LEGAL AND ORGANISATIONAL GROUNDS FOR ASSERTIVE COMMUNITY TREATMENT AND INTENSIVE CASE MANAGEMENT IN POLAND

HOUSING FIRST
EVIDENCE BASED ADVOCACY

EXPERT OPINION FOR THE PROJECT "HOUSING FIRST EVIDENCE-BASED ADVOCACY"

Katarzyna Lech, Julia Wygnańska

Translation: Anna Moroz-Darska

The authors used both the experience of the original Housing First program developed and described by Sam Tsemberis Ph.D. (Tsemberis, 2010), and subsequent European programs as summarized by Nicolas Pleace (Pleace, 2012) which were translated into Polish and included in the electronic publication "Najpierw mieszkanie – materiały źródłowe" (Wygnańska, 2014) prepared for the "Housing First – evidence-based advocacy" Project by the Ius Medicinae Foundation under the program "Citizens for Democracy" financed by EEA.

www.czynajpierwmieszkanie.pl/en

ICELAND LIECHTENSTEIN NORWAY eea grants

FUNDACJA IM. STEFANA BATOREGO

POLSKA FUNDACJA DZIECI I MŁODZIEŻY

INTRODUCTION

This article was drawn up on the basis of the expert opinion entitled "Support for the chronically homeless experiencing mental illness in compliance with Housing First principles" (Lech 2015) prepared as a part of the "Housing First – Evidence-Based Advocacy" [1] (HFEA) project run by Fundacja Ius Medicinae. The opinion was focused on the determination of possibilities for the provision of specialist support consistent with the Housing First principles as a part of the Polish community psychiatry system. The opinion did not concern the provision of housing – that question was the subject of another document ("Ambitious principles of the Housing First Programme in the Polish housing reality. Feasibility study", prepared under the same project (Różycka, 2015). The expert opinion devoted to specialist support was based on an assumption that it would be possible to secure housing units. What constituted a challenge was to determine how to organise teams providing assertive community treatment and intense case management for the persons with the profile of a client of the Housing First programme, who have been provided with housing and use their unit in compliance with the principles of the programme. The full text of the expert opinion is available in the Polish language – and this article is based on it.

[1] www.czynajpierwmieszkanie.pl/en

Unfortunately, in Poland problems of homelessness and mental disorders are considered separately. They are the subject of attention of two different ministries, and there are separate national-scale programmes, coalitions of organisations, services and facilities dealing with each of the issues – despite the fact that facilities for the homeless admit clients suffering from mental diseases, and psychiatric hospitals treat patients whose housing situation is extremely difficult.

There are some bottom-up compassion-driven initiatives developed by associations acting for the benefit of the mentally ill or the homeless, and there are individual doctors who treat the homeless suffering from mental diseases with particular care. However, we do not know the share of persons with mental diseases in the homeless population. Not long ago an aggregative study was conducted under the HFEA project, and it was discovered that during the two years under analysis, Warsaw-based facilities for homeless men provided services to 333 men with a dual diagnosis (including 180 men possessing medical documents confirming the co-occurring disorders; in the remaining cases, one of the disorders was recorded in the registers kept by the facility, and the other was suspected by the staff (Wygnańska, 2016)).

On the other hand, the Polish healthcare system handles the problem of the homelessness of the mentally ill patients mainly by placing them in social welfare homes (dom pomocy społecznej - SWH). If they cannot be admitted for a longer time due to the lack of available places, persons in relative remission are discharged from hospital and transferred to residential medical care facilities, where they wait until a place in SWH is found for them.

People with a dual diagnosis are in a very difficult situation. The scale of the phenomenon is unknown since for many years it was common practice to omit the second or subsequent diagnoses when filling in statistical medical forms. There have been no reliable epidemiological studies. As we can read on the website of the National Bureau for Drug Prevention, addiction treatment facilities are not prepared to treat patients with a double diagnosis:

"Such patients [with a dual diagnosis] are referred to mental health outpatient units, and in the case of acute psychotic disorders to psychiatric hospitals. In 2008, Poland had two departments in psychiatric hospitals and two drug rehabilitation centres offering comprehensive treatment (of both psychiatric and addiction problems). They offered the total of 69 beds. (…) The majority of inpatient addiction treatment facilities admit such patients after their mental health is stabilised in a psychiatric facility (…) According to the fact book "Narkomania 2009" ("Drug Addiction 2009"), there were 20 inpatient facilities admitting persons with a dual diagnosis in Poland. However, the number of facilities specialising in the treatment of this sort of disorders is much lower."[2]

Due to a very poor availability of comprehensive treatment for people with a dual diagnosis, such patients normally get to facilities offering the treatment of addictions, or those treating serious mental disorders – depending on which diagnosis seems to be the leading one (Meder, 2006). Acting informally and spontaneously, some therapists inspire cooperation between outpatient addiction treatment units and community mental health services for the benefit of the patient with a dual diagnosis, but such actions are unique and rare. According to the founding father of the Housing First programmes, separate treatment of each of the diagnosed disorders is ineffective (Tsemberis, 2010). Professor Meder, a Polish researcher, expressed a similar opinion (2006):

"(…) ineffective treatment is usually connected with focusing on one of the diagnoses — concerning either mental health or addiction. Due to the diversity of their problems resulting from the co-existence of two disorders, patients break their abstinence, "fall out" from therapeutic groups for the psychotics, and addiction treatment programmes are too difficult or restrictive for them— they are unable to meet the requirements posed by the group (…)".

Also prof. Meder's recommendations concerning support for this group of people are excellently

[2] http://www.kbpn.gov.pl/portal?id=107196

compatible with the Housing First idea. The professor postulated that persons with a dual diagnosis should be treated by integrated therapy: "conducted by a single team and combining the treatment of disorders connected with the abuse of psychoactive substances with the treatment of their mental disease – both in the area of pharmacotherapy and psychotherapy. The therapy should be multidirectional (covering both psychotic problems and addiction), long-term (2-3 years), focusing on community impact, and flexible (changed and adjusted to the patient's needs at a given time). (…)The patient's ability to maintain increasingly long abstinence, and limitation of his/her simultaneous use of many substances may be considered therapeutic success."

In practice, the only team working with dual diagnosis patients was established by the Institute of Psychiatry and Neurology in Warsaw in 2004. At the moment, no new patients are admitted. According to specialists, the centre located in Gliwice is the only facility dealing with the treatment of dual diagnosis. A dual diagnosis treatment department is to be opened in one of the hospitals in Krakow. In Poland, there is a huge demand for specialist centres dealing with double diagnosis patients, which would operate in accordance with the model developed by SAMHSA (Substance Abuse and Mental Health Services Administration; www.samhsa.gov).

The persons suffering from both chronic homelessness and double diagnosis are in the most difficult life situation. They are considered the most difficult clients (ones who cannot be helped and should be helped by some other body operating hyper-specialist programmes) by both the facilities for the homeless and the community psychiatry institutions. We will first briefly present the current situation of community psychiatry in Poland and then discuss in detail possibilities for using the current regulations devoted to community mental health services and specialist care services for the benefit of the provision of support to this group of people in compliance with the Housing First principles.

COMMUNITY PSYCHIATRY IN POLAND

The development of the community approach in Polish psychiatry follows global trends. Since the time of the so-called "great closure", when mentally-ill persons were rejected from society, and closed in conditions violating human dignity, we have been painstakingly heading towards the complete social reintegration of people experiencing mental disease, moving from the lack of understanding of the reasons behind such diseases, and an absence of ideas, to successful treatment. The outbreak of anti-psychiatry in the 1960s, the development of the humanistic thought, and an increasingly deeper understanding of the causes as well as more effective pharmacotherapy created grounds for the community approach in psychiatry as early as in the second half of the 20th century.

In Poland, the first community treatment teams began to be established in the 1980s. The idea of "a hospital without walls" was accepted, and gradually implemented by much of the professional community. Still, the hospital-centred model of psychiatric care has long been maintained as the only right option and, unfortunately, is still preferred in many places in Poland.

Following the new Mental Health Protection Act of 1994, in 1995 a schedule of activities was also adopted providing that the community psychiatry model would become the main goal of the development of psychiatry. Mental health services were to be provided mainly in outpatient units, various forms of indirect care, and in a variety of housing forms, such as protected housing, and hostels. The main rule behind the provision of assistance to persons with mental disorders was to be assistance in the place of one's residence and in the local community.

Following global trends (such as the 2001 WHO report, 2003 WHO guidelines for Mental Health Centres, and the 2005 Mental Health Declaration for the European Union, also referred to as the Green Paper) a group pf Polish experts developed a draft National Mental Health Protection Programme in 2006. The authors included specialists grouped around the Institute of Psychiatry and Neurology in Warsaw: Ludmiła Boguszewska, Włodzimierz

Brodniak, Czesław Czabała, Marek Jarema, Wanda Langiewicz, Katarzyna Prot-Klinger, Stanisław Pużyński, Elżbieta Słupczyńska, and Jacek Wciórka.

The main goal determined in the draft programme was the provision of multilateral, integrated, and readily available health care and other forms of assistance enabling life in the community, family and professional environment to persons with mental disorders through the systemic promotion of:

- the community model of psychiatric health care
- diverse forms of social assistance and support
- patients' participation in professional life
- coordination of various forms of care and assistance

In January 2009, interministerial and public consultations for draft regulation on the national programme were carried out. After long work on the reported comments, and subsequent consultations, the Council of Ministers adopted the regulation (equivalent to an act of law) together with the enclosures, on 28 December 2010. The programme became effective in February 2011 (Council of Ministers, 2011).

In the meantime, in 2008, the Mental Health Protection Act was amended. Regulations concerning enforced treatment were changed, largely limiting the possibility of treatment without the patient's consent. On the one hand, the right of self-determination has thus ben strengthened, but on the other the number of people remaining without hospitalisation or any other professional help despite the worsening of their disease symptoms, increased. As a result of the introduced changes, patients who in compliance with the current state of knowledge should continue to be treated under in-patient conditions were given the possibility of signing out of the hospital. Since the introduction of the act, patients who do not have any address can leave the hospital while not yet experiencing remission, at their own request. In this way, contact with the patient can be lost for a long time, until the subsequent dramatic worsening of his/her condition and hospitalisation.

In 2015, the State's obligation to execute the National Mental Health Protection Programme (the Council of Ministers, 2011) came to an end. Unfortunately, the current degree of achievement of its goals is insufficient for several reasons, including the scarcity of funds designated towards the purpose both by the Ministry of Health and the payer, i.e. the National Health Fund.

In Poland's income classification, about 4% of health care expenditure should be designated towards psychiatry. We keep hearing about the poor allocation of funds: "The limit of services granted by the National Health Fund does not cover the demand for community treatment, so most activities focus on patients with a diagnosed F20, F31, or F32 according to ICD 10 [schizophrenia, bipolar disorder, an episode of depression], while the other patients are treated on an emergency basis (Patura-Szost E. 2015)". What is worrying is the low share of people with mental disorders who receive help – only about 25% of the patients (Lipowicz, 2014).

The Act and the National Programme seem to be superior in relation to the regulations of the National Health Fund, but since the Fund is the only payer for the services in question, in practice it dictates the principles of the functioning of the community psychiatric assistance in Poland. Due to the low price of services from the NHF-approved range of services in the area of community psychiatry, limitation of the number of services approved in contracts with facilities, and an impossibility to obtain a contract for many services in the area of community psychiatry, the availability of modern forms of psychiatric assistance is insufficient.

Suffice to say, in compliance with the recommendations concerning organisational solutions in psychiatric health care as a part of the national programme, there should be one community treatment team per 50,000 citizens, and therefore Poland should have contracts with about 770 such teams, whereas fewer than 150 of them operated at the beginning of 2015. In half of the provinces, there were about 20% of the necessary teams.

2015 saw a real risk of the loss of the achievements of the national programme and a return to the past conditions. In the face of this situation, the

psychiatric community took action and wrote "An open letter. Rescue the National Mental Health Protection Programme" (13.08.2015), which was signed by the authorities of the Polish psychiatry:

(…) "The proposed liquidation of the act-equal rank of the National Mental Health Protection Programme consisting in its transfer to the National Health Programme designed by the Public Health Act, thus making it just one of many operational goals, decisively lowers the rank, importance, and role of the Programme. This would be a sign of stark contempt and injustice towards all those who expect a strong reform of the current psychiatric care system, including in particular its users: the mentally ill (starting with children and youth, through people at all the stages of their life cycle, to seniors, and their families."(…)[3]

Owing to the involvement of the signatories of the letter and non-governmental organisations, as well consolidation of activities of "peer experts" with the activity of professionals, parliamentary activities as a result of which the specialist National Programme was to be absorbed by the more general Public Health Act were successfully blocked in September 2015. Works on the preparation of a new edition of the Programme for 2016-2020 are in progress.

The slow introduction of the National Programme can be an impediment during an enforcement of the right to psychiatric care for the potential clients of the "Housing First" programme in Poland. However, there are no reasons why they should not get exactly the same assistance as other people in the regions, in which there are community treatment teams. In compliance with the principle of social solidarity, and the prevention of stigmatisation and exclusion when disagreeing with the watering down of the responsibility of the state for the provision of the same psychiatric care to all citizens, we need to act decisively and consistently to win the best community services for the potential clients of the HF programme.

[3] http://otwartydialog.pl/pl/baza-wiedzy/media/list-otwarty-npozp/?gclid=CjwKEAjw4s2wBRDSnr2jwZenlkgSJABvFcwQCKS_QAR-XfTuuBd_21eNVO4v9ZA2ltcXErLTllwu1BoCuQLw_wcB

POLISH EQUIVALENTS OF THE ACT AND ICM TEAMS

In his book, Tsemberis (2010) describes two forms of organisation of interdisciplinary support for the clients of the Housing First programmes: assertive community treatment (ACT) and Intensive case management (ICM). Equivalents of both forms can be found in Polish regulations and the practice concerning mental health and social assistance. The Polish equivalent of ACT is referred to as the community treatment team, while specialist care services are the equivalent of ICM (the Social Assistance Act).

THE COMMUNITY TREATMENT TEAM AND THE ASSERTIVE COMMUNITY TREATMENT

THE ASSERTIVE COMMUNITY TREATMENT (ACT)

ACT teams are established to work with the chronically homeless persons suffering from serious mental disorders such as schizophrenia and other psychotic disorders or deep depression, accompanied by an abuse of addictive substances. They are the people whose situation is the most difficult because they usually have additional health-related problems, such as chronic diseases.

Historically, ACT teams originate from the "hospitals without walls" concept developed in Madison, Wisconsin, USA in the 1970s. In the Pathways Housing First (PHF) programme, ACT teams are described as having 8 basic features (Tsemberis, 2010).

- They are interdisciplinary and include specialists in psychiatry and nursing, social workers, vocational counsellors, substance abuse counsellors, addiction therapists, professionals dealing with such issues as dual diagnosis, primary health care, and housing, the so-called "experts by experience" (peer experts), and (sometimes) systemic family therapists.
- They are based on teamwork and role exchange: joint problem solving, daily meetings

of the team, weekly discussion of cases, individual peer supervisions.
- They have a low employee-client ratio: one employee looks after a maximum of 10 clients. The team looks after about 70 clients and the current situation of each of them is well known to all the employees.
- Focus on work in the client's environment: home visits are the most frequently used option, as well as going out together to settle the client's various matters.
- Contact with the clients is frequent and close: meetings take place at least once a week, and in a crisis there may even be two meetings a day. Contact with the clients is also maintained when they are hospitalised or penalised.
- The teams work within a defined area.
- The teams are available to the clients for 24 hours a day, 7 days a week, partly via an on-call duty.
- The clients' participation in the programme is not time-limited: support is provided as long as the client needs it.

Involving the client in the development and implementation of an individual recovery plan is an exceptionally important feature of the work of ACT teams. The manner of treatment and other impact is always agreed with the client. The client is the person deciding about the course of the process and the part of the ACT team's offer which he/she wants to use at a given stage. Owing to the above, the client becomes a member of the team, actively working towards his/her recovery.

Teamwork and field work are the gist of the teams' activity – therefore, daily meetings of its members are considered very important. The meetings resemble morning briefings in hospital departments. They include:

- a short discussion of the current matters concerning all the clients
- an exchange of important information from the day before so that all the members can be updated
- discussion of the course of the recovery process
- development of a plan of work for the day
- updating of the weekly and monthly plans.

Once a week individual cases are discussed in more detail during a team meeting with an aim of a review and modification of long-term recovery plans, relapse prevention plans, crises, and other difficulties.

THE COMMUNITY TREATMENT TEAM (CTT)

In Poland the first individual Community Treatment Teams (CTTs) began to be established in the 1980s, but their development was given a go-ahead only after the adoption of the National Mental Health Protection Programme (NMHPP, 2011). Just like in the United States, in Poland, professionals, persons experiencing mental illness and their families, fully understand the need for a deinstitutionalisation of mental care. The decisive role of the only payer, i.e. the National Health Fund (NHF), is a serious limitation. It is actually the payer who dictates the rules of operation, the type and amount of services provided by teams, as well as the team membership, the number of persons covered by the support, and the location.

Community Treatment Teams operate under various institutions as:

- care providers which sign independent contracts with the NHF
- separate units operating as a part of large mental hospitals, in their area, or by psychiatry departments in multiprofile hospitals
- units closely cooperating with mental health units, mainly supplementing the range of the offered psychiatry services with home visits
- units operating in new structures referred to as mental health centres (MHC). The latter do not have a uniform character: some of them have an inpatient department, a day-care department, an outpatient unit, an outpatient mental health unit (OMHU), an outpatient addiction treatment unit (OATU), and a community treatment team. Others offer only some of the above forms of care, e.g. CTT and OATU, CTT and OMHU or CTT, and a day-care department.

Theoretically speaking, the mission of CTTs is their work within a community for the benefit of persons suffering from serious mental disorders – mainly psychoses and affective disorders. Some CTTs pay

home visits, mainly to patients with dementia, or work with children suffering from autism (Patura-Szost, 2015). In such cases, the "contract provisions are insufficient" to cover adult patients with serious mental disorders in a particular area with care (Patura-Szost, 2015).

The work of some CTTs is mainly focused on home visits (75% and more), while others operate in a manner resembling an ordinary outpatient mental health unit, providing services mainly in their own location. As the results from a survey conducted in January 2015 show, both the number of persons covered by the support, the number and professional qualifications of their members, as well as the type of the services provided vary (Patura-Szost, 2015). In the study, the number of persons covered by the care of a single CTT ranged from 17 to 700 (sic!). The number of team members was also different: it ranged from 3 to 16 persons (and after the rejection of the extreme results, it ranged from 5 to 50 clients per employee). The number of clients per CTT member did not correlate in any way with the number of psychiatrists employed. The teams which filled in the questionnaire employed from 1 to 6 psychiatrists. The study was a pilot project and its conclusions suggest that it is necessary to closely monitor the functioning of CTTs in Poland.

Taking the above into account, we can still attempt a comparison of the Polish community treatment teams and the assertive community treatment teams (ACT) operating as a part of the Pathways to Housing Housing First programmes.

A COMPARISON OF ACT AND CTT

The mission of both teams is similar – it consists in supporting the recovery of people with serious mental disorders. The teams aim at working in the community of their patients with a view to limiting the number of hospitalisations and serious mental crises.

Both types of teams operate within a closely defined area, although the notion of a "catchment area" is no longer used in Poland and any patient who meets the criteria of a diagnosis according to the ICD-10 and asks for CTT support should be admitted. Still, from the practical point of view, it makes no sense to admit patients from a different catchment area if the journey to the patient's home exceeds the time determined by the NHF for a home visit, i.e. an hour and a half. This is why patients living at a considerable distance away are generally asked to report by themselves to the facilities located nearest their address, if any.

The composition of ACT and CTT is different, because a CTT is a purely medical facility and does not employ people without education in this area. Such services as assistance in looking for a job or keeping one's flat fall outside of the CTT's range of activity.

As a rule, a CTT must include a team head, a nurse, a psychiatrist working on a part-time basis and a community therapist with a certificate from the Polish Psychiatry Association. The NHF provided that additional employees may include certified psychotherapists or psychotherapists doing their training, psychologists, and doctors doing specialist training. The employment of a social worker is not provided as an option, although in some teams belonging to larger facilities, such as an MHC or a hospital, a social worker is also available to CTT patients on a part-time basis. Some CTT teams established by non-governmental organisations and signing a contract with the NHF only in the area of the provision of health-related services, employ experienced social workers, but their work is financed from sources other than the NHF.

The structure of a CTT does not include the position of a secretary. This function is often successfully fulfilled by persons employed at the reception desk. It would be hard to say though that they are always considered CTT members. They do not have any financial means at their disposal which could be used towards the provision of emergency support to the clients, as is the case in ACT teams.

The tasks of a nurse in the ACT team slightly exceed the competences of a nurse in the Polish health care system, in which a nurse does not have the right to write prescriptions. According to the NHF, a nurse should be a member of the team, but his/her activities (including injections) are not included in the range of payable services, and are therefore free of charge (!), unless the nurse is simultaneously a community therapist, and only then is a part of

his/her work (talking to the patient or a home visit) taken into account by the payer in settlements with the CTT.

None of the CTTs operating in Poland has an addiction therapist – which is different from the ACTs. Despite the existence of programmes of work with dual diagnosis patients, there are no therapists working in this system in Poland. Normally, when an actively addicted patient gets to a CTT, he/she is referred to facilities offering only the treatment of addictions. Sometimes, there is some cooperation between OATU and CTT therapists working with the same person. Patients under the influence of psychoactive substances are not admitted to a CTT. In view of a frequent coexistence of addiction in people with a diagnosed mental disorder, it is naturally necessary for programmes addressed to dual diagnosis persons to be implemented as a part of a CTT in Poland – just as is the case for ACT teams in the USA.

In both ACT and CTT teams, the head should have a considerable clinical experience and a university degree in psychiatry or psychotherapy. The CTT head does not have to be a certified community therapist. The tasks of heads in both types of teams include the coordination of team work, organisation of team meetings, and cooperation with other organisations dealing with psychiatry in a given area.

CTT employees are obliged to develop individual therapy plans for each client, although the patient does not have to actively participate in the activity. The plan should obviously be accepted by the client, but it not clear what happens when he/she has a different vision of treatment than that of the CTT staff.

Cooperation with families is naturally possible, but it is often the case then, in view of the personal data protection act, that the patient's family and the treatment team experience misunderstandings in this field. Family therapists are not employed in CTTs, although the NHF provides for the possibility of work with the family in its accepted range of services.

It basically depends on the organisational culture of a given CTT whether or not daily meetings of team members are held and whether there is time to jointly discuss difficult cases and crisis situations. Because team meetings are not included in the NHF-approved range of services, the NHF does not pay for the time spent on them.

In some CTTs, similarly as in ACT teams, there are daily meetings of team members. In others, the number of meetings grows as the organisational structure becomes more complex, e.g. due to the establishment of Mental Health Centres and the necessity to exchange day-to-day information between the particular MHC sub-units. There are also such CTTs, in which there are no team meetings (!) at all, and information about the patients is provided to the other team members spontaneously, irregularly, and adventitiously.

ACT teams provide their support in the area of physical health to the clients who accept it. As results from many studies, and from my own clinical experience, the physical health of some persons suffering from mental disorders is poor and/or worsens faster than that of the average population. It partly results from the side effects of medicines, and sometimes from risky behaviours of the mentally ill and/or addicted persons.

Supervision is a noticeable difference between the ACT and CTT teams. In ACT, individual peer supervision is provided to team members by an experienced clinician – the team head. It is not defined whether the persons providing supervision must be certified psychotherapy supervisors. In CTTs we only talk about supervision when referring to the work of psychotherapists during training. NHF requires that therapists in training work under the supervision of a certified supervisor, but it does not cover the related cost. Therefore, the therapists must pay for their supervision with their own private funds – otherwise the NHF will not pay for their work.

Some CTTs, feeling the need to look after the hygiene of the teams' work, organise a sort of group supervision for all of their members. It does not have to be conducted by a certified supervisor – but, importantly – by someone from outside the team. Unfortunately, neither time nor funds for the purpose were taken into account in the range of services approved by the NHF.

SPECIALIST CARE SERVICES AND INTENSIVE CASE MANAGEMENT

INTENSIVE CASE MANAGEMENT (ICM) TEAMS

Along with ACTs, intensive case management (ICM) teams provide access to medical, psychological, and rehabilitation care to clients of the Housing First programmes (Tsemberis, 2010).

Contrary to what their name suggests, the teams are appointed to work with the clients who need less intensive care than the users of ACT services. ICM clients normally do not suffer from serious mental disorders. However, they are chronically homeless and suffer from addiction (of various degrees). They sometimes use detoxification, emergency medical services, or hospital treatment. Sometimes, they get into prisons (Tsemberis, 2010).

The basic assumptions and rules of operation of ICM teams are as follows:

- persons with mental problems may recover and/or change their life
- when working, it is important to focus on the client's resources
- the environment is a mine of resources, not a nest of adversities and barriers
- the clients are the managers of their own recovery process
- from the point of view of the programme, it is fundamental that the relationship between the client and the ICM team member is authentic
- community is the basic area of the team's activity.

Each ICM team includes its head, intensive case managers, and a secretary. In Poland, the role of the intensive case manager can be compared to the community therapist working at a CTT and not being a nurse, a psychotherapist, or a psychiatrist. Normally, ICM teams in the PHF programme employ a psychiatrist or a psychiatric nurse (who has broader rights in the US health system than in the Polish one) on a part-time basis.

Basically, intensive case management is not based on direct professional work with the clients, but only on the provision of intermediary services in getting access to the highly specialist services they are entitled to, which are adequate at a given moment of the recovery process, are available in the client's community and are provided by facilities other than the ICM team.

ICM team members offer direct help with such matters as personal budget management, cleaning, the preparation of meals, washing clothes and intermediation in access to services satisfying higher level needs (e.g. health-related or spiritual ones) offered by the institutions existing in the client's community.

Individual team staff members organise care for their clients, but everyone knows the current stage of the recovery process of all the clients – so that when necessary the team members can substitute for each other at work.

The number of clients per team member ranges from 10 to 20 depending on the intensity of the assistance the individual clients need. The team works five days a week, but telephone contact is available on a 24/7 basis.

Members of the ICM team mainly work in the field, have weekly meetings and additionally meet once a month to discuss difficult cases and crises.

The ICM services are not limited in time. Together with his/her intensive care manager, the client decides about the arrangement of fewer and fewer meetings and services until they are no longer necessary. The clients remain beneficiaries of the project even if they lose their flat, if they are hospitalised, or stay in any other institution.

Depending on the client's health condition, visits at his/her place may take place (after agreeing the time and date) once a week, twice a week, or once a month. It is assumed that if a visit is paid once a month, then a second meeting is arranged at the ICM's location in the same month.

In a crisis, the frequency of visits is increased. Basically, it is important to notice the first indicative symptoms and prevent the worsening of the client's mental condition or any other crisis arising.

Peer supervisions are conducted by the team head, who holds an hour-long meeting with each team member every two weeks.

Members of ICM teams bring hope and reassurance.

SPECIALIST CARE SERVICES (SCS)

We may feel that the regulation of the Minister of Social Policy on Specialist Care Services (SCS) for Persons with Mental Diseases (MPiPS, 2005) is a mirror version of the principles regulating the functioning of ICM teams.

Under the regulation, SCS are addressed to persons suffering from mental diseases, and they are to:

- teach and develop the abilities necessary for people to live independently (in particular the ability to satisfy one's basic needs and the ability to function in society), to intervene and help in family life, assist in dealing with official matters, provide support in getting a job, and help in money management
- offer care – as a form of supplementation of the treatment process
- provide physical rehabilitation and improvement of the disturbed functions of the body
- assist in housing-related matters.

Information provided on the website of one of the Warsaw-based social welfare centres reads as follows:

"Specialist care services are provided to persons with mental disorders in their place of residence (i.e. in their flats) and in their nearest surroundings. The services are provided on a daily basis Mondays to Sundays from 7:00 a.m. until 8:00 p.m.. Most often, the services involve the provision of support and assistance in the satisfaction of the daily needs and the development of abilities necessary to satisfy them independently, joint organisation of time and spending time together, using services provided by a variety of institutions, assistance in dealing with official matters, support in getting a job, psychosocial support, and assistance in psychosocial interventions. Our facility does not directly employ persons providing specialist care services for the mentally ill. We commission the provision of such services to specialist companies or organisations selected in accordance with the public procurement law. These companies employ persons who directly perform specialist care services"[4]

The variety of specialists who are to provide SCS under the regulation gives an impression that persons with mental disorders may obtain highly specialist, comprehensive help in all the areas of life with which they cannot cope independently.

Most often, however, SCS dedicated to the mentally ill consist in the provision of care services. Sometimes, staff offer SCS help in dealing with official matters. Therapy is a rarity, however, and the provision of services under SCS is very poorly remunerated.

COMPARISON OF ICM AND SCS

What is the main difference between SCS and intensive case management (ICM) is the way in which clients are assigned their services. Categorised as social assistance services, SCS are granted on the basis of an administrative decision determining their scope, the number of hours, range, as well as the monthly cost and the payment deadline.

In practice, this means that some potential beneficiaries of SCS resign from them due to the necessity to partly incur their cost. Often the number of hours of assistance is insufficient. It also happens that SCS are not provided on a constant basis: when the money is "finished" in the social welfare centre, the client remains without assistance for some time to become a beneficiary again. The frequent changes of staff in many institutions directly providing SCS are not conducive to the development of a permanent relationship with the beneficiary, thus failing to provide stable support.

Most specialists employed as a part of SCS are very sensitive, involved in their work, and willing to cooperate with the health care for the benefit of the mentally ill persons remaining under their care. Still, when looking at the Polish reality, it is difficult

[4] http://ops-wola.waw.pl/opswola/jak-pomagamy/zdrowie-psychiczne/specjalistyczne-uslugi-opiekuncze/specjalistyczne-uslugi-opiekuncze-dla-osob-z-zaburzeniami-psychicznymi

to talk about any vision of support based on principles which are the basis for the functioning of ICM teams.

When SCS are provided, it is not the beneficiary who decides how many, when and what sort of services will be provided to him/her. The client does not even participate in the development of a plan of assistance. He/she is a passive recipient of services, and in fact the slogan "help in recovery" could be replaced with "help in being ill" (Prot-Klinger, 2011).

I have never worked as a part of an SCS team, but I know that their organisational culture is very distant from that existing within ICM teams. There is some exchange of information on the clients, but it seems that each person works independently and there is no team-thinking.

Sometimes SCS employees contact health care professionals in matters concerning their clients, but it is not a routine or structured contact. Such contact is more often in the face of a mental crisis and unfortunately often omits the client, who learns about attempts at contacting the psychiatrist as the last person involved.

I realise that the above may be unfair to some specialists providing SCS, but it does result from my experience that misunderstandings and sometimes abuse take place at the border point of the SCS and patient rights, the protection of personal data, and human dignity.

OTHER SELECTED FORMS OF SUPPORT OFFERED TO MENTALLY ILL PERSONS

When planning PHF in Poland, it is worth taking into consideration the possibility of involving various institutions operating within the local environment in the work for the benefit of the clients. I would entrust the responsibility for the implementation of the PHF programme to the willing non-governmental organisations. Other organisations and institutions – also medical ones – should play support functions in compliance with their primary area of activity. It is worth attempting to invite both the Police and the Church (which are not mentioned below) to cooperation at the local level. Also, which seems obvious, it would be worthwhile to start cooperation with the local social welfare centres which are to satisfy the indispensable life needs of persons and families unable to independently meet the challenges posed by life and to make them able to live in conditions respecting human dignity. Chronically homeless persons with dual diagnosis and/or mental disorders definitely belong to this group.

COMMUNITY SELF-HELP CENTRES (CSHC)

As we can read in the publication issued by the Board of Mazowieckie Forum Środowiskowych Domów Samopomocy, CSHC are divided into type A, type B, and mixed homes (Bąkowska, 2012). They are run by the local governments as an assignment delegated by the government administration and financed from the budget of the province governor. They act as:

- units of social welfare centres
- independent organisational units
- facilities run by non-governmental organisations

Their activity is regulated by two acts:

- the Mental Health Protection Act of 19-08-1994
- the Social Assistance Act of 12-03-2004

Type A homes are designed for persons with chronic mental disorders. Their establishment was an expression of the idea of the introduction of community forms of semi-stationary assistance aimed at the keeping of persons suffering from chronic mental disorders in their natural environment (Bąkowska, 2012). CSHC are primarily to maintain and develop participants' abilities necessary for them to conduct as independent a life as possible.

Many of these facilities run evening clubs, and offer many therapeutic and rehabilitation activities during the day.

Sometimes homeless and/or mentally ill persons find shelter in CSHC during the day. They can wash their clothes there, have a meal, take a shower, shave, etc.. If homeless persons get to CSHC, they are asked to use other forms of help. They get full information about the local shelters (including night shelters), and places in which they can get clothes and hot meals. Unfortunately, sometimes

chronically homeless persons do not want to use help other than that available on the spot. In such cases, CSHC employees agree to provide further assistance of the beneficiary's choice.

Successful cooperation between various services acting for the benefit of a mentally ill homeless person is not infrequent. Mr K.'s story, which happened in Warsaw, is a good example to confirm the above.

Mr K. forgot that he had a flat and became homeless. He started to wander about the city, after some time started to sleep in night shelters, and finally got to a CSHC. At that time he was actively psychotic and displayed many symptoms making meaningful communication difficult. Fortunately, CSHC staff knew him, as at some point in the past he had used the services offered by their facility. They knew that he had left his home and disappeared. He was unsuccessfully searched for by his family and the police, to which his disappearance was reported. It is possible that due to his disease, Mr K. was so much afraid that his family would take his flat away from him that, being in psychosis, he decided that it was actually the case. Therefore, he left his home and… became homeless.

When he appeared at the CSHC, the centre staff established cooperation concerning his situation with an inpatient department and CTT of the district mental centre. Mr K. got attached to a psychotherapist from CTT, began to trust him, and after being discharged from the inpatient department, he returned to his own flat. He decided that he would continue his treatment at CTT and he simultaneously used the services offered by CSHC. In time, he renewed contact with his family, started to think about ways to settle his rent debt and made personal development plans. There were times when his psychosis exacerbated and made his normal life difficult, but owing to his trust in his CTT therapist and CSHC staff, he managed to be treated at home and avoided subsequent hospitalisation.

It was a non-invasive network of support which enabled him to move out of his homelessness.

For me, the above is one of the examples showing that the cooperation of various organisations acting locally for the benefit of the mentally ill is more effective than their separate activity.

NON-GOVERNMENTAL ORGANISATIONS OPERATING IN THE MENTAL HEALTH AREA

Non-governmental organisations working in the area of the protection of mental health take on themselves an extremely important mission of the implementation of the postulates of the National Mental Health Protection Programme (2010), irrespective of the actual involvement of local and central government institutions, or the National Health Fund (which are statutorily obliged to act towards the purpose).

They largely deal with prevention and education. They undertake the fight with stigmatisation. It is mainly non-governmental organisations which run protected flats, and fight for the keeping of the flats of mentally ill persons threatened with eviction.

Sometimes a social welfare centre, which is a facility established to support people facing exclusion, can only offer people standing on the verge of eviction help, adding them to the list of those waiting for a place in a social welfare home. In such situations, it is the energetic and effective activity of people from associations or foundations which makes it possible to find some other, more recovery-friendly, solutions.

A day-care centre for the mentally ill homeless persons has been operated for years by the St. Brother Albert's Shelter in Wrocław (www.wdpf.org.pl). Both the shelter and the outpatient centre are run by non-governmental organisations.

There are associations which bring together patients and their families (such as the Warsaw-based Stowarzyszenie Integracja, www.stowarzyszenie-integracja.pl), and others, in which peer experts and experts through education develop joint projects (e.g. Polskie Towarzystwo na rzecz Psychologicznego i Społecznego Podejścia do Psychoz = Polish Society for Psychological and Community Approach to Psychoses, www.ptpspp.org.pl).

The prevention of mental disorders, running support groups, and management of protected housing or hostels are only some of the areas of activity of these organisations. Their members also deal with the advocacy, i.e. contact with the media, and local and central government officials. They sit on councils working towards an improvement of mental care in Poland.

Supporting mentally ill patients in getting a job is yet another area of activity of non-governmental organisations. They help such people establish social cooperatives, and also create jobs themselves (e.g. in the Krakow-based Pan Cogito hotel; www.stowarzyszenie-rozwoju.eu). Further, they organise cooperation with companies on the open job market, so that the recovering individuals can do their internship or traineeship, obtain recommendations, and increase their chance to find a job. A good example here is the alliance between Fundacja eF-Kropka and the restaurants managed by the Kręglicki family (www.ef.org.pl).

SUMMARY

Without doubt, there is a huge need for the Housing First programme in Poland. What is important, it fits in very well with the institutional solutions promoted in the National Mental Health Protection Programme (Council of Ministers, 2011). However, taking into account the current degree of implementation of the National Programme and the huge underfunding of community psychiatry, as well as the manner in which the specialist care services are provided, it seems that we need to look for hybrid solutions, combining the principles of the Housing First with the possibilities of the current model of community treatment, social assistance, and the activity of non-governmental organisations.

A hybrid team would have to be appointed by a non-governmental organisation. Non-governmental organisations operating in the area of mental health are marked by high involvement, good anchoring in the local environment, experience in winning funds, flexibility of operation, the ability to assert patients' rights and are present all over Poland. The teams' beneficiaries would become tenants and as such they would use the locally available support network. Along with the development and monitoring of a recovery plan together with the client, the teams' tasks would include intensive support in the assertion of all the client's rights to professional assistance in the area of broadly-understood health, including mental health, addiction, social assistance, or moving out of joblessness.

The therapists from the team (and we see certified community therapists in this role) would work using the resources available in the local environment, similarly as is the case in the original Housing First. They would commission a considerable amount of professional impact services to healthcare entities cooperating with them, such as community treatment teams, addiction treatment units, and day-care departments.

Unfortunately, we also need to discuss questions to do with finance. The financing of hybrid teams with funds from the National Health Fund seems to be unrealistic. The NHF concludes contracts only with health care entities providing services in compliance with the catalogue of services enclosed with the Order of the Head of the NHF (NHF, 2013). Normally, the granted limit of services does not cover the needs. However, on the other hand, wherever Community Treatment Teams exist, there are no reasons why the beneficiaries of the PHF programme could not obtain exactly the same help as the other people in the region. The financing of the teams from social assistance funds seems equally unrealistic (although, if the regulation on the provision of specialist care services (MPiPS, 2005) was treated literally, then hybrid teams could apply for co-financing of their activity with social welfare funds). Scant and irregular financing is the problem here – and after the budget for a given year is exhausted, the provision of services is suspended for some time.

Summing up, considering their involvement, anchoring in the local environment, experience in winning funds, flexibility in operation, as well as the ability to assert patients' rights, the non-governmental organisations dealing with mental health are most likely to become the pioneering bodies in the implementation of the PHF programme in Poland.

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