opportunities to meet needs for closeness and develop independent interpersonal relationships outside the family of origin.

These findings also illustrate the complexity of psychosocial functioning among people with schizophrenia. Social contacts may be constrained by symptoms, social stigma, and beliefs about relationships with others.

1B. Education and occupational activity (pooled data)

Table 2 presents the respondents’ education, occupational activity, and financial circumstances.

Table 2. Education and occupational activity of patients with schizophrenia (N = 108)

Characteristic	Percentage
Higher education	11%
Ever employed	70%

Characteristic	Percentage
Employed at the time of the study	12%
Intention to seek employment	32%
Receiving a disability pension	56%
Financial situation assessed as sufficient	57%
Receiving financial support from family	47%
Receiving a retirement pension	19%
Holding a disability certificate	73%
Including severe disability	25%
Receiving support from a social welfare center	44%

Only 11% of respondents had completed higher education. This may reflect the early onset of illness and interruption of education before individuals could obtain qualifications corresponding to their abilities.

Occupational activity was relatively low. Although 70% of respondents had previously been employed, only about one in eight was employed at the time of the study. Most received disability pensions, while others received retirement pensions.

The high proportion of respondents with a disability certificate, including certificates of severe disability, indicates substantial barriers to employment. These barriers may reflect both health-related limitations and workplaces that are insufficiently adapted to the needs of people with mental disorders.

At the same time, approximately one-third of respondents expressed an intention to seek em-

ployment, suggesting potential for occupational participation with appropriate support.

Financial support from family and reliance on social assistance were common. More than half of respondents nevertheless considered their financial situation sufficient. This assessment may reflect expectations shaped by limited resources, restricted opportunities, and long-term adaptation to financial constraints.

2A. Psychiatric treatment of patients with schizophrenia in Krapkowice and Strzelce counties

Effective treatment of schizophrenia requires an integrated approach combining pharmacotherapy and psychosocial support. The quality and accessibility of psychiatric care depend on how services are organized, which may influence patients’ experiences and treatment. This section compares selected aspects of psychiatric treatment in Krapkowice and Strzelce counties.

The survey analysis included 20 indicators concerning treatment, such as hospitalization and pharmacotherapy, and subjective assessments of care, such as trust in the physician, staff support, and the ability to talk to staff during a crisis. The aim was to explore the relationship between the organization of psychiatric care, patient satisfaction, and the treatment process.

Table 3 presents the treatment-related results for the two counties. Figures 1–4 illustrate selected differences in patients’ assessments of care.

Table 3. Comparison of psychiatric treatment indicators in Krapkowice and Strzelce counties (N = 108)

Psychiatric treatment indicator	Krapkowice (n = 56)	Strzelce (n = 52)
No history of hospitalization	9%	6%
Positive assessment of inpatient care / unable to assess	31% / 29%	21% / 21%
History of psychiatric day hospital treatment	59%	8%
Positive assessment of day hospital treatment / unable to assess	69% / 29%	80% / no data
Participation in educational programs about the illness	27%	12%
Trust in the treating physician	89%	33%
Opportunity to discuss the illness	55%	17%
Support from medical staff	80%	15%
Satisfaction with outpatient treatment	76%	15%
Seeking help in difficult situations	45%	21%

Psychiatric treatment indicator	Krapkowice (n = 56)	Strzelce (n = 52)
Ability to talk to staff during a crisis	69%	10%
Belief that earlier help could have prevented hospitalization: yes / difficult to say / no	50% / 38% / 13%	70% / 16% / 14%
Need for contact with a psychologist or psychotherapist	67%	71%
History of suicide attempts / of these, requiring hospitalization	29% / 59%	25% / 62%
Adherence to pharmacotherapy	98%	100%
Use of oral medication	76%	79%
Ability to recall medications used	76%	42%
Need for supervision of medication use	35%	33%
Receipt of community-based treatment	77%	0%
Staff assistance with everyday matters	71%	2%

Key differences in psychiatric treatment between the two counties

1. Trust in the treating physician was reported by 89% of respondents in Krapkowice County and 33% in Strzelce County (Figure 1).

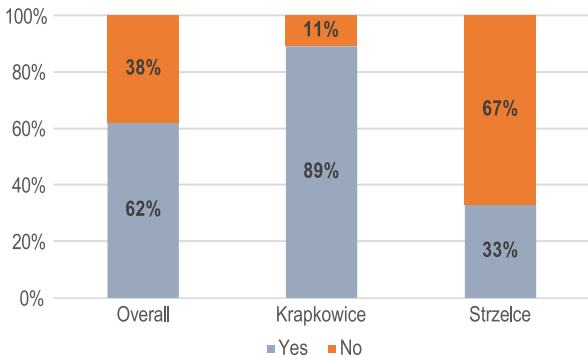


Figure 1. Respondents reporting trust in their treating physician, overall and by county

2. Support and understanding from medical staff concerning important issues related to the illness were reported by 80% of respondents in Krapkowice County and 15% in Strzelce County (Figure 2).

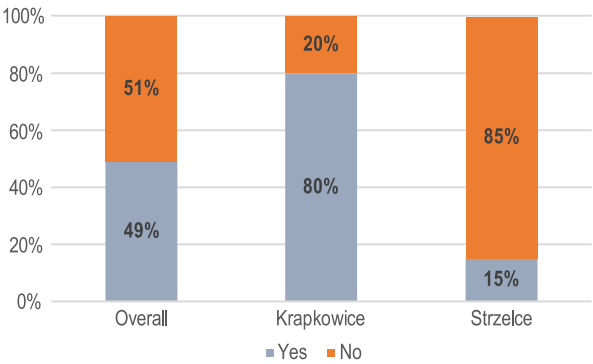


Figure 2. Respondents reporting support and understanding from medical staff, overall and by county

3. Satisfaction with outpatient treatment was reported by 76% of respondents in Krapkowice County and 15% in Strzelce County (Figure 3).

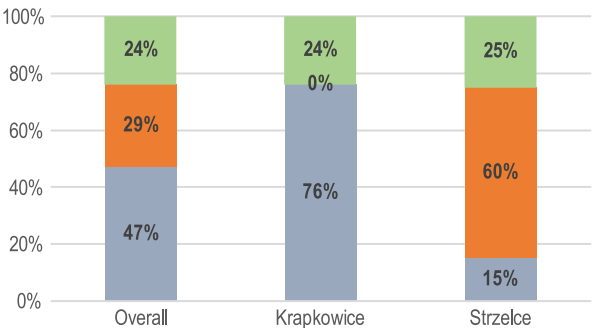


Figure 3. Respondents satisfied with their current outpatient treatment, overall and by county

4. The ability to talk to staff during a crisis was reported by 69% of respondents in Krapkowice County and 10% in Strzelce County (Figure 4).

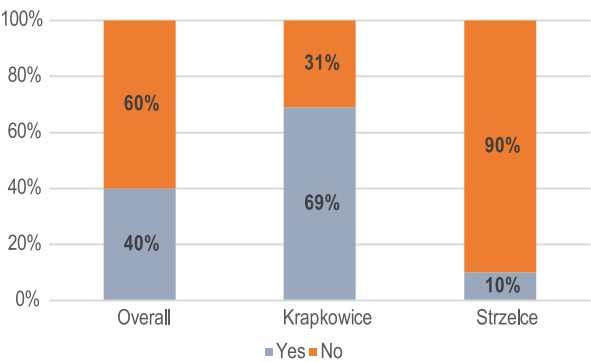


Figure 4. Respondents reporting the ability to talk to staff during a crisis, overall and by county

The comparison revealed marked differences in access to comprehensive psychiatric care. In Krapkowice County, where a broader range of community-based services was available through the outpatient clinic, community treatment team, and day hospital, respondents more frequently used non-inpatient forms of support. They also reported greater trust in staff, a stronger sense of being cared for, and greater treatment satisfaction.

In Strzelce County, where only a mental health outpatient clinic operated before the introduction of the CZP, ratings of feeling cared for, opportunities to discuss the illness, and treatment satisfaction were lower. The absence of a day hospital and community treatment team limited opportunities for early intervention and coordinated care in patients’ everyday environment.

The community treatment team appeared to be an important element of the support system. Where the team was available, respondents reported greater engagement in treatment, greater willingness to use available support, and higher ratings of care quality.

2B. Subjective well-being of patients with schizophrenia in Krapkowice and Strzelce counties

Patients rated their subjective well-being on a scale from 1 to 10 and answered questions

about quality of life, social relationships, self-acceptance, and sense of meaning. Four indicators relevant to psychiatric care were included in this article: overall assessment of treatment, social functioning, life satisfaction, and assessment of current care. Table 4 presents the mean ratings for each county.

Table 4. Subjective well-being and assessments of treatment and care in Krapkowice and Strzelce counties

Indicator (mean rating on a 1–10 scale)	Krapkowice	Strzelce
Overall assessment of treatment	8.3	4.05
Assessment of social functioning	6.72	4.35
Assessment of life satisfaction	7.6	5.02
Assessment of current care	8.64	3.7

Respondents in Krapkowice County gave higher ratings for overall treatment quality, current psychiatric care, social functioning, and life satisfaction. In Strzelce County, where access to integrated psychiatric care was more limited before the introduction of the CZP, all four ratings were lower. These results suggest an association between the organization of psychiatric care, subjective well-being, and treatment experiences.

DISCUSSION

The survey findings suggest an association between the quality of psychiatric care and the daily functioning and perceived quality of life of patients with schizophrenia. A better-organized care system was accompanied by a stronger sense of being cared for, greater life satisfaction, and greater trust in medical staff.

The analysis of social and occupational circumstances showed that a substantial proportion of respondents were outside the labor market and had limited social and economic resources. Most nevertheless reported positive family relationships and a supportive social environment, which may support stability and recovery. Most held a disability certificate, highlighting the need to adapt support to their individual occupational and social needs.

The comparison revealed marked differences in treatment assessments and perceived well-

being between the two counties. In Krapkowice County, where a comprehensive community-based care model was available before the reform through an outpatient clinic, a community treatment team, and a day hospital, respondents reported higher treatment ratings, greater trust in physicians and staff, better access to support during crises, and a stronger sense of being cared for. Ratings were lower in Strzelce County, where only a mental health outpatient clinic had operated before the introduction of the community-based mental health care system. Respondents in that county were less likely to report being able to talk to staff during a crisis, trusting their physician, or being satisfied with treatment.

These findings suggest that the availability and comprehensiveness of psychiatric care, including integrated community-based interventions, may be associated with both subjective treatment assessments and broader mental well-being [13, 11, 15, 16].

Organizing psychiatric treatment around community-based care may support mental health stability, enable a faster response to difficulties, and reduce the risk of hospitalization. People recovering from a mental health crisis often need psychological support, information, health education, and a consistent, supportive care team alongside pharmacotherapy.

A treatment model limited to inpatient and outpatient care may be insufficient to meet the needs of people with schizophrenia [4, 5, 18, 6, 7, 17]. Further efforts are needed to develop patient-centered care in the community, based on coordination, continuity, and accessibility. Mental Health Centers offer this model by providing treatment, responding rapidly to crises, undertaking preventive activities, and offering social and therapeutic support [17, 18, 19]. Well-organized community treatment teams, outpatient clinics, day hospitals, and health education provide a framework for effective, person-centered care. Differences in satisfaction with care and subjective well-being may also reflect local conditions rather than the formal type of CZP alone. Relevant factors include infrastructure, the experience and commitment of the care team, the degree of service integration, and organizational practices at individual facilities. These factors may influence support quality, patients' sense

of safety, and the effectiveness of community-based interventions, regardless of whether the center is Type A or Type B.

Following the introduction of the community-based psychiatric care model, a second survey is planned among the same patients in Krapkowice and Strzelce counties, within the Type B Mental Health Center serving both counties. This follow-up will allow assessment of the organizational changes and extend the present observations in the context of psychiatric care reform in Poland.

Limitations

The study used a questionnaire developed by the authors, comprising 99 closed – and open-ended questions on social and occupational circumstances; access to and assessment of psychiatric treatment, including inpatient care, day care, community-based treatment, and pharmacotherapy; relationships with medical staff; contact with the community treatment team; life satisfaction and subjective well-being; psychological needs; and social relationships. Only selected aspects of quality of life were therefore assessed, and no standardized measure was used. Some data were based on retrospective patient assessments, which may have affected their accuracy.

CONCLUSIONS

1. In this preliminary study, patients receiving community-based psychiatric care reported greater treatment satisfaction, a stronger sense of security, and greater engagement in treatment [1, 13, 14, 17]. These findings suggest that integrated support may help build relationships and trust between patients and medical staff.
2. Patients' subjective experiences, including feeling cared for, being able to communicate with staff, and satisfaction with treatment, are important indicators of care quality. These assessments can inform the evaluation of organizational changes.
3. Differences in the availability of psychiatric care between regions may contribute to inequalities in treatment experiences and perceived support [8, 14, 17]. The development of community-based services may help im-

prove equitable access to support regardless of place of residence.

4. Assessing patients' social functioning and life satisfaction should be a regular component of health service quality monitoring. Patient-reported ratings can help identify areas requiring improvement.
5. Establishing Type B Mental Health Centers in regions previously lacking comprehensive psychiatric care may improve patients' quality of life and reduce the risk of marginalization among people with schizophrenia [14, 16, 17].
6. Continuing the study after the introduction of the Type B Mental Health Center serving both counties will allow assessment of patients' experiences following the reform and of the performance of the new care model.

Author's statement

This article was prepared as part of work toward a doctoral dissertation at the Medical University of Łódź.

REFERENCES

1. Velligan DI, Mueller J, Wang M, DiCocco M, Diamond PM, Maples NJ, Davis B. Use of environmental supports among patients with schizophrenia. *Psychiatr Serv.* 2006; 57(2): 219–224. <https://doi.org/10.1176/appi.ps.57.2.219>.
2. Pinikahana J, Happell B, Hope J, Keks NA. Quality of life in schizophrenia: A review of the literature from 1995 to 2000. *Int J Ment Health Nurs.* 2002; 11: 103–111. <https://doi.org/10.1046/j.1440-0979.2002.00233.x>.
3. Juntapim S, Nuntaboot K. Care of patients with schizophrenia in the community. *Arch Psychiatr Nurs.* 2018; 32(6): 855–860. <https://doi.org/10.1016/j.apnu.2018.06.011>.
4. Masroor A, Khorochkov A, Prieto J, et al. Unraveling the association between schizophrenia and substance use disorder-predictors, mechanisms and treatment modifications: a systematic review. *Cureus.* 2021; 13(7).
5. Hoseinipalangi Z, Golmohammadi Z, Rafiei S, et al. Global health-related quality of life in schizophrenia: systematic review and meta-analysis. *BMJ Support Palliat Care.* 2022; 12: 123–131.
6. Ministerstwo Zdrowia. Reforma polskiej psychiatrii – terazniejszość i przyszłość. Available from: <https://www.gov.pl/web/zdrowie/reforma-polskiej-psychiatrii-terazniejszosc-i-przyszlosc>.
7. Bai W, Liu ZH, Jiang YY, et al. Worldwide prevalence of suicidal ideation and suicide plan among people with schizophrenia: a meta-analysis and systematic review of epidemiological surveys. *Transl Psychiatry.* 2021; 11: 552. <https://doi.org/10.1038/s41398-021-01671-6>.
8. McCutcheon RA, Reis Marques T, Howes OD. Schizophrenia—an overview. *JAMA Psychiatry.* 2020; 77(2): 201–210. <https://doi.org/10.1001/jamapsychiatry.2019.3360>.
9. Insel T. Rethinking schizophrenia. *Nature.* 2010; 468: 187–193. <https://doi.org/10.1038/nature09552>.
10. Standard organizacyjny opieki zdrowotnej w Centrum Zdrowia Psychicznego – założenia projektu. Warszawa, 4 stycznia 2022.
11. Molstrom IM, Nordgaard J, Urfer-Parnas A, Handest R, Berge J, Henriksen MG. The prognosis of schizophrenia: A systematic review and meta-analysis with meta-regression of 20-year follow-up studies. *Schizophr Res.* 2022; 250: 152–163.
12. Jarema M, Murawiec S, Szafrński T, Szaniawska A, Konieczny Z. Subiektywna ocena farmakoterapii i jakości życia w schizofrenii. *Postępy Psychiatrii i Neurologii.* 2000; 9: 137.
13. Jarema M, Bury L, Koniecznyńska Z, Zaborowski B, Cikowska G, Kunicka A, et al. Comparison of quality of life of schizophrenic patients in different forms of psychiatric care. *Psychiatr Pol.* 1997; 31(5): 585–594.
14. Velligan DI, Rao S. The epidemiology and global burden of schizophrenia. *J Clin Psychiatry.* 2023; 84(1): MS21078COM5. <https://doi.org/10.4088/JCP.MS21078COM5>.
15. Dong M, Lu L, Zhang L, et al. Quality of life in schizophrenia: a meta-analysis of comparative studies. *Psychiatr Q.* 2019; 90: 519–532. <https://doi.org/10.1007/s11126-019-09633-4>.
16. Lora A, Compagnoni MM, Allevi L, et al. The quality of mental health care delivered to patients with schizophrenia and related disorders in the Italian mental health system. The QUADIM project: a multi-regional Italian investigation based on healthcare utilisation databases. *Epidemiol Psychiatr Sci.* 2022; 31:e15.
17. Rosenberg S, Harvey C. Mental health in Australia and the challenge of community mental health reform. *Consortium Psychiatricum.* 2021; 2(1): 40.
18. Rozporządzenie Ministra Zdrowia z dnia 27 kwietnia 2018 r. w sprawie programu pilotażowego w centrach zdrowia psychicznego. *Dz.U.* 2018 poz. 852.
19. Wciórka J. Transformacja opieki psychiatrycznej w Polsce – osiągnięcia, zagrożenia, potrzeby. *Psychiatr Pol.* 2018; 52(2): 187–199. <https://doi.org/10.12740/PP/OnlineFirst/80908>.