



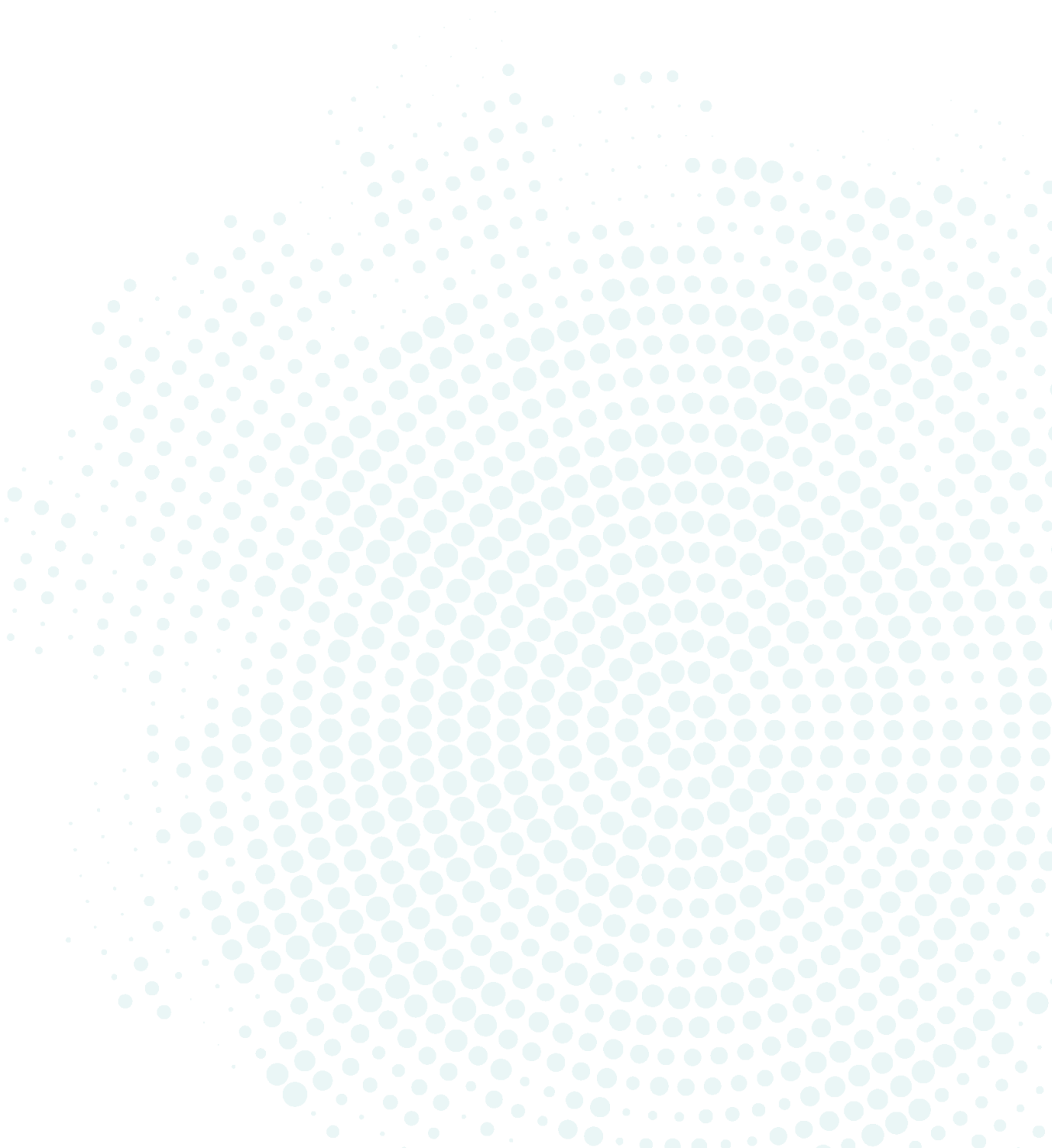
Towards a community-based model of mental health care in Poland

Findings of the rapid assessment



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ABSTRACT

The report “Towards a community-based model of mental health care in Poland: findings of the rapid assessment” presents the results of an assessment conducted by the WHO Regional Office for Europe at the request of the Ministry of Health of Poland. The assessment engaged a broad range of stakeholders across Poland, including representatives of community mental health centres, national and local health authorities, mental health professionals, NGOs, and service users. The goal was to evaluate the country’s readiness to scale up the community-based model of mental health care nationwide, building on the experience of the Pilot Programme on Mental Health Centres. The assessment explored existing strengths, ongoing barriers, and stakeholder priorities, with a focus on the alignment of governance, service delivery, financing, and workforce development. More broadly, the report aims to clarify the strategic and operational steps needed to complete the transition towards a community-based model of mental health care. It identifies critical gaps in coordination, care navigation, clinical standards, and data monitoring, and proposes actionable directions to support equitable, person-centred, and recovery-oriented mental health services throughout Poland.

KEYWORDS

ACCESS TO MENTAL HEALTH SERVICES; COMMUNITY-BASED MENTAL HEALTH CARE; MENTAL HEALTH SYSTEM TRANSFORMATION IN POLAND; RECOVERY-ORIENTED CARE; HEALTH WORKFORCE PLANNING; INTEGRATED HEALTH SERVICES.

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The views expressed herein should not, under any circumstances, be considered an official position of the European Union.



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Abbreviations

AI	artificial intelligence
COVID-19	coronavirus disease
CZP	<i>Centrum Zdrowia Psychicznego</i> [community mental health centre]
EU	European Union
EUCOMS	European Community Mental Health Service providers network (EUCOMS)
NFZ	Narodowy Fundusz Zdrowia [National Health Fund]
NGO	nongovernmental organization
PZK	Punkt Zgłoszeniowo-Koordynacyjny [CZP Registration and Coordination Point]

Executive summary

This rapid assessment, undertaken by the WHO Regional Office for Europe at the request of the Polish Ministry of Health and supported by the European Commission as part of the “Addressing mental health challenges in the European Union, Iceland and Norway” project, presents a pragmatic yet comprehensive analysis of the current state of mental health care service delivery in Poland, with a particular focus on community-based models of care.

Context and objectives

Poland is undergoing a system-wide transformation in mental health care, anchored in a shift from hospital-centric care to territorially organized, community-based and coordinated mental health care services. This transformation is building on the substantial progress that has been made since 2018 when *Centrum Zdrowia Psychicznego* (CZPs) [community mental health centres] were established under the Pilot Programme on Mental Health Centres (the Pilot Project) and which now provide mental health care coverage for over 50% of the adult population. The Ministry of Health’s commitment of investment funds of over *polski złoty* (PLN) [Polish złoty] 4 billion in 2024 has provided an unprecedented opportunity to scale up what works in the transformation of the mental health care system throughout the country.

The assessment aimed to evaluate the country’s readiness for a national scale-up of the community-based model of mental health care, identify system strengths and persistent barriers, and propose feasible, evidence-informed next steps that are aligned with international standards. The assessment findings draw upon extensive stakeholder engagement, site visits, a desk review of key national documents and data sources, and the triangulation of national and international evidence.

Strategic findings

Strong political will, clear vision

The National Mental Health Protection Programme 2023–2030 and its comprehensive, intersectoral implementation plan, the Roadmap for National Mental Health in Poland 2025–2028, set the foundations for coherent system transformation; what is needed now is the implementation.

Locally developed solutions are already working

Effective CZPs offer concrete, transferable solutions to mental health care. This provides inspiration both nationally and internationally.

System gaps must be closed

Key gaps include the following:

- The lack of an institutionalized national coordination mechanism for mental health care makes it difficult to scale up the transformation of the system in a coherent manner. Stakeholders at the national, regional and local levels lack a clear governance framework and defined roles, which leads to fragmented efforts.
- The current model lacks a standardized, detailed structure for care pathways, especially at the provider level. This has led to inconsistencies in the implementation of the Pilot Project.
- There are no formal stepped care navigation mechanisms to guide those in need to the appropriate level of care. These mechanisms should be based on the severity of the mental health condition, with clear triage and referral processes to ensure the efficient use of highly specialized resources and reduce bottlenecks in accessing specialist services.
- There are no clear requirements for patient-centred care coordination between inpatient and community care, particularly for acute cases.
- Clinical and organizational guidelines, standards of care and professional competency standards for delivering community-based mental health care have not yet been developed, and there are no formal requirements for their implementation.
- Financing remains fragmented and it does not support collaboration between the different levels of care in the health system and the service providers. It also lacks quality targets to steer compliance with care standards and stimulate efficiency.
- The health-care system lacks a consolidated database and agreed indicators for service quality, costs and outcomes. Data remain isolated, which limits effective oversight, treatment provider accountability and learning.

Policy priorities for action

1. Preserve and scale what works. Expand the CZP model nationally, retaining its flexibility to adapt to local needs, avoiding a rigid, one-size-fits-all approach and maintaining the ability to set up both Type A and Type B CZPs. Selecting a suitable type of CZP within each local context could be done based on specific criteria, although national service standards and performance benchmarks should be set.

2. Leverage effective CZPs as national and international resource hubs, and document, support and replicate their good practices as systemic solutions.
3. Establish care-navigation systems within each CZP to allow them to triage and allocate appropriate care pathways to individuals by:
 - designating the function of stepped care pathway navigation to the CZP Registration and Coordination Points with the responsibilities for triage and case allocation;
 - directing people with mild or moderate mental health conditions to the CZP's frontline mental health teams composed of lower trained mental health care professionals such as generalist psychologists (without specialization) or psychiatric nurses, working under the supervision of highly trained specialists in same CZP (e.g. psychiatrists and clinical psychologists);
 - directing people with moderate-to-severe or severe mental health conditions to CZP specialist teams and dedicated specialists, and improving their access to CZP services.
4. Ensure coordination between inpatient and outpatient community-based services by setting up shared care pathways, legal procedures and joint planning across inpatient and outpatient CZP service levels.
5. Strengthen the mental health care workforce by developing and implementing competency standards, formalized training pathways and task-sharing mechanisms.
6. Financing mechanisms should be shaped to reward quality, care coordination and achievement of recovery-oriented health outcomes, rather than the volume of services provided.
7. Adopt national clinical guidelines and standards of care, and embed recovery-oriented practice into the system.
8. Expand use of digital e-health tools and telehealth to increase reach, especially in underserved regions.

Strategic directions for action emerging from the rapid assessment

The rapid assessment has laid out a realistic and actionable path towards completing Poland's transition to a modern, community-based mental health care system within a set time frame. The proposed next steps and recommended actions reflect a high degree of consensus among most stakeholders, and an alignment with international standards and the policy foundations already in place.

However, realizing this vision will require more than policy intent alone as it is not a case of "business as usual".

The intended goals will not be achieved through routine measures or fragmented planning. Exclusively extending the duration of implementation of the Pilot Project will not deliver the qualitative, sustainable implementation of the community-based model of care at the national level.

Setting up a coordinated and sustained effort, supported by dedicated capacity, clear governance and targeted investment, such as a specific mechanism for ensuring implementation and coordination of the transformation of the Polish mental health care system, is of critical importance. It is important to recognize that this is beyond the scope of work and capacity of a single department within the Ministry of Health as such a large-scale transformation requires dedicated resources for national implementation, monitoring of policies and progress, and technical coherence of the transformation efforts. The following strategic directions of action are proposed:

1. Ensure with immediate effect the smooth coordination of the implementation of the community-based model of mental health care and stepped care pathways at the national and regional levels to transform mental health care services, and align and integrate the efforts of different stakeholders across multiple components of the mental health care services and sectors. As this capacity does not yet fully exist, an intermediary coordination mechanism should be established in the short term to guide implementation, build institutional readiness and ensure consistency across regions during the transition phase.
2. Implement a nationally integrated model of community-based mental health care services across the life course. A comprehensive model of care – anchored in territorial responsibility – should be fully operationalized nationwide to ensure service availability for all age groups. This will require a harmonized legal, policy and governance framework, along with financing mechanisms aligned with population needs and which are flexible enough to support locally adapted solutions.
3. Build workforce capacity to deliver person-centred, community-based mental health care by coordinating with other capacity-building projects and initiatives, developing national competency standards for the new model of care and delivering targeted training sessions. Competencies for interdisciplinary collaboration must be expanded across health, education, social care and other relevant sectors.

4. Operationalize intersectoral collaboration for mental health care and well-being at all levels through clear governance arrangements, shared responsibilities and sustainable resources.
5. Ensure the system-wise transformation of the mental health care system addresses the needs of vulnerable populations, with particular attention being paid to groups such as refugees, people receiving forensic mental health care in the criminal justice system, children and older adults.
6. Develop and institutionalize a national system for monitoring, evaluation and data use with a comprehensive monitoring and evaluation system, with clear indicators, cross-sectoral data integration and regular analysis, to inform continuous improvement and accountability.

Conclusion

Poland has the chance to develop a modern, high-quality mental health care system grounded in equity, recovery and community, but this will require a focused and determined leadership.

1. Rapid assessment report methodology

WHO was asked by the Ministry of Health of Poland to provide support to the Team for Systemic Changes in Mental Health Centres, appointed by the Ministry of Health, to deliver its mandate, including preparing a rapid assessment report of the current state of the mental health care system in Poland.

1.1 Duration of the assessment and methods used

The assessment in Poland was carried out over a 9-week period, from 17 February to 25 April 2025. During this time, meetings, interviews and discussions were conducted with a wide range of stakeholders, including service providers, professional associations, service users and representatives from nongovernmental organizations (NGOs). Field visits were organized to a variety of mental health care service-provider organizations and community-based teams, which enabled the assessment team to observe service delivery in practice, collect relevant documentation and engage directly with staff. In addition, consultations were held with stakeholders involved in policy-making and decision-makers to gain insights into current policy frameworks, implementation challenges and strategic priorities. To maximize efficiency and broaden participation, interviews were conducted both face-to-face and online. This combined approach ensured a balanced and comprehensive overview of the mental health care system at both national and local levels.

The methods used in this assessment consisted of:

- site visits to service providers in multiple regions;
- interviews (online and in-person) with key informants (using a semi-structured interview format);
- a desk review of key national documents and data sources; and
- a review and triangulation of the findings for reliability and validity.

The assessments findings were checked during a validation meeting with the Ministry of Health team who had originally asked WHO to conduct this assessment.

The key principles underlying the conduct of a rapid assessment are:

- speed: the entire assessment, including report writing, was completed within 9 weeks;

- efficiency: the assessment took a pragmatic approach of mixing online interviews with face-to-face meetings and site visits in Poland, with the assessment team stopping at the point of saturation on each topic covered;
- pragmatism: exposed to a wealth of information, the assessment team prioritized practical adequacy over scientific perfection; while it reviewed and analysed a broad range of data, it chose to focus on data that were directly relevant to the set objectives of the rapid assessment;
- participatory: the assessment covered a range of key stakeholders relevant to each of the four functions of the health system; and
- triangulation: the assessment team reviewed a wide range of existing sources to verify information collected during the assessment and increase the validity and reliability of the assessment findings and quality of the recommendations proposed.

The rapid assessment drew on five main technical documents for its conceptual framework, as well as being informed by internationally available scientific literature.

1. The *WHO European framework for action on mental health 2021–2025* (2).
2. WHO's *Comprehensive Mental Health Action Plan 2013–2030* (3).
3. The European Community-based Mental Health Service Providers Network (EUCOMS) position paper on principles and key elements of community-based mental health care (4).
4. The European Union (EU) Compass scientific paper on providing community-based mental health services (5).
5. WHO's Health Systems Framework (6).

1.2 Limitations of the findings of the rapid assessment report

This rapid assessment report does not seek to provide a comprehensive overview of the history of mental health transformation in Poland, which has been presented in a number of previous publications. It also does not seek to present an in-depth analysis of Polish mental health care policy and legislation, including compliance with international human rights covenants and instruments. Instead, it focuses on areas relevant to the objectives of the assessment, bearing in mind the principle of pragmatism noted above.

The findings of this assessment support the community-based model of care as a valid and evidence-aligned direction for mental health system transformation. However, the assessment does not constitute an evaluation of financial efficiency, probity, or provider-level performance within the Pilot Project.

Accordingly, this rapid assessment was not mandated to audit financial performance, investigate the misuse of public funds, or assess profit margins or commercial practices of service providers.

In addition, following potential limitations of this report should be noted.

- The information was gathered through mixed approaches adopted in different settings. Due to travel restrictions, the assessment team visited and was able to observe only selected mental health care service-provider organizations. Otherwise, it conducted face-to-face or online interviews with key stakeholders. Although the team has sought to triangulate findings from different sources to ensure accuracy of data, this limitation should be noted, which may have an impact on its findings.
- The report reflects findings from key stakeholder interviews as one of its main data sources. The selection of participants was carefully carried out to reflect a broad range of stakeholders who were representative of the different components of the mental health care system and who had an interest, importance and influence in relation to the mental health care system. The assessment team was constantly careful to maintain its neutrality during discussions. The report faithfully reflects the information collected from these stakeholders, who were encouraged to share their knowledge trustingly and transparently. While acknowledging and reporting their views, examples and experiences, the assessment team notes the potential limitation of their subjectivity, which may limit their validity.
- The assessment team was not mandated, and did not seek, to audit services. It has, however, conducted brief observations of the visited sites. As these observations were opportunistic, their findings cannot be extrapolated; these observations reflect exclusively on, and are a snapshot of, moments in time and the circumstances observed.
- Certain topics relevant to the Polish mental health care system overall fall outside the remit of this review and, consequently, these areas have not been examined in detail. These topics include:
 - the mental health care system's response to people at risk of developing mental health conditions;
 - the services/interventions for people with mild-to-moderate mental health conditions: peer support and community support groups, family and caregiver support, lifestyle interventions and workplace and school mental health programmes;
 - management of complex conditions and or rare disorders for people with moderate and moderate-to-severe mental health conditions;
 - pharmacotherapy for people with mental health conditions; and
 - services for people with mental health conditions provided in other sectors (e.g. social care institutions, services provided within the defence sector, justice sector, education sector).

2. Background: context and drivers of mental health care system transformation

2.1 Assessment framing and the European/global context

Mental health has become a key priority at both global and European levels, reflecting the growing recognition of its importance to public health, economic stability and social well-being. The WHO Regional Office for Europe's Mental Health Coalition flagship initiative contributes to universal health coverage for people with mental health conditions and promotes comprehensive, integrated and community-based care (2).

In December 2023, the Mental Health Coalition and the European Commission signed a contribution agreement to implement the project "Addressing mental health challenges in the EU, Iceland and Norway". The project aims to strengthen mental health care policies, plans and programmes in these countries using WHO technical tools and expertise. It does so by:

- organizing a series of policy discussions with each participating Member State to identify needs and challenges;
- advocating for stronger implementation of existing mental health policies, plans and programmes; and
- reviewing and refining new policies to ensure tailor-made solutions for each Member State.

This rapid assessment contributes to the project's component on supporting policy dialogue and national capacities for mental health service transformation.

2.2 Population mental health needs in Poland: why system-wide transformation is necessary

Unmet needs in mental health care represent a significant public health challenge in Poland, accounting for over a quarter (27%) of all unmet health care needs – substantially exceeding the European Union (EU) average (7). This gap persists despite progress made since 2018 in expanding community-based mental health services.

Poland has the fourth-highest suicide rate in Europe among men under 65 years (20.75 per 100 000 in 2021) and the third-highest standardized death rate from alcohol-related mental and behavioural disorders. Suicide rates among boys and young men aged 15–24 years are the second-highest in Europe (17.04 per 100 000 in 2021), nearly double the European average (8.66 per 100 000 in 2020) (8).

Polish girls aged 13 and 15 years report the highest rates in Europe of loneliness (36% and 38%, respectively), and report among the highest rates of frequent low mood (52% and 56%) (9).

Among older adults (≥ 65 years), 50% of men and 60% of women report multiple chronic conditions – among the highest proportions in the EU. International evidence indicates strong comorbidity between multimorbidity and depression (10).

Socioeconomic factors also contribute: Eurofound's Living, working and COVID-19 e-survey found that 71% of Poles in financially insecure households were at risk of depression, compared with 49% in financially secure households (EU averages: 62% and 37% respectively) (11).

The National Mental Health Protection Programme 2023–2030 identifies these population-level needs as the foundation for a more responsive, equitable, and community-based care system (12). Rising unmet needs are evident across all age groups, particularly children, young people and older adults. National reports highlight the burden of anxiety, depression, substance use and psychosocial crises, with persistent regional disparities in access – especially in rural areas.

Research and strategic analysis point to several drivers of increasing need:

- post-pandemic health debt;
- social isolation and economic insecurity;
- geopolitical stressors (e.g. the war in Ukraine);
- underdiagnosis or untreated early-onset mental health conditions; and
- a sharp rise in adolescent distress and behavioural disorders (13).

The treatment gap is exacerbated by geographical inequities, stigma and systemic fragmentation. Service-use data confirm marked differences in access and outcomes by region, with rural and eastern areas typically underserved.

2.3 Momentum for transformation: from pilot to national scale-up

There is currently strong momentum for the transformation of Poland's mental health care system. After several years of piloting the *Centrum Zdrowia Psychicznego* (CZP) [community mental health centre] model, developments since April 2024 have marked a shift from local experimentation to system-wide preparation for national scale-up. This period has been characterized by a series of coordinated actions, in which

the Ministry of Health has taken important policy decisions, supported by technical contributions from WHO and other partners. Box 1 outlines the milestones highlighting the progression from setting priorities, to planning, to institutionalizing reform mechanisms.

Box 1. Key reform milestones in 2024–2025

June 2024 – Mental Health Forum

Co-organized by the Ministry of Health and WHO and held in Warsaw on 6–7 June 2024, the Forum brought together national and international stakeholders to take stock of reform progress and identify priorities for the next phase. The Forum concluded with a Consensus Statement outlining seven national priorities for mental health care, including: transformation to a community-based model, strengthening child and adolescent mental health, intersectoral cooperation, financing models, support for Ukrainian refugees, anti-stigma actions and forensic psychiatry. The Forum provided a critical platform for consolidating national commitment, with WHO's role helping to anchor the discussions in international best practices and align them with broader European policy frameworks.

August–November 2024 – Development of the Intersectoral Roadmap for National Mental Health

Following the Forum, commissioned by the Ministry of Health and developed with WHO technical support, the Roadmap set out a structured plan for implementing the National Mental Health Protection Programme 2023–2030 and provides an operational framework for national scale-up⁽¹⁾.

The Roadmap was prepared through broad consultation with stakeholders and identifies roles and responsibilities across sectors and outlines mechanisms to translate strategic priorities into operational steps. The Roadmap is intended to serve as the main framework for national scale-up, addressing one of the critical gaps identified during the Pilot Project: the absence of a detailed, shared implementation pathway.

November 2024 – Policy Dialogue on Mental Health

The Ministry of Health, in collaboration with WHO

and with the support of the European Commission, convened a Policy Dialogue on Mental Health⁽²⁾. The Dialogue brought together representatives from the Ministry of Health, the Mental Health Council, service-provider organizations, the National Health Fund (NFZ) and international experts (including WHO, EUCOMS and the European Psychiatric Association). Discussions focused on three central challenges for scaling up the transformation:

- defining the stepwise and network-based model of care and pathways;
- clarifying the roles and responsibilities of service providers; and
- determining sustainable financing mechanisms.

WHO's contribution was instrumental in framing the technical options and providing comparative experience from other European countries undergoing similar reforms.

December 2024 – Appointment of the Team for Systemic Changes in Mental Health Centres

The Ministry of Health established a new Team mandated to develop national quality standards for community-based services. The Team also envisaged embedding the Roadmap as the key implementation tool for the transformation.

2025 – Consolidation phase

The Special Team's work on quality standards and the WHO-supported Rapid Assessment of Mental Health Services in Poland represent critical steps in consolidating reform.

These activities are expected to inform the roll-out of consistent, equitable and sustainable community-based mental health care nationwide. WHO technical input has supported both the drafting of quality standards and the operationalization of the Roadmap, providing continuity across these reform milestones.

1 Ministry of Health of Poland, WHO Country Office Poland. Intersectoral Roadmap for National Mental Health; 2024. Unpublished report.

2 WHO Regional Office for Europe, Ministry of Health of Poland. Policy Dialogue on Mental Health, Warsaw, 18 November 2024 – Meeting Summary. Unpublished report.

Taken together, these developments illustrate an intensified reform process since April 2024, with national policy commitments reinforced through international collaboration. The sequence of the Forum, the Roadmap, the Policy Dialogue, and the establishment of the Special Team demonstrates a progression from priority-setting to planning and to the institutionalization of reform mechanisms. Throughout this process, WHO has acted as a consistent technical partner, helping to sustain momentum and ensure alignment with global and European standards.

2.4 Summary

Poland's mental health care system is at a pivotal stage of transformation, moving from a hospital-based model towards community-based care. High and growing levels of unmet need underscore the urgency of reform, while recent developments since 2024 demonstrate strong national momentum for scale-up. The combination of the Pilot Project experience, the National Mental Health Protection Programme 2023–2030 and the sequence of recent policy initiatives provides a foundation for structured, system-wide change. Ongoing work on national quality standards, financing mechanisms and implementation support will be critical to ensuring that the transformation results in consistent, equitable and sustainable access to community-based mental health care across the country.

3. Findings of the assessment

3.1 Mental health care policy and strategic direction for national transformation

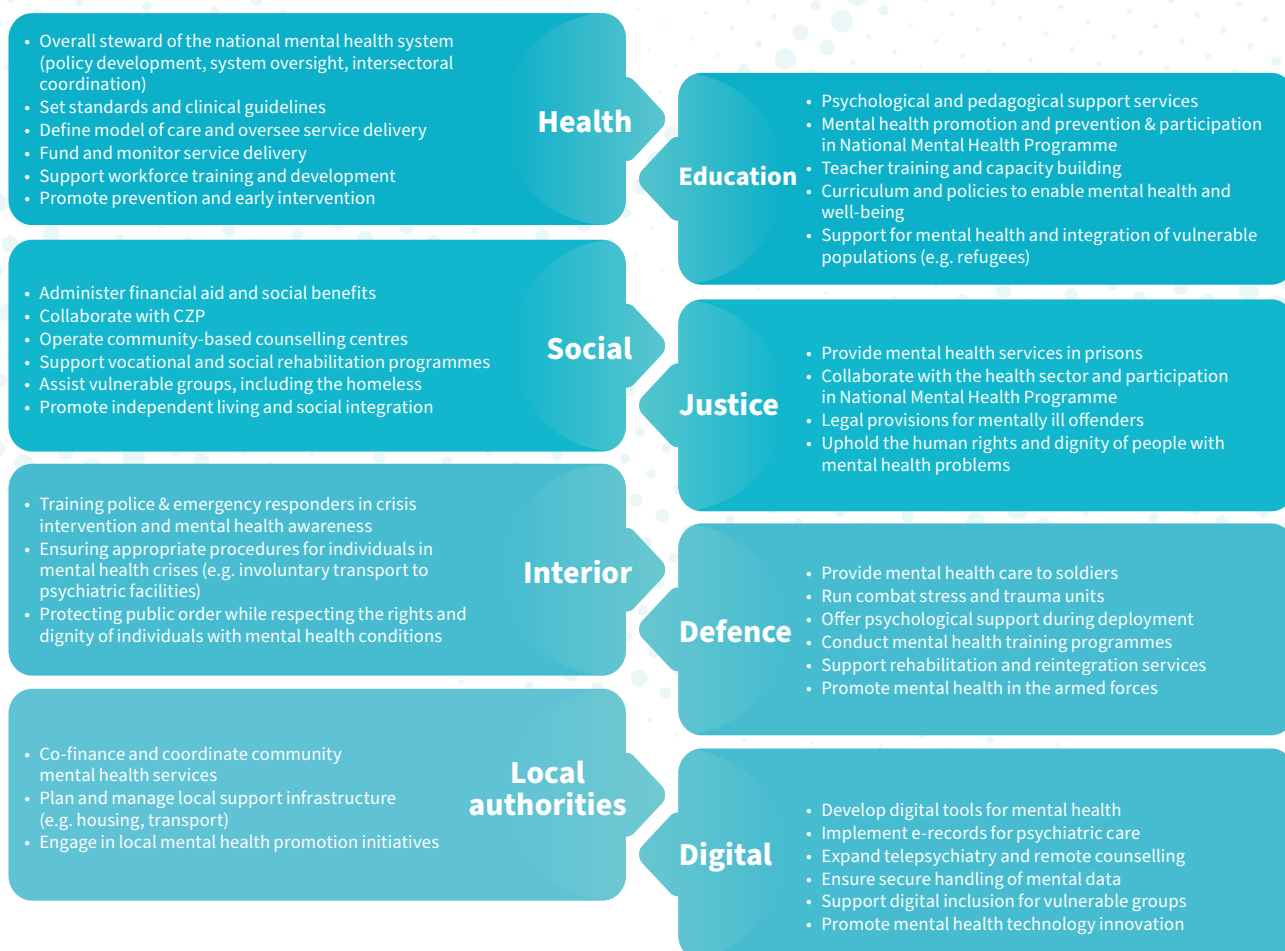
3.1.1 Governance of mental health care

The overall responsibility for mental health policy and system governance lies with the Ministry of Health, which leads strategic planning, regulatory oversight and stewardship of service delivery. The NFZ is the main purchaser, responsible for financing and commissioning services. However, governance of mental health care in Poland extends beyond the health sector. Given the cross-cutting determinants of mental health, effective delivery depends on collaboration with other sectors, including education, social policy, justice, defence, digital affairs, interior/public order and local government. They are mandated to contribute to different aspects of promotion, prevention, early intervention, social support and public-safety functions (Fig. 1). This cross-sectoral dimension reflects the fact that mental health is not only a matter of clinical care, but also of social protection, education, public safety and community well-being.

3.1.2 Mental health policies

Poland has demonstrated political will and leadership in prioritizing mental health. The National Mental Health Protection Programme 2023–2030 and its comprehensive, intersectoral implementation plan, the *Roadmap for National Mental Health in Poland 2025–2028*, reflect a shared vision for an integrated, person-centred mental health care system. High-level engagement from the Ministry of Health and a wide range of key stakeholders in mental health care has helped build consensus on the need for coherent, sustainable reform. In 2024, the Ministry of Health announced an unprecedented investment of over 4 billion (PLN) [Polish zloty] to support infrastructure, workforce development and the broader scaling up of community-based mental health care services nationwide. Poland's National Mental Health Protection Programme 2023–2030 aims to provide a comprehensive person-centred system of care for people with mental health conditions to combat stigma and foster inclusivity through awareness campaigns. Its primary objectives include ensuring the availability of integrated and accessible services, promoting early intervention and supporting recovery-oriented approaches.

Fig. 1 Cross-sectoral responsibilities in Poland's mental health care system



The current programme builds on the previous programme (*Narodowy Program Ochrony Zdrowia Psychicznego 2017–2022* [National Mental Health Programme 2017–2022]), which marked a pivotal shift in mental health care with the introduction of the Pilot Project and the initiation of the transition from hospital-based to community-based care for mental health. The programme outlined a strategic framework for delivering comprehensive, multidimensional and universally accessible health and social support services for people with mental health conditions. Central to this vision was the development of a nationwide network of mental health centres, structured according to the principles of community-based care, which aimed to support people to maintain active roles in their family and social environments. However, the programme faced several challenges, including uneven regional implementation, limited funding allocations and insufficient coordination between the health and social care sectors. The absence of binding organizational standards and performance monitoring mechanisms also hindered the consistency and sustainability of the reforms across the Polish regions.

In response, the National Mental Health Protection Programme 2023–2030 emphasizes scaling up the CZP model, addressing regional disparities and embedding mental health more firmly within primary and community care frameworks (Box 2). As well as clinical reform, it also prioritizes combating stigma and fostering social inclusion through nationwide awareness campaigns and public education. The Programme also envisions stronger intersectoral collaboration, particularly with education, social welfare and employment services, to address the broader social determinants of mental health. By adopting a long-term, systemic perspective, the Programme aims to consolidate recent advancements while remedying the persistent gaps in service provision to ensure equitable and effective mental health support for all citizens.

Box 2. National Mental Health Protection Programme 2023–2030

At the health policy level, the central guiding document for mental health care is the National Mental Health Protection Programme 2023–2030, promoting a shift from institutional psychiatric care to a territorial, community-based, integrated model of care for mental health. This vision has been reiterated in other national policy documents, including *Healthy future: strategy framework for the health system for 2021–2027* (14).

The Programme emphasizes:

- universality and accessibility of services;
- integration with social, educational and addiction services;
- development of mental health centres across Poland with territorial responsibility;
- reduction of stigma and social exclusion;
- development of preventive and promotive interventions; and
- deinstitutionalization, especially for children and adolescents.

The process of transformation of the Polish mental health care system seeks to address the needs of all age groups and vulnerable groups at the national level and to offer equitable, qualitative and effective mental health care close to where people live. A stepwise and network-based model of care centred in the community should encompass a comprehensive range of mental health care services across various care pathways and operate in close collaboration with the relevant mental health care services outside of the health sector.

3.2 Community-based model: structure, diversity and system-wide transformation

3.2.1 Overview of the CZP model of care

Poland's mental health care transformation marks a paradigmatic shift from institutional, hospital-centred care to a community-based model grounded in territorial responsibility, continuity and person-centred support.

At the heart of this reform is the CZP model – developed as a comprehensive alternative to the previously fragmented and centralized system. The CZP model aims to deliver integrated, recovery-oriented services in alignment with international best practices. It was first implemented through the Pilot Project, which established territorially defined provider models responsible for delivering or coordinating a full spectrum of services – outpatient, inpatient, day care and home-based care – for all adults in a designated catchment area. Financed through capitation-based global budgets, CZPs are designed to provide flexibility and enable the delivery of care that is both locally adapted and integrated across service types.

However, CZPs represent only one part of the broader mental health care system. Adult services in Poland are currently delivered through a mixed landscape of organizational models:

- CZPs, covering approximately half of the population, offering integrated, community-based care within specific catchment areas;
- outpatient psychiatric clinics (in Polish “w zakresie opieki psychiatrycznej i leczenia uzależnień, w tym poradnie zdrowia psychicznego dla dorosłych” [trans. - in the field of psychiatric care and addiction treatment, including mental health clinics for adults]), mainly operating in non-CZP areas, which often deliver medicalized care – such as psychiatric consultations and pharmacotherapy – with limited multidisciplinary input and weak links to community or inpatient services; and
- psychiatric hospitals and general hospital-based psychiatric wards, which continue to deliver both acute and long-term inpatient care nationwide.

Achieving a fully community-based model will require system-wide coordination, beyond simply expanding CZPs. It will necessitate redefining roles, responsibilities, and referral pathways across outpatient clinics, inpatient facilities and community teams, while ensuring continuity, quality and territorial accountability.

Each CZP serves all adults within a defined geographical area. The strategic vision is for a cohesive, territory-based mental care health system, organized by population size – typically 100 000 adults per CZP catchment area. CZPs operate under contracts with the NFZ and are financed through global budgets designed to encourage integration and responsiveness (Fig. 2).

Key features of the CZP model

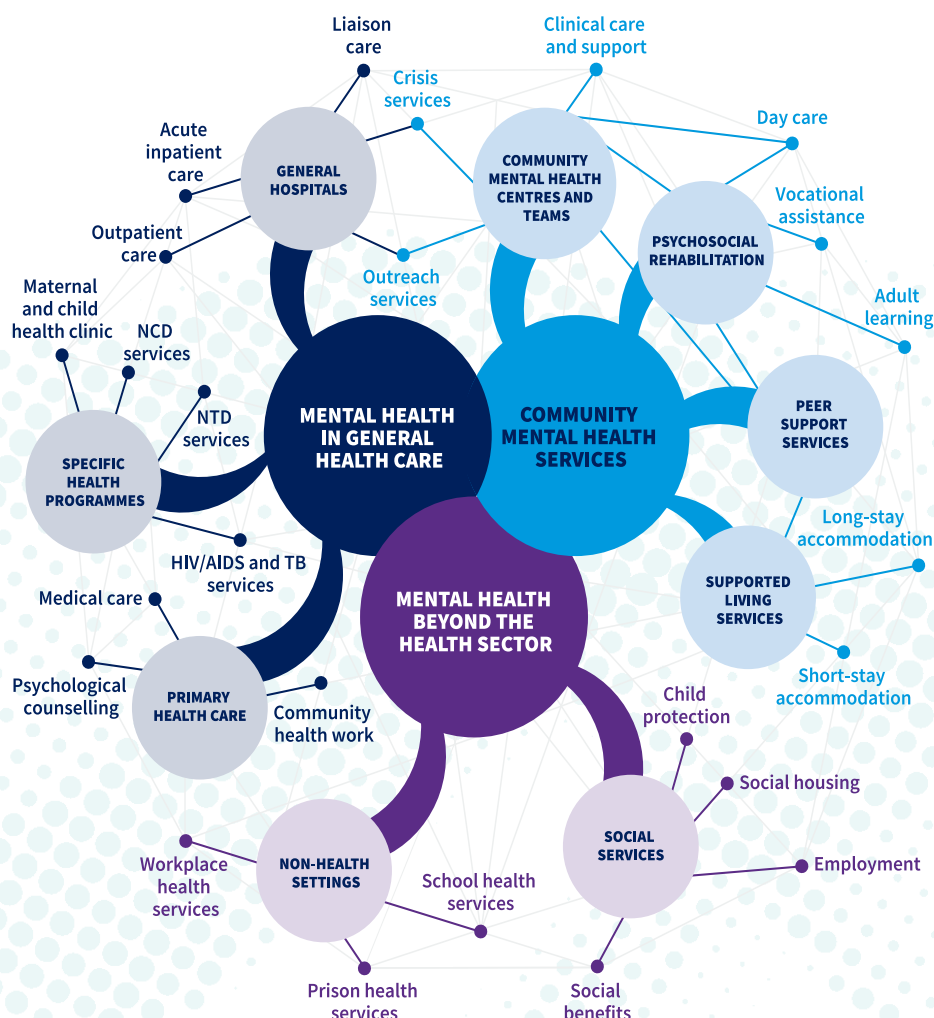
Several defining features characterize the CZP model:

- decentralized service provision based on defined catchment areas;
- flexibility for local adaptation;
- integrated care delivery, including outpatient, inpatient, day care, and home-based interventions;
- territorial responsibility to ensure comprehensive, continuous care for local populations; and
- capitation-based global budgeting, allowing financial flexibility and organizational autonomy.

Multidisciplinary teams and service functions

CZPs deliver care through multidisciplinary teams comprising psychiatrists, psychologists, psychotherapists, psychiatric nurses, social workers and peer-support workers (recovery assistants). Each CZP is expected to provide:

- continuous 24/7 emergency mental health care;
- outpatient and day care services;
- home-based and mobile crisis interventions;
- acute inpatient psychiatric care (when necessary); and
- coordination with local schools, social services and family networks.

Fig. 2 Model network of community-based mental health services.

Source: WHO (1).

Local adaptations and organizational variations

Because the Pilot Project was initiated to assess the practical feasibility of this model of mental health care within a real-world context, the principle of flexible local adaptation is central to it. Each CZP in the Pilot Project was entrusted with designing and delivering services that were tailored to the specific needs of the population it serves, and the local infrastructure and available community resources. This adaptive capacity was deemed essential to fostering local ownership and ensuring contextual relevance. During the course of the Pilot Project implementation, different approaches to service delivery emerged as follows.

- Two main organizational types CZPs that aim to provide integrated care based on local needs and organized locally are:
- Type A CZPs, which integrate both outpatient and inpatient care under a single organizational umbrella;
- Type B CZPs, which provide outpatient and community services and rely on external hospitals for inpatient care.

In the CZP model, a critical distinction is made between Type A and Type B centres. Type A CZPs have integrated acute inpatient units that are under their direct management, which allow for closer coordination across service levels and improved continuity of care. In contrast, Type B CZPs provide outpatient and community services only, and rely on external hospitals for inpatient care; however, there is no legal or regulatory requirement obliging hospitals to partner with CZPs. These arrangements were shaped by local needs; however, during the Pilot Project, no formal criteria were established to guide the selection of one model over the other in specific local contexts.

- **Adaptations** to urban versus rural settings, which affect accessibility, workforce deployment, and service configuration;
- **Variations in location**, with CZPs based in psychiatric hospitals, general hospitals, or as stand-alone community centres; and
- **Differences in governance**, with CZPs operated by public institutions or private providers contracted to deliver publicly funded care.

3.2.2 CZP implementation – input from previous assessments

CZP implementation in Poland has progressed significantly since the launch of the Pilot Project, and, currently, CZPs provide coverage for over 50% of the adult population, yet assessments of the outcomes vary considerably between different evaluations. This assessment was not mandated to, nor did it seek to, conduct a comprehensive assessment of the implementation of the Pilot Project. As part of the desk review for this rapid assessment, two evaluations of the Pilot Project were examined:

- a presentation by the NFZ, delivered at a national conference held in Mikołajki, Poland, 25–27 October 2024;³ and
- a report produced in October 2024 by the Care Transformation Team for Psychiatric and Addiction Treatment, established by resolution of the Council for Mental Health under the Ministry of Health.⁴
- Although both the NFZ presentation and the Team's report agree that the CZP implementation has progressed significantly, the outcome assessments differ.

Findings of the NFZ analysis

According to NFZ analysis data:

- as of 2023, 117 CZP contracts had been signed, which cover approximately 51% of Poland's adult population within their catchment area;
- in 2023, the CZPs provided care to an average of 3.2% of the adult population, with 57.1% of CZPs providing care to less than 3.1% of the adult population. Some CZPs served only 0.5–1.6% of the adult population, whereas some CZPs covered well above this average (e.g. a CZP in Stupsk covered 6.4% of the adult population);
- in 2023, CZPs provided care to 65% of the total number of people with mental health conditions who were treated in the public system, an increase from 25% in 2019. NFZ data do not specify where the other people were treated. There are significant differences in coverage between centres, with some CZPs reaching up to 93% of the local treated population, while others reached < 15–25%.

Although the NFZ analysis has data on a significant number of indicators (e.g. bed occupancy, average length of hospitalization), it does not provide information on the psychiatric hospitalization rate for the current CZPs in the country, or the rates of involuntary admissions. Also, the analysis for inpatient care does not provide information on how various CZPs fare on these indicators, or stratify the findings by Type of CZP (Type A or Type B). For example, the analysis shared does not allow correlations to be seen between the organizational structure, the human resource profiles (number and mix of professions) and service-level outcomes.

Findings of the report from the Mental Health Council subgroup

The analysis report from the Mental Health Council subgroup emphasized the flexibility of local implementation as a core strength of the Polish CZP model. Key findings are listed below.

Strengths

- Local tailoring of CZP services enables context-sensitive care and supports local ownership.
- Some centres – especially in Koszalin and Kraków – have built strong partnerships with municipal authorities, NGOs and social care institutions, enhancing service comprehensiveness and patient outcomes.
- Examples of proactive community engagement, integration of peer support and collaboration with social services demonstrate the model's potential.

Challenges

- Variability in staffing, infrastructure and management arrangements affects the quality and consistency of services.
- Absence of binding organizational standards has led to inconsistencies in service delivery across regions.
- Significant regional disparities persist, with some areas lacking any operational CZPs.
- Overlapping service contracts outside the CZP framework undermine coherence and consistency.

The report also pointed out serious limitations in monitoring and evaluation.

3 Introduction to the report on the implementation of the pilot programme in mental health centres, Mikołajki – 25–27 October 2024. (Note: though this is not a formal report, it has been presented by the NFZ as its formal analysis and shared with the rapid assessment team).

4 Rowiński T, Depukat A. Analytical report on selected evaluation indicators of the pilot of mental health centers under the National Mental Health Programme 2017–2022 and 2023–2030. Unpublished observations, 2024.

- Fragmented data systems and inconsistent indicator definitions make it difficult to interpret key performance metrics (e.g. readmission rates, continuity of care).
- Many community care elements – such as recovery assistants, intersectoral coordination and psychoeducation – are not captured by NFZ reporting tools, leaving critical outcome areas unmeasured.
- Although some reductions in hospitalization were observed in CZP areas compared to non-CZP regions, methodological limitations prevent causal attribution.

Studies and reports produced by other Polish experts

As part of the desk review component of this rapid assessment, a wide-ranging review of literature was conducted to capture additional perspectives on the implementation of the CZP model. This was not a systematic review, but rather a targeted effort to incorporate reports, academic publications, position papers and internal documents shared by stakeholders. Several contributors provided written materials in lieu of participating in interviews. These documents, although diverse in form and origin, were carefully reviewed for relevant insights, and their content has been included in the analysis where appropriate. This process helped ensure that a broad spectrum of views was considered, including those of actors who may not be represented in formal assessments.

Drawing on this broader body of literature, a number of recurring challenges have been identified that may hinder the national scale-up of the CZP model.

- **Incomplete legal framework:** the absence of updated statutory regulations supporting the organizational and financial underpinnings of the CZP model creates uncertainty for providers.
- **Uneven implementation:** there is significant variability in the maturity and functionality of CZPs across the country. Some centres are well-established and innovative, while others face organizational and operational difficulties.
- **Human resource constraints:** a shortage of trained professionals across all disciplines, especially in rural areas, limits capacity. The lack of dedicated training in community-based and recovery-oriented care further hampers service quality.
- **Fragmented integration with other sectors:** there is insufficient coordination between mental health services and social care, housing, employment support and education.
- **Lack of standardized performance metrics:** the absence of a coherent monitoring and evaluation framework impedes the assessment of outcomes and value for money.
- **Funding constraints outside pilot areas:** the global budget mechanism applies only to CZPs under the Pilot Project which creates funding inequities with traditional services that continue under fee-for-service schemes.
- **Absence of a consistent evaluation framework:** the lack of a standardized research and evaluation model has limited the ability to assess causality or attribute outcomes to pilot interventions. As a result, findings cannot be interpreted with scientific rigour, and key variables have not been systematically controlled or measured.

The information gathered through the desk review was triangulated with the fieldwork findings and informed both the analysis and the formulation of this assessment's recommendations.

3.2.3 Summary

The CZP model represents a central pillar of Poland's ongoing shift towards community-based mental health care. While the model is structured around principles of territorial responsibility, integration and local adaptation, its implementation to date has revealed significant variation in structure, performance and system alignment. Findings from recent assessments and stakeholder-submitted literature indicate both promising developments and persistent challenges related to service coverage, coordination, evaluation and sustainability. These observations offer important context for understanding the current state of transformation and identifying areas requiring further policy and operational attention.

Both CZP types have demonstrated success in various local contexts, while also facing common challenges. The Pilot Project revealed considerable variation in how services are structured and delivered – reflecting differences in local infrastructure, governance arrangements and workforce capacity. These inconsistencies are partly due to the absence of national clinical guidelines and quality standards, which have yet to be developed and implemented. While some centres demonstrate strong outreach, integration of peer support and effective collaboration with local services, others continue to face challenges in staffing and coordination with external inpatient providers. The lack of formal criteria for selecting CZP types has further contributed to this variability. Moving forward, consolidating lessons

from the Pilot Project, documenting and disseminating good practices, and introducing national standards and support mechanisms – while preserving local flexibility – will be key to supporting consistent quality and equitable access across the country.

3.3 Towards equitable care: integrating functional and needs-based approaches in scaling up community-based mental health care

Although stakeholders generally agree on the need for universal, community-based mental health care, the current model of care has often applied uniform targets to a merged population, without fully accounting for the differences in care needs, service intensity and professional support required across these groups. This assessment focused specifically on people with mild and mild-to-moderate mental health conditions and people with moderate-to-severe and severe mental health conditions, recognizing that designing effective service models for these populations is a critical step in building a sustainable, needs-based system.

To move from a shared vision to an actionable, scalable national model of care, it is essential to differentiate between the three distinct population groups the system must serve.

- People at risk of developing mental health conditions, including individuals experiencing significant life stressors, social disadvantage or early and subclinical symptoms of psychological distress that do not yet meet the diagnostic threshold for a mental health condition.
- People with mild and mild-to-moderate mental health conditions, including people experiencing common conditions such as mild depression or anxiety disorders. These conditions account for the largest proportion of people with mental health conditions, and are estimated to affect approximately 20% of the population. They often emerge or intensify during periods of societal stress, such as economic downturns, geopolitical instability or global health crises, for example, the coronavirus disease (COVID-19) pandemic. When not addressed early and effectively, mild and mild-to-moderate conditions can escalate and require more intensive and costly specialist interventions. Many of these conditions are also co-morbid with somatic health conditions, including diabetes, cardiovascular diseases and cancers, in which poor mental health is linked to lower treatment adherence and worse physical health outcomes. Ensuring timely identification and effective treatment for people with mild and mild-to-

moderate conditions is, therefore, both a priority for mental health services and a broader public health imperative.

- People with moderate-to-severe and severe mental health conditions, such as schizophrenia, bipolar disorder and major depressive disorder, represent a smaller share of the population, with prevalence estimated at 2–3%, in line with European averages. Despite the smaller size of this population, these people bear a disproportionate burden of illness that extends beyond the individual to affect families, health systems and wider society. Severe mental health conditions are associated with high rates of comorbidity, particularly with chronic physical illnesses, substance use and socioeconomic disadvantage. People with these conditions face a reduced life expectancy, often by 10–20 years. They are also among those most vulnerable to social exclusion, unemployment and homelessness, which further compounds their health challenges and limits recovery opportunities.

Differentiating these groups enables health systems to match services and resources to levels of need. It is important to emphasize that categorizing people into these three groups provides a functional and needs-based framework for delivering mental health care. This classification guides the design and delivery of proportionate, stepped-care interventions, rather than aligning directly with diagnostic codes. The care needs for these three groups differ substantially in terms of the intensity, frequency and duration of care, the types of professionals involved, and the degree of intersectoral collaboration required to support recovery. Although integrated care is essential, the design of service models and care pathways must be sensitive to the differing profiles, vulnerabilities and support needs of each group. A core principle underpinning this approach is the use of a stepped-care pathway navigation mechanism, which ensures that people receive interventions matched to the intensity of their needs (Box 3). Recognizing this allows for a more responsive and proportionate allocation of interventions, while remaining consistent with diagnostic frameworks where relevant.

Box 3. Stepped care pathway navigation mechanisms in mental health care

A stepped care pathway navigation mechanism in mental health care is a structured pathway that guides those in need to the appropriate level of care based on the severity of their condition. The goal is to ensure that people with mild and mild-to-moderate mental health conditions receive timely support delivered primarily by lower trained professional providers, such as generalist psychologists and family doctors, while reserving specialist staff (including psychiatrists and clinical psychologists) for more complex cases. In practice, this means establishing clear triage and referral processes so that not every person goes directly to a psychiatrist or a clinical psychologist to allow the specialist's time to be preserved for complex cases and reduce the bottlenecks in accessing specialist services.

This approach also promotes early intervention and continuity of care, and prevents the escalation of mild and mild-to-moderate mental health conditions into more severe, treatment-resistant conditions. Most care-navigation models follow a stepped-care approach, where treatment intensity increases only as needed. Patients are first offered low-intensity or routine interventions and are then “stepped up” to specialist care only if initial steps prove insufficient. This requires a robust triage process and coordination among providers.

Making progress towards a scalable, effective national model of care for mental health will depend on these four key dimensions:

- the package of services and interventions to be provided;
- the organizational structures responsible for delivery and care coordination;
- the human resources required to implement the model; and
- the financial mechanisms, funding levels and performance criteria – including incentives and disincentives – embedded in the system.

Focusing on these dimensions will offer a pragmatic route to alignment across stakeholders and support informed policy and investment decisions.

This report focuses on the model of care in Poland for two population groups: people with mild or mild-to-moderate mental health conditions, and those with moderate-to-severe or severe mental health conditions.⁵ For each group, the analysis outlines the recommended package of services, associated organizational structures and required human resources needed to ensure effective and equitable care delivery. The financing of mental health care – including financial accessibility of services, the structure of mental health expenditure, financing of the CZPs and issues related to contracting and performance-based financing – are addressed in section 3.4 to allow for an in-depth exploration of financing mechanisms for all population groups and levels of care.

3.3.1 Access to care and care pathways for people with mild and mild-to-moderate mental health conditions

According to the most recent estimates, mental health conditions in Poland account for 1259 disability-adjusted life years per 100 000 population, with anxiety and depression being the most prevalent (15).

Particularly concerning are trends in the mental health of children and adolescents. Poland records some of the highest levels of psychological distress among young people in Europe.

- Polish males aged 15–24 years have the second-highest suicide rate in Europe (17.04 per 100 000 in 2021), nearly double the European average (8.66 per 100 000 in 2020) (8).
- Polish girls aged 13 and 15 years report the highest levels of loneliness in Europe, with 36% and 38% respectively feeling lonely “most of the time or always” (9).
- Frequent low mood is also widespread, with 52% of 13-year-old girls and 56% of 15-year-old girls reporting they felt low more than once a week – the second- and third-highest rates in Europe (9).

These figures highlight urgent mental health needs among young people and the wider population, underscoring the importance of ensuring timely and effective responses for people with mild and mild-to-moderate conditions.

⁵ In line with the defined scope of this rapid assessment, the mental health care system's response to people at risk of developing mental health conditions falls outside the remit of this review.

Despite growing recognition of the need to address mild and mild-to-moderate mental health conditions, which – especially among young people – are on the rise, there is no clearly defined or standardized package of care (catalogue of interventions) for this population. Interventions such as psychoeducation, brief psychotherapies and digital tools for self-help and self-management are inconsistently available. A key concern highlighted during the validation meeting with the Team for Systemic Changes in Mental Health Centres, led by the Ministry of Health, that current legislation restricts access to psychological services for individuals with mental health conditions, and requires a referral from a psychiatrist. This regulatory barrier creates avoidable bottlenecks in care pathways and diverts psychiatrists' time from complex clinical tasks to administrative functions. Addressing this issue could significantly enhance service efficiency, improve access to timely care and ensure optimal use of specialist resources. Moreover, there is no formal stepped care pathway navigation mechanism to direct those in need to the appropriate level of care, and no organizational structure has been specifically assigned to be the frontline providers for mild and mild-to-moderate mental health conditions.

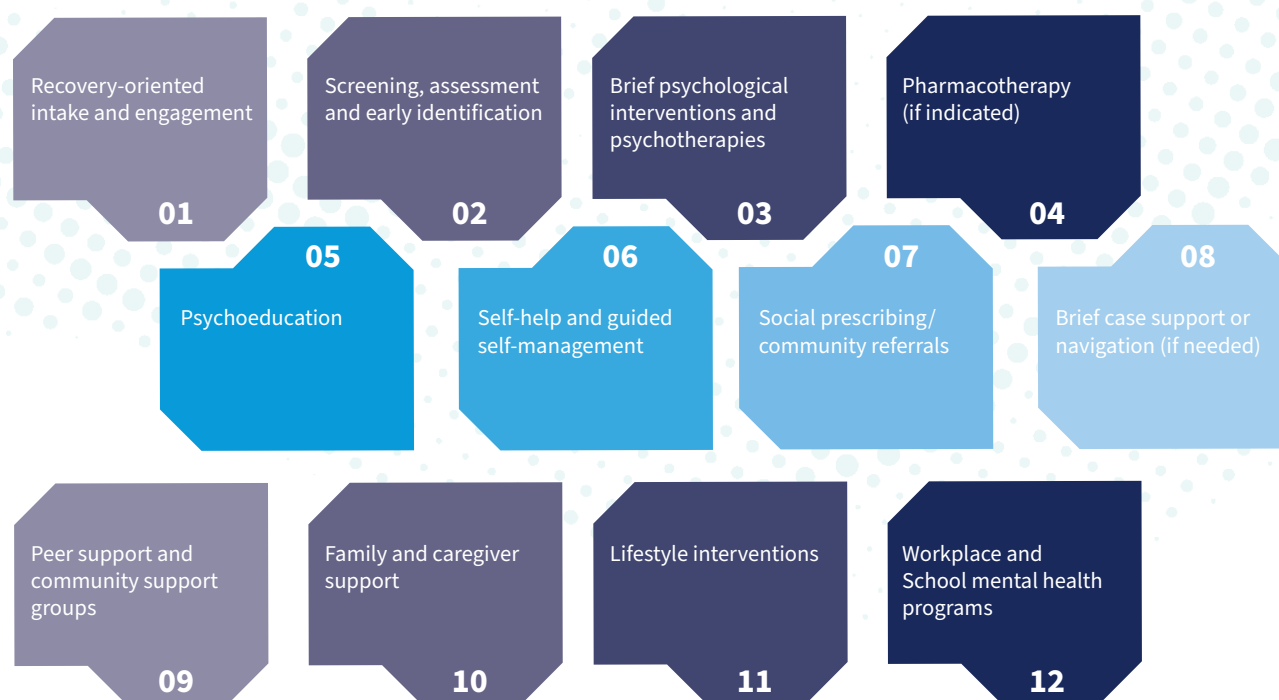
Package of services and interventions

According to the international body of evidence and established best practices, people experiencing mild or mild-to-moderate mental health conditions benefit from a tailored, proportionate package of interventions and services, with the aim of addressing psychological distress early, promoting recovery and preventing progression to more severe mental health conditions.

Fig. 3 presents a synthesized package of interventions and services for this target group, informed by international best practices and guidance. Sources include WHO normative documents (e.g. mhGAP, the Comprehensive Mental Health Action Plan, and community mental health service guidance (16-18)) as well as leading academic literature.

Among the Polish stakeholders involved with the assessment team, there was a consensus that the care needs of people experiencing mild or mild-to-moderate mental health conditions are qualitatively distinct from those with moderate-to-severe mental health conditions. It is therefore both appropriate and necessary that people with mild or mild-to-moderate mental health conditions have access to a tailored set of interventions that are responsive to their specific needs. In the Polish context, the assessment team has mapped out the current provision of services for this population group (Table 1). For each recommended service or intervention targeting

Fig. 3 Core interventions and services recommended for people with mild and mild-to-moderate mental health conditions



people with mild or mild-to-moderate mental health conditions in Poland, Table 1 presents:

- the existing strengths and effective practices;
- the challenges and opportunities for improvement; and
- the proposed directions for action grounded in international standards and adapted to the Polish policy and service delivery context.

The next steps that have been proposed to improve access to an appropriate package of services and interventions for people with mild or mild-to-moderate mental health conditions in Poland are:

- largely agreed upon by national stakeholders, reflecting a strong domestic consensus;
- anchored in international evidence and good practices, ensuring alignment with effective, proven approaches; and
- achievable within the existing mandate and capacities of the Ministry of Health and the wider mental health community and do not require any systemic overhaul or legislative changes, as they primarily call for a dedicated implementation effort or project to ensure coordinated follow-through and sustained progress.

The legal mechanisms required mostly lie within the authority of the Ministry of Health to establish as routine practice through:

- secondary legislation (e.g. *rozporządzenia* [regulations]); and
- internal normative acts (e.g. *zarządzenia* [orders] or *uchwały* [resolutions]).

This means that the next steps required are realistically achievable within a short- to medium-term time frame (1–4 years).

Table 1. Package of services and interventions accessible in Poland for people with mild or mild-to-moderate mental health conditions

Package of services/ interventions	Strengths and effective practices	Challenges and opportunities for improvement	Proposed next steps
1. Recovery-oriented intake (ROI) and engagement^a	• Availability. People from this target group are expected to benefit from the intake process at the Coordination Point within the CZPs.	• Standardization. Currently, intake procedures are not standardized, nor are there established requirements to ensure the use of recovery-oriented approaches and techniques. There are no specific procedural guidelines in place to support effective engagement with this population.	• Standardization. Embed requirements in clinical guidelines and quality standards community-based mental health care, leveraging good practices both in Poland and internationally. • Data and monitoring. Embed indicators for monitoring and evaluation on availability of the service and implementation according to set guidelines and quality standards in routine monitoring and evaluation (M&E) of the mental health care system.
2. Screening, assessment and early identification	• Availability. Each CZP incorporates a PZK, serving as the initial point of contact. These centres are responsible for providing information about available services, conducting preliminary needs assessments, formulating initial treatment plans and coordinating access to appropriate psychiatric and social welfare services. Psychologists often serve as initial points of contact, conducting assessments and coordinating care pathways, thereby enhancing accessibility and reducing delays in treatment initiation.	• Mental health screening and early identification practices are not consistently embedded within primary health care settings. This disconnect can lead to missed opportunities for early detection and intervention, particularly for people presenting with mild symptoms. • The limited availability of trained mental health professionals, particularly in rural and underserved areas, limits the capacity for mental health screening and early intervention initiatives.	• Standardization. Embed requirements in clinical guidelines and quality standards community-based mental health care, leveraging good practices both in Poland and internationally. • Data and monitoring. Embed indicators for monitoring and evaluation on availability of the service and implementation according to set guidelines and quality standards in routine M&E of the mental health care system.
3. Brief evidence-based psychological interventions and psychotherapies^b	• Availability. CZP teams provide psychological interventions and psychotherapies to people who access their services, which are widely acknowledged as essential and highly effective. • There is broad consensus among stakeholders that this target group does not require interventions to be delivered by clinical psychologists or psychiatrists. Rather, brief, evidence-based psychotherapies can and should be provided by appropriately trained professionals with lower levels of formal qualification, such as non-clinical psychologists or psychiatric nurses who hold relevant certification.	Availability. There are currently no national targets concerning access to psychological therapies for people with mild-to-moderate mental health conditions. • At present, services for this target group largely fail to capitalize on the potential of evidence-based guided and unguided e-mental health solutions, including AI-enabled tools, to expand access to brief psychological interventions and psychotherapies. Where such innovations are employed, their use remains sporadic and typically limited to the context of time-bound digital health pilot projects, rather than being integrated into routine service provision. • Access to these interventions is reported to be limited for this target group within the public sector. As a result, those in need are most likely to obtain these crucial forms of support through private, for-profit providers – either via publicly funded arrangements with contracted providers under the national health insurance scheme, or through direct out-of-pocket payments in individual private practices.	• Standardization. Embed requirements in clinical guidelines and quality standards for delivery of these services, including the agreed interventions, use of guided and unguided e-mental health solutions, including AI-enabled tools, leveraging good practices both in Poland and internationally. • Requirements in clinical guidelines and quality standards should be legally applicable to all service providers, regardless of the setting in which they provide these services (i.e. public or private). • Data and monitoring. Embed national targets concerning access to psychological therapies for people with mild and mild-to-moderate mental health conditions. • Embed indicators for monitoring and evaluation on availability of the service and implementation according to set guidelines and quality standards in routine M&E of the mental health care system.

Table 1. contd.

Package of services/ interventions	Strengths and effective practices	Challenges and opportunities for improvement	Proposed next steps
		• Standardization. In the absence of a formal stepped care pathway navigation mechanism within the Polish mental health care system, significant variation in practice has emerged across CZPs. Findings of the Assessment show that some CZP teams routinely allocate psychiatrists and clinical psychologists to provide psychological interventions to people with mild and mild-to-moderate mental health conditions. Although this approach may appear to enhance service quality, it comes at a cost: the time and expertise of highly specialized professionals are diverted from those with moderate-to-severe mental health conditions, who are most in need of such care. Furthermore, this practice risks the over-medicalization of mild-to-moderate mental health issues, potentially undermining recovery and leading to inefficiencies in service delivery. • In the private sector, the delivery of psychotherapy to this target group is routinely carried out by highly trained specialists – namely, psychiatrists and clinical psychologists – representing a potentially inefficient use of expertise and further exacerbating inequities in access. • Given the relatively loose regulatory oversight of this segment of the mental health care system, there is limited assurance that those accessing such services consistently receive evidence-based care. Compounding this challenge is the low level of mental health literacy among the general population and the persistence of widespread stigma. In this context, service users and consumer groups currently have minimal influence over ensuring access to safe, effective and evidence-informed therapies. • Data and monitoring. There are a lack of systematic data on the proportion of this population receiving such therapies.	

Table 1. contd.

Package of services/ interventions	Strengths and effective practices	Challenges and opportunities for improvement	Proposed next steps
4. Pharmacotherapy (if indicated)^c	• Availability. According to insights gathered from participants in the Assessment, people with mild and mild-to-moderate mental health conditions do have access to pharmacotherapy when deemed necessary. • There was broad agreement among key stakeholders that, with appropriate training and – where necessary – clinical supervision from psychiatrists, the responsibility for prescribing medication for people with mild-to-moderate mental health conditions could be more effectively delegated to general practitioners, who are already authorized to prescribe these medications. Such a shift would align with international evidence and best practice models, supporting more efficient and accessible care within the primary health system.	• Availability. There are currently no up-to-date data on the proportion of people with mild-to-moderate mental health conditions who receive pharmacological treatment, either within public primary care services or through private providers. • Psychiatrists remain the primary prescribers of medication for people with mild-to-moderate mental health conditions, followed by general practitioners. This observation is corroborated by existing research evidence. • Several stakeholders voiced concerns regarding a potential overreliance on medication in contexts where access to appropriate psychotherapeutic support remains limited, highlighting the risk of suboptimal, unbalanced care pathways for this population.	• This assessment did not specifically examine pharmacotherapy in depth, therefore proposed steps are deferred.
5. Psychoeducation	• Availability. Professionals within CZP report providing psychoeducation alongside support for self-help and self-management.	• Standardization. There remains a lack of clarity regarding the specific tools and interventions employed in delivering these services, as well as whether staff have received training in established, evidence-based approaches. • The integration of digital solutions in Poland remains at an early stage, with uptake still limited and, in many cases, virtually absent.	• Standardization. Embed requirements in clinical guidelines and quality standards for delivery of these services, including the agreed tools and interventions, use of guided and unguided e-mental health solutions, including AI-enabled tools, leveraging good practices both in Poland and internationally. • Data and monitoring. Embed indicators for monitoring and evaluation on availability of the service and implementation according to set guidelines and quality standards in routine M&E of the mental health care system.
6. Self-help and guided self-management			

Table 1. contd.

Package of services/ interventions	Strengths and effective practices	Challenges and opportunities for improvement	Proposed next steps
7. Social prescribing/ community referrals^d	• Availability. At present, collaboration with specialist services and other key stakeholders – such as social care providers – tends to be ad hoc and reliant on the personal initiative of individual practitioners. • Poland's participation in the Social Prescribing-EU initiative, launched in January 2025 under the Horizon Europe framework, offers a promising avenue for progress (19). The SP-EU project seeks to develop and evaluate tailored social prescribing models aimed at improving access to care for vulnerable groups across Europe – including refugees, first-generation migrants and older adults experiencing social isolation. This initiative may provide a valuable foundation for embedding social prescribing more systematically within the Polish mental health care system.	• Availability. The integration of structured social prescribing within the Polish mental health care system remains at an early stage. • Standardization. There is limited evidence of systematic implementation of social prescribing practices, such as formalized referrals to community-based resources including creative arts programmes, volunteering opportunities or physical activity initiatives. This absence of structured pathways represents a missed opportunity to address the broader social determinants of mental health through community-based, non-clinical interventions. • People who initiate such linkages often face systemic disincentives to engage in coordinated intersectoral work.	• Standardization. Embed guidance in clinical guidelines and quality standards community-based mental health care, leveraging good practices both in Poland and internationally. • Develop standardized collaborative agreements with relevant local partners. • Data and monitoring. Embed indicators for monitoring and evaluation on availability of these interventions in routine M&E of the mental health care system.
8. Brief case support or navigation (if needed) Low-intensity case management to assist with service navigation or situational stressors (e.g. housing, legal, financial)	• Availability. CZPs are mandated to coordinate with local social welfare services. In some regions, well-established partnerships facilitate timely and effective referrals for housing, employment and financial support. Moreover, some municipalities have successfully developed joint protocols between CZPs and local social services. • There is broad agreement that strengthening intersectoral linkages is essential to ensuring a holistic response to the social determinants of mental health.	• Standardization. The effectiveness of this coordination remains variable. Stakeholders reported that some areas, collaboration is fragmented, often hindered by administrative complexities and jurisdictional boundaries. • Broader integration with the social care system remains incomplete.	• Standardization. Embed guidance in clinical guidelines and quality standards community-based mental health care, leveraging good practices both in Poland and internationally. • Develop standardized collaborative agreements with social care services and other relevant local partners. • Data and monitoring. Embed indicators for monitoring and evaluation on availability of these interventions in routine M&E of the mental health care system.

AI: artificial intelligence; CZP: Community Mental Health Centre; M&E: monitoring and evaluation; PZK: CZP registration and coordination point; ROI: recovery-oriented intake.

Note: Access to some of the services and interventions outlined in Fig. 4 for people with mild-to-moderate mental health conditions falls outside the scope of this rapid assessment and, consequently, these areas have not been examined in detail: (4) pharmacotherapy, (9) peer support and community support groups, (10) family and caregiver support, (11) lifestyle interventions and (12) workplace and school mental health programmes.

a. ROI emphasizes a strengths- based, person-centred approach to initial contact, fostering trust and autonomy.

b. Includes cognitive behavioural therapy (CBT), behavioural activation, and Problem Management Plus (PM+), Self-Help Plus (SH+), Interpersonal Therapy (IPT) – brief version.

c. Reserved for cases where psychological interventions are insufficient or not feasible.

d. Linking people to non-clinical community resources, such as creative arts, physical activity programmes and volunteering.

Human resources

Effective and scalable care for people with mild or mild-to-moderate mental health conditions requires a well-coordinated, multidisciplinary workforce. In Poland, although key professionals such as psychologists, psychotherapists, psychiatric nurses, psychiatrists and general practitioners are involved in the care of this population, their roles are inconsistently defined, and systemic constraints continue to limit optimal task allocation, collaboration and training.

Psychologists, particularly those without clinical specializations, are playing a growing role in community mental health care in Poland, including in CZPs. Psychologists without clinical specializations are one of the most abundant mental health workforce resources in Poland, supported by a robust graduate pipeline, with 17 universities across the country offering psychology programmes. However, their status within the health system remains ambiguous. The absence of a formal legal framework and statutory regulation for the profession hinders workforce planning, limits accountability and raises concerns about quality assurance. Although many non-clinical psychologists are competent and motivated, they currently operate without mandated continuing education or structured professional supervision. A draft law is under discussion that would formally recognize clinical psychologists as health professionals, introduce supervised internships and align training pathways with European standards. In the meantime, a stepped-care model is emerging in practice, whereby early-career psychologists provide brief interventions under the supervision of senior colleagues. Stakeholders widely agree that, with the appropriate supervision and training, psychologists without clinical specializations can effectively deliver psychological support to people with mild or mild-to-moderate mental health conditions.

Psychotherapists play a vital role in delivering structured psychological interventions for people with mild or mild-to-moderate mental health conditions. In recent years in Poland, the profession has received growing recognition. However, psychotherapists are not yet formally regulated as health professionals under national law, which creates inconsistencies in standards, recognition and integration within the public health system.⁶ Although many psychotherapists operate in private practice, their engagement in public mental health services remains limited, partly due to opaque employment pathways and the absence of unified qualification requirements. In CZPs, psychotherapists could significantly contribute to addressing one of the most critically under-provided services in the system i.e. access to psychotherapy

for those with mild and mild-to-moderate mental health conditions, while also supporting other professionals through supervision and the use of collaborative care models.

Psychiatrists remain heavily involved in the diagnosis and treatment of people with mild and mild-to-moderate mental health conditions, including by prescribing medication. Although their expertise is essential for complex and severe cases, reliance on psychiatrists for lower-acuity cases may represent an inefficient use of highly specialized resources. Several stakeholders emphasized the need to better delineate psychiatrists' roles, and suggested reserving their time for more complex care and providing supervisory support to other professionals.

Psychiatric nurses are a potentially underused resource. There is a general consensus among stakeholders that, with targeted training and clearly defined scopes of practice, psychiatric nurses could provide psychoeducation, support self-management and even deliver brief psychological interventions for people with less complex mental health care needs. However, their involvement remains limited in practice due to insufficient role development, lack of formal training in psychosocial interventions and the continued dominance of medicalized care models in mental health.

General practitioners are legally authorized to prescribe psychotropic medication and are often the first point of contact for people with mild and mild-to-moderate mental health conditions. However, their capacity to provide holistic care is limited by time constraints, a lack of mental health care training and weak integration with community mental health services. There is strong support among stakeholders for enhancing the role of general practitioners through targeted mental health training and improved coordination with CZPs, particularly to reduce unnecessary referrals to specialist care and ensure timely interventions.

Cross-sector professionals, such as social workers, prevention workers or health educators, and community support workers, also have an important role to play, particularly in areas such as psychoeducation, early identification, self-help support and social prescribing. However, current intersectoral collaboration remains fragmented, with coordination between health, social and community services often dependent on individual initiative rather than systemic protocols or funding mechanisms.

6 In most European countries, psychotherapy is not regulated as a stand-alone health profession, but rather as a specialty or advanced qualification pursued by licensed professionals such as psychologists, psychiatrists or medical doctors. This recognizes psychotherapy as a clinical skill set that is built upon core professional training, rather than a profession in its own right.

Recommended actions

To enhance access, equity and efficiency in Poland's mental health care system, it is recommended that a strategic approach be taken to address persistent structural gaps across professional groups.

Key actions include developing national competency standards for community-based interventions targeted at people with mild or mild-to-moderate mental health conditions, coupled with establishing clearly defined scopes of practice across the professional groups involved in their care. A set of concrete measures can guide the development and implementation of these standards, as follow.

- Define core competencies for each professional group for community-based mental health care, aligned with contemporary, person-centred models of community-based care and the needs of diverse service settings.
- Produce standardized guidelines outlining the roles, responsibilities and expected contributions of each professional group across the key functions of care in the quality standards.
- Enable task-shifting and stepped care, as well as a more deliberate redistribution of roles, particularly by empowering lower trained professionals, formalization of training standards and investment in robust supervisory structures, drawing on international best practices and examples of good practices in Poland.
- Introduce a tiered certification system based on formal training, supervised practice and demonstrated clinical competence for all professions, with a particular focus on the professions that are currently not fully regulated. To ensure fairness and sustainability, access to training should be equitable across professional groups. The training of generalist health psychologists should be formally integrated into the education and health workforce system, as with the psychiatric residency, so that it is publicly funded rather than paid out of pocket by trainees. This approach would promote parity between two critical professional groups – psychologists and psychiatrists – and enable the scale-up of the psychology workforce, which is essential for expanding access to evidence-based care within a community-based mental health model.
- Expand access to continuing professional development for community-based care through accredited programmes and structured clinical mentorship, with a particular focus on underserved regions.
- Expand workforce development opportunities, with an emphasis on evidence-based brief psychological interventions and the delivery of digital mental health or artificial intelligence (AI)-based solutions.

- Incentivize collaborative practice by embedding multi-professional training and team-based performance indicators into routine service delivery.
- Link competency standards to broader quality systems, including supervision standards, service accreditation and outcome monitoring mechanisms.

Organizational structure for delivering services and pathways of care

Current policy documents underscore the importance of early, equitable and barrier-free access to mental health services for all those in need. Stakeholders in the mental health care sector recognize the robust evidence base and the international best practices that advocate delegating responsibility for managing people with mild or mild-to-moderate mental health conditions to primary care (20). There is broad consensus that primary care in Poland should assume a significant role in the care and treatment of this population.

There is also widespread acknowledgement that the current capacity of primary care is insufficient to fulfil this role, and, for primary care to realistically take on this responsibility, a substantial and sustained investment in capacity-building would be required, which is widely understood to be a long-term undertaking. Concurrently, stakeholders have highlighted alternative that are solutions more immediately suited to the Polish context.

Within the framework of the Pilot Project, this function was intended to be fulfilled by the CZPs. They operate under an open-door model, designed to ensure minimal waiting times and embodying a no-wrong-door approach, which allows any adult to access support directly, without the need for prior specialist referral. The Pilot Project envisioned that people with mild or mild-to-moderate conditions would initiate their care journey via walk-in access at a CZP coordination point, from which they would be directed to the appropriate services. Although CZPs have a general mandate to support this population, this has not been translated into explicit coverage targets or accountability mechanisms.

Due to the high burden of the conditions and the limited human and financial resources, no health system can afford to assign responsibility for providing treatment and care for people with mild and mild-to-moderate mental health conditions to specialized services. To ensure both equitable access and effective use of resources, a stepped pathway for a care-navigation mechanism is put in place to ensure appropriate referral to relevant services and teams of professionals. Despite this strong commitment to universal, low-threshold access, the absence of formal stepped pathway of care-navigation functions, standard

operating procedures or clinical guidelines for managing mild-to-moderate mental health conditions means that, in practice, there is no clearly defined care pathway for this group.

Recommended actions

These proposed recommended actions are largely agreed upon by national stakeholders, are anchored in international evidence and good practices, and are achievable within the existing mandate and capacities of the Ministry of Health and the wider mental health care community, with the legal mechanisms required to establish them as routine practice mostly within the authority of the Ministry of Health. This makes the next steps realistically achievable within a short- to medium-term time frame (1–4 years).

There was a strong and consistent consensus among Polish stakeholders that the care needs of people with mild and mild-to-moderate mental health conditions are qualitatively distinct from those with severe mental health conditions and require a tailored set of interventions/ services responsive to their specific needs. They also agree that setting up a stepped care pathway navigation system requires careful consideration of the Polish system specificities, namely that:

- the current capacity of primary care is insufficient to fulfil such a role;
- the CZPs are by now well recognized among the general population as barrier-free access points to mental health care services for all those in need.

The following next steps are proposed.

- Formally designate the function of care pathway navigation embedded with responsibilities for triage and case allocation to the CZP Registration and Coordination Points.
- Establish a dedicated frontline mental health care team within each CZP, tasked with the care management of people with mild and mild-to-moderate mental health conditions within the CZP's catchment area. The work of this team would be complementary to the work of the specialists in the CZP who would be tasked with the care management of people with moderate-to-severe and severe conditions within the CZP's catchment area, working as specialist community mental health care teams.
- Ensure that these frontline mental health care teams are composed of lower trained mental health care professionals, such as generalist psychologists (without clinical specializations) or psychiatric nurses to ensure the most efficient use of specialist resources.

- Mandate regular supervision of these frontline mental health care teams by the specialists from the specialist community mental health care teams in the same CZP, including psychiatrists and clinical psychologists.
- Review the existing legislation and explore policy options that would allow direct access to psychological services (without compulsory referrals from psychiatrists) to streamline care and optimize the use of the psychiatrists' resources.
- Set clear and measurable targets for population coverage by the frontline mental health care teams, and set quality of care and cost-effectiveness indicators for addressing the needs of this group.
- Expand and update the CZP service package for this target group, paying particular attention to recovery-oriented and socially integrated services.
- Require systematic coordination of frontline mental health care teams and primary care providers (family doctors and nurses), particularly for the provision of pharmacological treatments, lifestyle interventions and the engagement with wider community actors such as schools, workplaces and support organizations.
- Establish structured collaboration between frontline mental health care teams and intersectoral partners, including workplace and school-based mental health programmes, to promote early identification, continuity of care and broader psychosocial support.

These proposed steps are brought together in Fig. 4, which illustrates a model of care for people with mild to mild-to-moderate mental health conditions, showing how responsibilities, services and interventions can be distributed across the care pathways.

This approach would align with the overarching principle of universal access to community-based, low-threshold mental health care, and would provide a basis for establishing and monitoring specific clinical and financial outcomes.

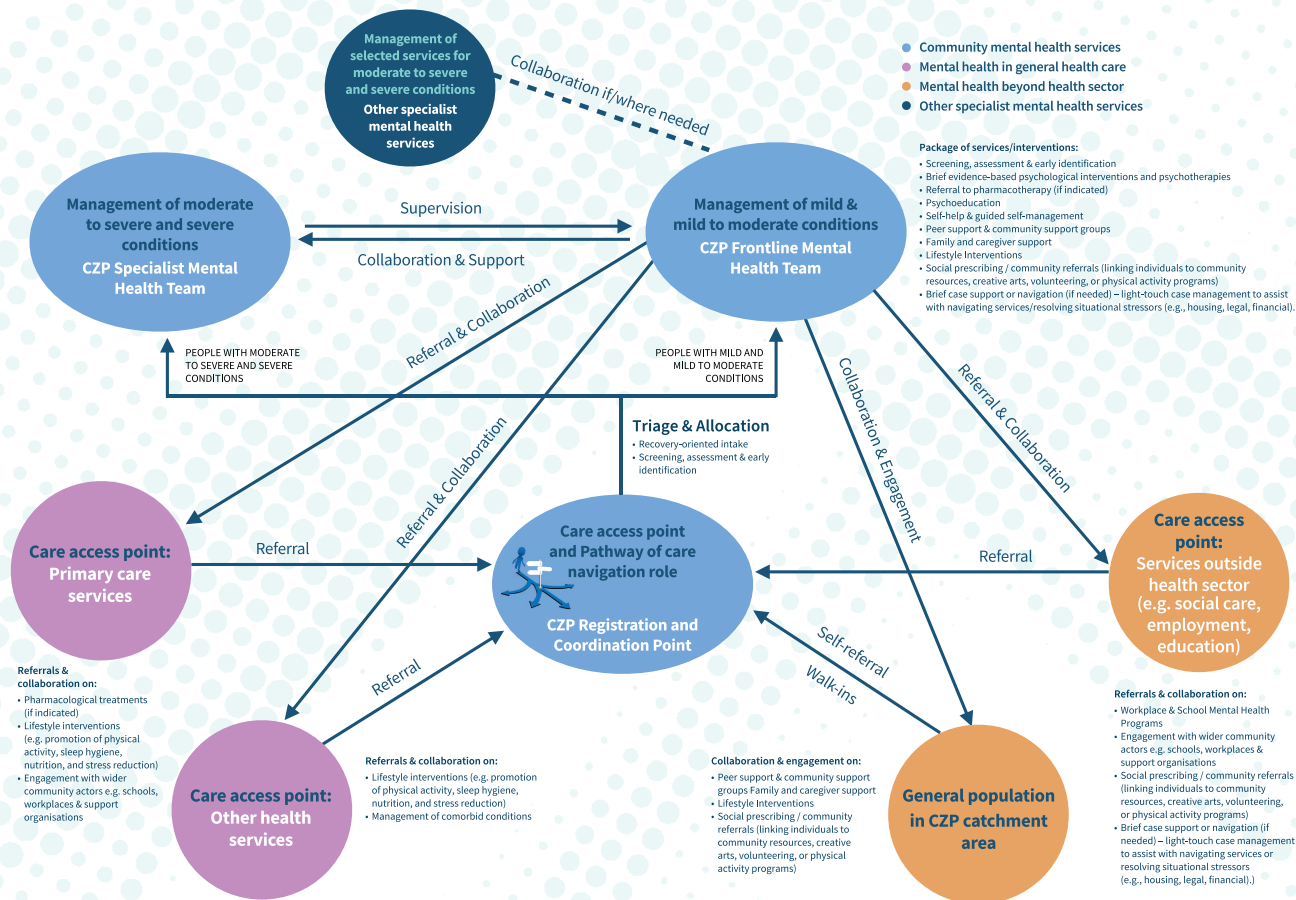
In the medium to long term, it remains essential to position primary care as an active provider of mental health care services for people with mild and mild-to-moderate conditions in Poland. This will require investment in targeted training on mental health assessments and brief interventions, the development of shared care protocols between primary and specialist services, and the integration of mental health care indicators into routine primary care monitoring.

3.3.2 Access to care and care pathways for people with moderate-to-severe and severe mental health conditions

In Poland, people living with severe mental health conditions, such as schizophrenia, bipolar disorder and major depressive disorder, represent a smaller share of the population, with prevalence estimated at 2–3%, which is in line with European averages.

Given the intensity and complexity of the needs of people with moderate-to-severe or severe mental health conditions, timely access to a coordinated, multidisciplinary and recovery-oriented care system is essential. Ensuring continuous access to community-based services, psychosocial support and integrated somatic care is not only a matter of clinical necessity but also of social justice and human rights.

Fig. 4 Proposed model of care for people with mild or mild-to-moderate mental health conditions allocating services and interventions across the care pathways



Package of services and interventions

In line with international evidence and established best practices, people experiencing moderate-to-severe or severe mental health conditions require a comprehensive and sustained package of interventions. These services are typically more intensive and complex than those needed by people with less severe mental health conditions, and involve coordinated care delivered by multidisciplinary teams across different settings. Fig. 5 outlines the core interventions and services commonly recommended for this population group, informed by international best practices and guidance. Sources include WHO normative documents (e.g. the *Comprehensive Mental Health Action Plan*, and community mental health service guidance (16-18)) as well as leading academic literature. The quality of life, stability and long-term recovery of people with more severe mental health conditions are closely dependent on the availability, accessibility and quality of these specialized services.

Among the Polish stakeholders engaged in this assessment, there was broad and consistent agreement that the care needs of people with moderate-to-severe or severe mental health conditions require a distinct and more intensive set of interventions compared with people with less complex needs. Moderate-to-severe and severe mental health are typically long-term and multifaceted, and are associated with high levels of disability and vulnerability, which warrants coordinated, multidisciplinary care across multiple service platforms. Within the Polish context, the assessment team mapped the existing package of services that is available for this population group (Table 2).

For the core services and interventions recommended for this target group, stakeholders expressed strong convergence on nearly all elements, and recognized the importance of an integrated care pathway that includes community-based supports, psychosocial interventions, housing and employment support and continuity of care mechanisms.

Fig. 5 Core interventions and services commonly recommended for people with moderate-to-severe and severe mental health conditions



Note: Highlighted in red an area of important divergences between stakeholders.

The red highlight of Service 13 in Figure 5,⁷ reflects notable stakeholder disagreement over the provision of acute inpatient care for crisis stabilization and intensive treatment. The nature of this disagreement and perspectives of different stakeholders are detailed below in the Organizational structure assigned to deliver services and pathways of care and the Pathway fragmentation and implementation challenges sections.

There are three additional issues that will also require further stakeholder engagement to reach consensus, namely:

1. which therapeutic approaches qualify as evidence-based, especially for severe mental health conditions;
2. what user and caregiver involvement in treatment planning should look like in practice; and
3. what the status of recovery assistants in treatment teams should be.

For each recommended intervention or service for people with moderate-to-severe and severe mental health conditions in Poland, Table 2 presents the:

1. existing strengths and effective practices;
2. challenges and opportunities for improvement, including the areas of disagreement; and
3. proposed directions for action, grounded in international standards and adapted to the Polish policy and service delivery context.

The proposed directions for strengthening the package of services for this group are:

1. widely supported by national stakeholders, with the exception of the outstanding issues noted above;
2. aligned with international best practices, ensuring the interventions are both evidence-based and recovery-oriented;
3. achievable within the existing mandate and capacities of the Ministry of Health and the wider mental health community, as long as a dedicated implementation effort or project is assigned to ensure coordinated follow-through and sustained progress.

The legal mechanisms required mostly already lie within the authority of the Ministry of Health to establish as routine practice through:

- secondary legislation (e.g. *rozporządzenia* [regulations]); and
- internal normative acts (e.g. *zarządzenia* [orders] or *uchwały* [resolutions]).

With focused leadership and a dedicated implementation initiative or technical working group, these steps are realistically achievable within a short- to medium-term time frame (1–4 years). Clarifying governance arrangements and aligning service models for acute inpatient care will be essential to ensure coherence, efficiency and person-centredness across the full continuum of care.

⁷ The management of complex conditions and/or rare disorders falls outside the scope of this assessment, and, consequently, these areas have not been examined in detail.

Table 2. Package of services/interventions accessible in Poland by people with moderate-to-severe and severe mental health conditions*

Package of services/interventions	Strengths and effective practices	Challenges and opportunities for improvement ^a	Proposed next steps
1. Recovery-oriented intake (ROI) Emphasizes a strengths-based, person-centred approach to initial contact, fostering trust and autonomy	• Intake practices All mental health service providers in Poland conduct intake, but these are often based on medicalized, clinician-led assessments. • CZP Registration and Coordination Points These were designed to provide open access and function as the first point of contact. • Discussions with stakeholders suggest broad agreement that these Coordination Points should become the standardized entry mechanism, explicitly defined within quality standards, accompanied by clear operational procedures and supported by targeted training for professionals in line with evidence-based, recovery-oriented practice.	• Intake practices At system level, intake procedures are not set up to be recovery-oriented or focused on person-centred approaches. • CZP Registration and Coordination Points The intake process is not formally standardized across CZPs, and not all staff conducting intake are trained in modern, recovery-oriented principles or person-centred methodologies.	• Embed in quality standards for community care that CZP Registration and Coordination Points become the standardized entry care point in the mental health care system, with ROI explicitly defined within quality standards, accompanied by clear operational procedures and supported by targeted training for professionals in line with evidence-based, recovery-oriented practice. • Embed training in ROI in regular training of all professionals in mental health care system that conduct intake procedures, including during new admissions. • Data and monitoring Embed indicators for monitoring and evaluation on availability of these interventions and implementation according to set standards in routine M&E of the mental health care system.
2. Assessment and diagnosis	Psychiatrists and clinical psychologists in Poland are highly qualified to deliver these services. There is growing professional and policy-level interest in task-shifting or expanding diagnostic roles to other qualified mental health professionals (e.g. clinical psychologists), though formal legal and regulatory changes are still needed.	• Current legal framework Assessment and formal diagnosis of mental disorders in Poland are legally reserved for psychiatrists. Clinical psychologists may contribute to the assessment process but do not currently have the legal authority to issue psychiatric diagnoses. • Workforce constraints Poland has one of the lowest psychiatrist-to-population ratios in Europe, which poses challenges in accessing timely diagnosis and care – especially in underserved regions.	• Current legal framework Integrate task-shifting or expanding diagnostic roles to other qualified mental health professionals (e.g. clinical psychologists) in the currently ongoing legal regulatory processes. • Define legally sanctioned competency standards (e.g. formal registration procedures for chartered clinical psychologists) and formal supervision arrangements mechanisms led by senior specialists. • Workforce constraints Embed in quality standards procedures for assessment and diagnosis supported, where needed and feasible, by telecare and digital/AI solutions.

* Areas of disagreement are indicated in red text.

Table 2. contd.

Package of services/ interventions	Strengths and effective practices	Challenges and opportunities for improvement ^a	Proposed next steps
3. Treatment planning	• Treatment planning It is widely acknowledged that effective care should include a mix of interventions. • Stages of care CZP teams often adapt their approach to different phases of care (e.g. routine support, escalated interventions in response to changing circumstances, and acute crisis management). • Role of community teams The Pilot Project model positions CZPs as the central coordinating body within a community-based system of care. • User and caregiver involvement There is broad agreement on the importance of involving service users and their families in the treatment planning process.	• Treatment planning Currently there is a lack of nationally binding quality standards or clinical guidelines that systematically govern treatment planning. • Stages of care Distinctions in approaches to different phases of care are not formally embedded in team protocols, nor are they consistently reflected in standardized treatment plans. • Role of community teams The practical implementation of this vision remains inconsistent. In particular, the leadership role of community teams in developing and overseeing treatment plans – especially during episodes of hospitalization – is neither clearly defined nor universally accepted. This ambiguity compromises the continuity and coherence of care and limits the ability of family caregivers to participate meaningfully in the support and recovery process. • User and caregiver involvement There is no shared understanding of what this involvement should look like in practice. The absence of operationalized standards in this regard continues to hinder the realization of person-centred and recovery-oriented care.	• Treatment planning Embed treatment planning procedures in nationally binding quality standards and clinical guidelines. • Stages of care Embed in quality standards the distinct approaches to different phases of care (standardized treatment plans, crisis intervention plans). • Role of community teams Engage in proactive, neutrally facilitated discussions with key stakeholders in both CZPs and inpatient services on distribution of roles and responsibilities. Discussions should be guided by international base of evidence and good practices, and by the agreed criteria that care needs to be person-centred and recovery-oriented. Once reached, embed standardized procedures on ways of collaborative working and allocation of roles and responsibilities in legally binding quality standards. Further, financial mechanisms for paying mental health care service-provider organizations should include quality-based incentives. • User and caregiver involvement Embed in quality standards clear operational procedures for involving them in treatment planning to ensure person-centred and recovery-oriented care. • Data and monitoring Embed indicators for monitoring and evaluation on implementation according to set standards of these interventions in routine M&E of the mental health care system.

Table 2. contd.

Package of services/ interventions	Strengths and effective practices	Challenges and opportunities for improvement ^a	Proposed next steps
4. Capacity-building for self-help and self-management	• Recognition of importance There is broad professional and policy-level acknowledgement that supporting self-help and self-management is beneficial and necessary for people with severe mental health conditions. • Availability Some services may provide elements of support for capacity-building for self-help and self-management.	• Availability There is no systematic tracking or evaluation of how widely these interventions are available. • Standardization Poland currently lacks a nationally endorsed, evidence-based package of self-help or self-management interventions specifically designed for people with severe mental illness, meaning implementation varies across providers.	• Availability Embed indicators for monitoring and evaluation on availability of these interventions in routine M&E of the mental health care system. • Standardization Embed evidence-based package of self-help or self-management interventions specifically designed for people with severe mental illness in national guidelines. • Data and monitoring Embed indicators for monitoring and evaluation on availability of these interventions and implementation according to guidelines in routine M&E of the mental health care system.
5. Evidence-based psychotherapy (individual or group)	• Availability in CZPs Evidence-based psychotherapies are accepted as important components of care and are increasingly provided in CZPs, particularly through CBT, trauma-informed approaches and psychosocial interventions. • Availability in specialist psychiatric hospitals and outpatient clinics Psychotherapy is available in some in some of these settings.	• Availability in CZPs Access to these services remains uneven. • Availability in specialist psychiatric hospitals and outpatient clinics These settings remain heavily dominated by pharmacological approaches. Psychotherapies are often under-resourced and not consistently evidence based. Waiting times can be long, and therapists are in short supply, especially those trained in modern, structured psychotherapies like CBT. • Private sector A significant portion of psychotherapy occurs privately; however, it operates with minimal regulatory oversight, raising concerns regarding quality and adherence to evidence-based standards. Access is further constrained by out-of-pocket costs, which create substantial equity barriers. • Geographical and systemic gaps There is no national monitoring system to track psychotherapy coverage rates, and availability varies widely by region. Services are often reliant on temporary project-based funding. • Disagreement over what is evidence-based There is variation among professionals about which therapeutic approaches qualify as evidence-based, especially for severe mental health conditions. • Mental health literacy Public understanding of psychotherapy remains limited; stigma persists, and consumer advocacy in ensuring access to high-quality interventions is weak.	• Availability across setting Embed requirements for provision of evidence-based psychotherapies in quality standards, with delivery targets. • Private sector Embed in quality standards requirements for adherence to evidence-based standards by all health-care providers, regardless of setting. • Geographical and systemic gaps Embed in quality standards procedures for telecare and digital/AI solutions, where needed and feasible. • Reaching agreement over “evidence-based” Engage in proactive, neutrally facilitated discussions with key stakeholders, guided by an international base of evidence and good practices. Once agreement reached, embed list of agreed interventions in legally binding clinical guidance and quality standards. • Mental health literacy Embed information on psychotherapies in psychoeducation programmes, anti-stigma campaigns and initiatives for mental health literacy. • Data and monitoring Embed indicators for monitoring and evaluation on availability of these interventions and implementation according to set guidelines and quality standards in routine M&E of the mental health care system.

Table 2. contd.

Package of services/ interventions	Strengths and effective practices	Challenges and opportunities for improvement ^a	Proposed next steps
6. Pharmacotherapies Note: This assessment did not specifically examine pharmacotherapy in depth	• Availability Pharmacological treatment is widely acknowledged as a fundamental component of care for people with severe mental illnesses in Poland and is consistently available across all services. Medications, including antipsychotics and mood stabilizers, are generally accessible through the NFZ. • Access and stability Although this Assessment did not specifically examine pharmacotherapy in depth, previous reviews indicate that medication access remains stable under the national reimbursement scheme. • Pharmacist integration Previous reports also noted the emerging interest in the integration of pharmacists into multidisciplinary care teams to support adherence monitoring and improve medication safety.	• Access and stability Concerns persist regarding the prevalence of polypharmacy, variable monitoring of side-effects and inconsistent adherence follow-up. These issues have been cited by stakeholders as barriers to optimal outcomes. • Pharmacist integration Previous reports that although some stakeholders report progress in implementing enhanced monitoring protocols, others continue to highlight ongoing risks associated with insufficient follow-up and the lack of standardized pharmacovigilance practices.	• This Assessment did not specifically examine pharmacotherapy in depth, therefore proposed steps are deferred.
7. Recovery assistant support (peer-support workers)	• Availability In Poland, peer-support workers are often referred to as <i>asystenci zdrowienia</i> [recovery assistants]. Recovery assistants are present in nearly all CZPs, especially those established under the Pilot Project.	• Availability Outside the CZP network, recovery assistants' presence is more limited, typically project-based or tied to NGO-led initiatives. • Status in treatment teams Although the inclusion of recovery assistants is widely welcomed, their formal role within multidisciplinary teams remains inconsistently defined. There is currently no unified agreement regarding their status as equal members of the treatment team alongside psychiatrists, psychologists, nurses and social workers. This lack of clarity affects their integration, limits their potential contribution to recovery-oriented care, and raises concerns around training, supervision and sustainable employment pathways.	• Availability Alongside with scaling up CZPs, scale up the availability recovery assistants. • Status in treatment teams Engage in proactive, neutrally facilitated discussions with key stakeholders, guided by international base of evidence and good practices. Once agreement reached, embed provisions on roles and status within teams in legally binding clinical guidance and quality standards. • Data and monitoring Embed indicators for monitoring and evaluation on availability of this intervention and implementation according to set guidelines and quality standards in routine M&E of the mental health care system.

Table 2. contd.

Package of services/ interventions	Strengths and effective practices	Challenges and opportunities for improvement ^a	Proposed next steps
8. Family and caregiver support and psychoeducation	• Availability Psychoeducation and support for families and caregivers are widely recognized as essential components of effective mental health care and are generally available across CZPs in Poland.	• Availability Outside the CZP network – such as in psychiatric hospitals or outpatient clinics – these services are provided less systematically and are often dependent on local leadership, temporary project funding or the involvement of NGOs. • Standardization There is no nationally endorsed, standardized set of interventions or psychoeducational materials tailored specifically for families and caregivers of people with moderate-to-severe and severe mental illness. This leads to inconsistent practices across providers. • Monitoring and data There is limited data available on actual coverage, intensity or outcomes of family and caregiver support interventions.	• Availability Extend systematic provision of family and caregiver psychoeducation and support beyond the CZP network to all mental health service providers, supported by stable, recurrent financing rather than reliance on local leadership, temporary project funding or NGO involvement. • Standardization Develop and nationally endorse a standardized package of evidence-based psychoeducational interventions and materials tailored to families and caregivers of people with moderate-to-severe and severe mental illness, and disseminate it to all providers to ensure consistent practice. • Data and monitoring Embed indicators for monitoring and evaluation on availability of these interventions and implementation according to set guidelines and quality standards in routine M&E of the mental health care system.
9. Assertive community treatment/intensive case management	• Availability Some elements are practised informally within CZPs – particularly for people with complex or high-risk needs.	• Availability These approaches are not systematically applied in CZPs or other settings. • Standardization These approaches are not standardized in national policy, clinical protocols or quality standards. The absence of clear guidelines leads to inconsistencies in implementation and makes scaling up or evaluating these practices difficult.	• Standardization Embed standardized procedures in clinical guidelines and in quality standards for community-based mental health care, leveraging good practices both in Poland and internationally. • Data and monitoring Embed indicators for monitoring and evaluation on availability of these interventions and implementation according to set guidelines and quality standards in routine M&E of the mental health care system.

Table 2. contd.

Package of services/ interventions	Strengths and effective practices	Challenges and opportunities for improvement ^a	Proposed next steps
10. Crisis resolution/ home treatment teams	• Availability Home treatment is part of the broader service offer in CZPs.	• Availability The integration of home-based care as a crisis-specific intervention is not uniformly defined. • Standardization There are no comprehensive national standards or protocols aligning these teams with evidence-based home treatment and crisis resolution and home treatment models. The crisis resolution at home function is not explicitly defined within the standard operating procedures of CZPs, nor is it uniformly structured as a distinct, multidisciplinary intervention. As a result, the provision of acute, community-based alternatives to hospitalization remains variable and dependent on local capacity and practice.	• Availability Home treatment is part of the broader service offer, but the integration of this function as a crisis-specific intervention is not uniformly defined. • Standardization Embed standardized procedures in clinical guidelines and quality standards for community-based mental health care, leveraging good practices both in Poland and internationally. • Data and monitoring Embed indicators for monitoring and evaluation on availability of these interventions and implementation according to set guidelines and quality standards in routine M&E of the mental health care system.
11. Case management	• Availability Within CZPs, people with severe mental health conditions are often assigned a designated staff member to coordinate their care across various settings, including inpatient, outpatient and home-based care. This practice broadly reflects the principles of case management and aims to ensure continuity and personalization of care.	• Availability In other mental health services (e.g. outpatient psychiatric clinics or hospitals), case management is rarely practised. • Standardization The role of the case manager is not formally defined within national regulations or clinical guidelines, nor is it systematically embedded in the standard operating procedures of CZP teams. As such, case management within CZPs remains a de facto practice, shaped by local interpretation and team capacity rather than structured policy. The lack of formal role definition, training standards and performance monitoring may limit the consistency and effectiveness of case coordination across the system.	• Standardization Embed standardized procedures in clinical guidelines and quality standards for community-based mental health care, leveraging good practices both in Poland and internationally. • Data and monitoring Embed indicators for monitoring and evaluation on availability of case management and implementation according to set guidelines and quality standards in routine M&E of the mental health care system.
12. Day activities (structured daytime activities, vocational programmes) and community rehabilitation programmes	• Availability CZPs offer routinely therapeutic day programmes or occupational activities. Standardization. There is no systematic provision or national guidance for delivering day activities or community rehabilitation within the health sector.	• Availability Outside of the CZP network, such services are even less consistently available. In psychiatric hospitals, therapeutic day wards may offer group activities as part of inpatient or day treatment, but these are often medically oriented and lack focus on recovery. Outpatient mental health clinics are reported to rarely provide structured daytime activities or recovery-oriented rehabilitation, with most focusing solely on clinical consultations. • Standardization There is no systematic provision or national guidance for delivering day activities or community rehabilitation within the health sector.	• Standardization Embed standardized procedures in clinical guidelines and quality standards for community-based mental health care, leveraging good practices both in Poland and internationally. • Data and monitoring Embed indicators for monitoring and evaluation on availability of these interventions and implementation according to set guidelines and quality standards in routine M&E of the mental health care system.

Table 2. contd.

Package of services/ interventions	Strengths and effective practices	Challenges and opportunities for improvement ^a	Proposed next steps
13. Acute inpatient care for crisis stabilization and intensive treatment	There is clear agreement that these services are necessary, though seen as an “brief interlude, a short part of the course of treatment”, a short part of the course of treatment.	There are notable disagreements among stakeholders on: - which organizational structures should be assigned to deliver these services; - what the effective and equitable financial mechanisms for these services are; and - what should be the required/ standard operation procedure for distribution of roles and responsibilities of inpatient and outpatient teams.	Engage in proactive, neutrally facilitated discussions with all key stakeholders in both CZPs and inpatient services. Discussions should be guided by international base of evidence and good practices, and by the agreed criteria that care needs to be person-centred and recovery-oriented. Once agreement is reached, embed standardized procedures in legally binding quality standards and other relevant legal and financial regulations. Further, financial mechanisms for paying mental health service-provider organization should include quality-based incentives.
14. Management of complex conditions and or rare disorders	Access to these services falls outside the scope of this Assessment, consequently, these areas have not been examined in detail.		
15. Physical health care integration	Availability All mental health care providers refer people in their care to general medical services or somatic specialists when physical health needs are identified. This is standard practice, and psychiatric services are not expected to directly deliver somatic care.	Availability Referrals are reactive and lack structured follow-up mechanisms. Proactive, structured integration between mental and physical health care is lacking. Standardization There is no formalized framework to ensure routine screening for physical health conditions – such as cardiovascular disease, diabetes or obesity – which are disproportionately prevalent in this population. Moreover, collaboration between psychiatric and general medical services is not governed by standardized protocols, and information sharing remains limited.	Standardization Embed standardized procedures in clinical guidelines and quality standards for both community-based mental health care and somatic services, leveraging good practices both in Poland and internationally. Data and monitoring Embed indicators for monitoring and evaluation on availability of these interventions and implementation according to set guidelines and quality standards in routine M&E of the mental health care system.
16. Care coordination	Availability CZPs are intended to provide integrated, person-centred care through multidisciplinary teams. The coordination of services across health, social care and community supports is effectively organized by some CZPs.	Availability The coordination of services – particularly across health, social care and community supports – remains largely dependent on local initiative and informal networks. Outside the CZP network, care coordination is even less developed, with specialist psychiatric services and outpatient clinics typically operating in siloed structures. Standardization There is currently no national framework that systematically defines roles, responsibilities and protocols for coordinating care pathways, especially for people with complex needs requiring support across inpatient, outpatient, home-based and social care settings.	Standardization Embed standardized procedures in clinical guidelines and quality standards for both outpatient and inpatient mental health services, leveraging good practices both in Poland and internationally. Data and monitoring Embed indicators for monitoring and evaluation on availability of case management and implementation according to set guidelines and quality standards in routine M&E of the mental health care system.

Table 2. contd.

Package of services/ interventions	Strengths and effective practices	Challenges and opportunities for improvement ^a	Proposed next steps
17. Protected living, supported housing	• Availability There are small-scale initiatives in the form of <i>mieszkania chronione</i> [protected housing] and <i>mieszkania treningowe</i> [training flats], funded and managed by municipal social assistance services, not directly through the health system.	• Availability Protected living/supported housing are not provided in a coordinated manner by CZPs, nor are they embedded within mental health care structures (e.g. CZPs). Access is limited and inconsistent across regions. • Standardization There is no national guidance or standardized model for supported housing for people with severe mental illness. Although CZPs are encouraged to build partnerships with local social assistance centres and civil society organizations, these collaborations are neither standardized nor structurally embedded in service planning or funding mechanisms.	• Standardization Embed guidance and requirements in clinical guidelines and quality standards community-based mental health care, leveraging good practices both in Poland and internationally. • Develop standardized collaborative agreements with local social assistance centres and other local partners, ensuring protected living/supported housing are structurally embedded in service planning or funding mechanisms. • Data and monitoring Embed indicators for monitoring and evaluation on availability of these interventions and implementation according to set guidelines and quality standards in routine M&E of the mental health care system.
18. Employment support – individual placement and support (IPS)	• Availability Some reports note that IPS is offered in isolated pilot initiatives, often NGO-led or EU-funded.	• Availability CZPs consistently noted they do not provide IPS. There is no systemic roll-out of IPS. • Standardization As this is not a recognized service/intervention for mental health services (despite it being a long-established evidence-based practice), there are no guidelines for delivering IPS.	• Standardization Embed guidance and requirements in clinical guidelines and quality standards community-based mental health care, leveraging good practices both in Poland and internationally. • Data and monitoring Embed indicators for monitoring and evaluation on availability of case management and implementation according to set guidelines and quality standards in routine M&E of the mental health care system.
19. Sheltered work/ protected employment	• Availability <i>Zakłady pracy chronionej</i> [sheltered employment] exists outside the health system. • Standardization As this is not a recognized service/intervention for mental health services, there are no guidelines for delivering it or integrating it with mental health care.	• Availability <i>Zakłady pracy chronionej</i> [sheltered employment] has been reported to not be specifically focused on recovery or integration. • Standardization As this is not a recognized service/intervention for mental health services, there are no guidelines for delivering it or integrating it with mental health care.	• Standardization Develop formal intersectoral collaboration mechanisms to support setting up of sheltered employment initiatives. • Data and monitoring Embed indicators for monitoring and evaluation on availability of these interventions in routine M&E of the mental health care system.

Table 2. contd.

Package of services/ interventions	Strengths and effective practices	Challenges and opportunities for improvement ^a	Proposed next steps
20. Support with health/social care/legal paperwork	Availability CZPs occasionally provide informal assistance through social workers or other staff.	• Availability CZPs do not have a formalized mandate, staffing allocation or training standard for supporting administrative and legal navigation. Outside of the CZP network, such support is even more limited, typically falling to family members or not occurring at all. • Standardization There are no national guidelines or formal intersectoral collaboration mechanisms to allow embedding structured support for administrative processes – through dedicated roles, legal counselling partnerships or collaboration with social services.	• Standardization Develop formal intersectoral collaboration mechanisms to allow embedding structured support for administrative processes – through dedicated roles, legal counselling partnerships or collaboration with social services. • Data and monitoring Embed indicators for monitoring and evaluation on availability of these interventions in routine M&E of the mental health care system.

AI: artificial intelligence; CBT: cognitive behavioural therapy; CZP: Community Mental Health Centre; EU, European Union; IPS: individual placement and support; M&E: monitoring and evaluation; NGO: nongovernmental organization; ROI: recovery-oriented intake.

Human resources

Poland possesses substantial expertise in mental health care, with staff being highly competent professionally. However, despite their competence in their fields of expertise, mental health care professionals across all disciplines, including psychiatric residents, report insufficient training in the critical skills and competencies required to operate in a modern, community-based system of care.

Poland also faces critical and persistent shortages of mental health care professionals across all key disciplines, and there is an urgent need to address structural workforce issues. Key professional roles remain undefined or unregulated, notably for psychologists without clinical specializations and psychotherapists. Interdisciplinary collaboration is inconsistent, and supervision mechanisms are often lacking. Table 3 details the strengths, challenges and proposed steps to address these challenges for the mental health workforce, in connection to their availability, distribution of roles and responsibilities and their competencies.

Table 3. Human resources for people with moderate-to-severe or severe mental health conditions*

Human resources	Strengths and effective practices	Challenges and opportunities for improvement ^a	Proposed next steps
Availability (numbers and distribution)	The mental health workforce includes a full spectrum of professional categories – including psychiatrists, clinical psychologists, psychotherapists, psychiatric nurses, social workers, occupational therapists and emerging roles such as peer-support workers. There is a wide recognition of the need to scale up availability and improve distribution of mental health professionals across Poland. Some stakeholders highlight recent efforts to strengthen the workforce pipeline. Governmentally supported measures to address these challenges include expansion of residency and postgraduate training slots in psychiatry and clinical psychology, as well as financial incentives to encourage deployment in locations with limited appeal for workforce placement.	Poland faces critical and persistent shortages of mental health professionals across all key disciplines. According to recent national data, the availability of mental health human resources per 100 000 population remains among the lowest in Europe. The estimated ratios include approximately nine psychiatrists and fewer than one child and adolescent psychiatrist per 100 000 population. Numbers for clinical psychologists, psychiatric nurses and social workers are also markedly low, particularly outside major urban centres. The workforce is highly concentrated in urban centres; rural and smaller towns often lack core staff. Burnout and turnover among existing staff are significant concerns, especially given high caseloads and limited multidisciplinary support structures. Hospital and CZP managers consistently report staffing levels that fall short of their service plans, with recruitment and retention challenges particularly pronounced in rural and underserved areas. Geographical maldistribution of professionals further exacerbates inequities in access to care, with entire regions lacking core members of multidisciplinary teams. Efforts to improve access in under-resourced or less frequently prioritized regions remain constrained by workforce shortages and limited incentives for deployment.	Develop a coordinated, cross-sectoral workforce plan (usually known as a National Mental Health Workforce Strategy) that aligns education and training pipelines with projected service needs. Include specific targets for different professions (psychiatrists, clinical psychologists, psychiatric nurses, social workers, peer-support workers) and for geographical distribution. Expand and diversify training pathways for all professional groups. Enable task sharing and optimize scope of practice to enable each professional group to operate at the top of their licence, particularly in resource-limited settings. Leverage telecare and digital solutions as a means to enhance access, support task sharing and reduce bottlenecks in areas where workforce shortages are most acute.

* Areas of disagreement are indicated in red text.

Notes: CBT=cognitive behavioural therapy; CZP = Community Mental Health Centre; IPS = individual placement and support.

Table 3. contd.

Human resources	Strengths and effective practices	Challenges and opportunities for improvement ^a	Proposed next steps
Roles and responsibilities within mental health teams	The model of care spearheaded by the CZPs formally promotes interdisciplinary teamwork. Some CZPs do implement protocols that support shared decision-making and regular case conferences.	The distribution of roles and responsibilities within mental health teams remains inconsistently defined and operationalized. There is currently no standardized framework that clearly delineates the nature and level of involvement of each professional group in specific care tasks – such as routine engagement, expert consultation or task-specific input. As a result, role allocation often depends on local leadership, individual initiative and institutional culture. In practice, effective interdisciplinary collaboration remains the exception rather than the norm. Hierarchical clinical cultures continue to dominate, particularly in relation to the authority of psychiatrists. Team meetings may occur regularly, but true shared decision-making and a level playing field across professions are rare. Peer-support workers and nonmedical staff often experience marginalization in team discussions. The absence of structured mechanisms to ensure equitable participation and foster mutual respect within teams further undermines genuine collaborative care planning. In many services – especially outside the CZP network – team-based approaches are either absent or superficial. Structural barriers such as entrenched professional hierarchies, lack of joint training and limited investment in team development continue to hinder the realization of integrated, person-centred care. Stakeholders have highlighted both progress in certain localities and persistent gaps that suggest interdisciplinary teamwork remains more aspirational than routine in much of the system.	Embed standardized guidelines outlining the roles, responsibilities, and expected contributions of each professional group across key functions of care (e.g. engagement, assessment, intervention, supervision) in the quality standards for community services. This framework should support stepped care and task-sharing models, drawing on international best practices. Introduce formal structures and processes to support shared decision-making and mutual accountability within teams. This should include protocols for joint care planning, co-facilitated case conferences and mechanisms to ensure the meaningful inclusion of peer workers and nonmedical staff. Develop and scale up interdisciplinary training programmes that focus on collaborative practice, communication and leadership. Encourage co-learning among psychiatrists, psychologists, nurses, social workers and peer professionals to foster mutual understanding and respect. Monitor and support local implementation.

Notes: CBT=cognitive behavioural therapy; CZP = Community Mental Health Centre; IPS = individual placement and support.

Table 3. contd.

Human resources	Strengths and effective practices	Challenges and opportunities for improvement ^a	Proposed next steps
Distribution of roles and responsibilities across the inpatient and outpatient teams	Findings from the assessment indicate broad agreement among stakeholders on the need for structured, patient-centred collaboration between inpatient and community mental health teams in the treatment of people with severe mental health conditions. Based on stakeholder input, there are good examples of inpatient – outpatient collaboration, as follows. - Integrated organizational structures (Type A CZPs). In organizational models where inpatient and outpatient services are structurally integrated – such as in Type A CZPs – collaboration tends to be more systematic and patient-centred. Features of this model include: - joint involvement of both teams in treatment planning and discharge processes; - regular visits by the community case manager during inpatient stays; - routine and coordinated communication between inpatient and outpatient staff. - In many cases, personnel work across both inpatient and outpatient settings, which facilitates continuity and shared responsibility for care. - Stand-alone inpatient services with effective local cooperation. In some locations, even where inpatient and outpatient services are not structurally integrated (e.g. psychiatric wards in general hospitals or stand-alone psychiatric hospitals), effective collaboration with community teams has been reported. This approach – though less common – is marked by: - mutual respect and regular communication between hospital and community teams; and - coordination around discharge and follow-up planning; - community team involvement during the inpatient episode, including visits and input into care planning. These examples demonstrate that, even without formal structural integration, meaningful coordination is possible where local relationships and shared values support it. This model is particularly relevant for Type B CZPs, which do not operate their own inpatient services.	Current practice Although hospital-based respondents may have endorsed the principle of collaboration, community teams (particularly within CZPs) reported that such collaboration is not consistently realized in practice. They noted that often collaboration between inpatient and community teams is fragmented or absent. Key challenges include: - hospital teams assuming exclusive control over treatment during admission, without involving the community team; - poor or non-existent communication between inpatient and outpatient providers; - incompatibility between hospital treatment plans and those developed by the community team; - lack of clarity regarding the reason for admission or follow-up arrangements, contributing to user confusion and service discontinuity; and - mutual distrust or disagreement between teams, undermining collaborative care. This way of working often reflects legacy practices that prioritize institutional autonomy and medical authority over person-centred, networked care. It is particularly problematic in regions lacking Type A CZPs or where hospitals are not inclined to engage with community-based services. • Standardization As noted in the Package of services and interventions section, stakeholders have not yet reached an agreement on the distribution of roles and responsibilities across the inpatient and outpatient teams. In particular, the leadership role of community teams in developing and overseeing treatment plans – especially during episodes of hospitalization – is neither clearly defined nor universally accepted. This ambiguity compromises the continuity and coherence of care and limits the ability of family caregivers to participate meaningfully in the support and recovery process.	Engage in proactive, neutrally facilitated discussions with key stakeholders in both CZPs and inpatient services on distribution of roles and responsibilities. Discussions should be guided by the international base of evidence and good practices, and by the agreed criteria that care needs to be person-centred and recovery-oriented. Once agreement is reached, embed standardized procedures on ways of collaborative working and allocation of roles and responsibilities in legally binding quality standards. Further, financial mechanisms for paying mental health care service-provider organization should include quality-based incentives.

Table 3. contd.

Human resources	Strengths and effective practices	Challenges and opportunities for improvement ^a	Proposed next steps
Competencies and skills	Poland possesses substantial expertise in mental health, with staff being highly competent professionally. - Psychiatrists are well-trained in diagnosis and pharmacological treatment, and some also in psychotherapy. - Clinical psychologists are highly skilled in psychotherapeutic approaches. Stakeholders increasingly support a shift in this division of labour, provided it is accompanied by clear standards of competence, statutory recognition and structured supervision mechanisms. - Psychotherapists play a vital role in delivering structured psychological interventions. As noted in previous section, the profession has gained growing recognition in Poland in recent years. - Psychiatric nurses are a core profession in specialist teams. In some CZPs they support self-management, provide psychoeducation and participate in community-based interventions. - Social workers and occupational therapists are present in CZPs. - Asystenci zdrowia [peer-support workers] are increasingly integrated into CZPs and their support is considered critical to the process of recovery. - Other sector professionals (e.g. educators, employment counsellors, housing support workers) are recognized as essential for enabling recovery of people with moderate and severe mental illness. - In addition to these role-specific challenges, there is broad consensus among stakeholders that structured, accredited postgraduate training programmes – particularly in recovery-oriented and community-based models – are needed for all professionals. These should be complemented by on-the-job learning, systematic supervision and multi-professional training opportunities. Some institutions have begun to revise curricula and establish partnerships with CZPs for clinical placements.	Role-specific competency challenges include the following. - Psychiatrists often lack formal training in team-based care, community psychiatry and nonmedical interventions. There is a recognized need to develop their leadership competencies in multidisciplinary and recovery-oriented care. - Clinical psychologists face restrictions in their scope of practice – most notably the inability to formally diagnose mental disorders under current legal frameworks. - Psychotherapists are not yet formally regulated as health professionals under national law, creating inconsistencies in standards, recognition and integration within the public health system. Although many psychotherapists operate in private practice, their engagement in public mental health services remains limited, partly due to unclear employment pathways and the absence of unified qualification requirements. In CZPs, psychotherapists could contribute significantly to address one of the most critically under-provided services in the system – access to psychotherapy, while also supporting other professionals through supervision and collaborative care models. - Psychiatric nurses are underused in the current system, and are often confined to medication-related roles despite their potential to systematically support self-management, provide psychoeducation and participate in community-based interventions. Expanded training could allow them to contribute more fully to psychosocial and recovery-oriented care. - Social workers and occupational therapists often lack clearly defined roles or structured training in mental health-specific competencies such as psychosocial rehabilitation, community reintegration and administrative support.	Prepare a unified national competency framework guiding the skills required to operate within a modern, community-based system of care.

Table 3. contd.

Human resources	Strengths and effective practices	Challenges and opportunities for improvement ^a	Proposed next steps
	Discussions are underway to develop national competency standards, though they are still at an early stage.	<i>Asystenci zdrowienia</i> [peer-support workers] do not have their competencies formally standardized, and their role within multidisciplinary teams remains poorly defined. There is limited provision for structured supervision, certification or protected employment pathways. - Other sector professionals (e.g. educators, employment counsellors, housing support workers) often lack awareness or training in mental health, and collaboration across sectors is hindered by the absence of shared frameworks and intersectoral coordination protocols. Cross-cutting workforce issues: - Most university-level training programmes for mental health professionals in Poland remain anchored in biomedical models of care, with limited exposure to contemporary approaches such as recovery-oriented practice, interdisciplinary collaboration or community-based service delivery. - Although some institutions have begun to revise curricula and establish partnerships with CZPs for clinical placements, such efforts remain the exception rather than the rule. Faculty expertise in newer models of care is also limited, and clinical placements in CZPs are not yet standardized. - Despite their competence in their field of expertise, the mental health professionals across disciplines, including psychiatric residents report insufficient training in key areas, including: - delivering services in line with principle and values of community-based models of care; - evidence-based psychotherapies (e.g. CBT, family interventions, trauma-informed approaches); - recovery principles and human rights in mental health; - interdisciplinary teamwork and shared decision-making; - leadership and service coordination in community-based models;	

Table 3. contd.

Human resources	Strengths and effective practices	Challenges and opportunities for improvement ^a	Proposed next steps
		• case management and psychosocial rehabilitation; • crisis resolution and home-based treatment; • motivational interviewing and communication skills; • violence prevention and de-escalation techniques; and • social inclusion and vocational support (e.g. IPS). • There is currently no unified national competency framework guiding the skills required to operate within a modern, community-based system of care. Continuing professional development is sporadic and largely dependent on external project funding or personal initiative.	

Notes: CBT=cognitive behavioural therapy; CZP = Community Mental Health Centre; IPS = individual placement and support.

Recommended actions

- Develop national competency standards for community-based mental health care, tailored to the needs of each target group, (i.e. people with mild and mild-to-moderate mental health conditions or those with moderate-to-severe and severe mental health conditions), coupled with the establishment of clearly defined scopes of practice across professional groups involved in their care. This will involve the following.
 - Defining core competencies for community-based mental health care for professionals working in community services, aligned with contemporary, person-centred models of community-based care and the needs of diverse service settings.
 - Embedding standardized guidelines outlining the roles, responsibilities and expected contributions of each professional group across the key functions of care in the quality standards, tailored to the functions they perform; for example, either within the frontline mental health care teams or the CZP's specialized mental health care teams.
 - Enabling task-shifting and stepped care, as well as a more deliberate redistribution of roles, by empowering lower trained professionals, formalizing training standards, and investing in robust supervisory structures, drawing on international best practices and Polish examples of good practice.
 - Introducing a tiered certification system based on formal training, supervised practice and demonstrated clinical competence for all professions, with a particular focus on professions that are currently not fully regulated. To ensure fairness and sustainability, access to training should be equitable across all professional groups. In particular, the training of generalist health psychologists and clinical psychologists should be formally integrated into the education and health workforce system – similarly to the psychiatric residency – so that it is publicly funded rather than paid out of pocket by trainees. This approach would promote parity between two critical professional groups – psychologists and psychiatrists – and enable the scale-up of the clinical psychology workforce, which is essential for expanding access to evidence-based care within a community-based mental health care model.
 - Expanding access to continuing professional development for providers of community-based care through accredited programmes and structured clinical mentorship, with a particular focus on the underserved regions of the country.
- Expanding workforce development opportunities, with an emphasis on evidence-based psychological interventions and the delivery of digital mental health care or AI-based solutions.
- Incentivizing collaborative practice by embedding multi-professional training and team-based performance indicators into routine service delivery. This would entail introducing formal structures and processes to support shared decision-making and mutual accountability within teams. This should include protocols for joint care planning, co-facilitated case conferences and mechanisms to ensure the meaningful inclusion of peer workers and nonmedical staff.
- Linking competency standards to broader quality systems, including supervision standards, service accreditation and outcome monitoring mechanisms.

Collectively, these measures would establish a coherent foundation for scaling up high-quality, equitable mental health care services across the country. In addition, to address the ongoing disagreement on the distribution of roles and responsibilities across the inpatient and outpatient teams, it is necessary to engage in proactive, neutrally facilitated discussions with key stakeholders in both CZPs and inpatient services.

Discussions should be guided by the international base of evidence and by good practices both in Poland and abroad, and by the agreed principle that care needs to be person-centred and recovery-oriented. Once agreement has been reached, embed standardized procedures on ways of collaborative working and allocation of roles and responsibilities in mandatory quality standards. Further, financial mechanisms for paying mental health care service-provider organizations should include quality-based incentives.

Organizational structure assigned to deliver services and pathways of care

Current mental health care delivery structures for people

The mental health care system that serves people with moderate-to-severe or severe mental health conditions remains structurally fragmented, with services delivered through a combination of new and legacy models. Although the CZP initiative has introduced a territorially based, community-oriented model in parts of the country, this structure is not yet universal throughout the country. Approximately half of Poland remains outside the CZP network and continues to rely on traditional, facility-based outpatient services and psychiatric hospitals, where care is predominantly medicalized and often lacks coordination with community or social services.

Services are delivered through the following parallel organizational structures:

- CZPs, which currently cover about half the population, operate as territorially defined providers responsible for delivering or coordinating a range of services including outpatient, day care, home-based care and, in some cases, inpatient care;
- *poradnie zdrowia psychicznego* [outpatient psychiatric clinics] in areas that do not have CZPs, which typically offer psychiatric consultations and pharmacological treatment, often without multidisciplinary input or structured collaboration with inpatient or community-based services;
- psychiatric hospitals and general hospital-based psychiatric wards, which continue to play a central role in acute and long-term inpatient care nationwide, including in areas with CZP coverage and those without.

Pathway fragmentation and implementation challenges

The needs of those with moderate-to-severe and severe mental health conditions are consistently acknowledged, with broad support for multidisciplinary, recovery-oriented services. Stakeholders expressed strong agreement on nearly all the core services and interventions recommended for this target group, recognizing the importance of an integrated care pathway that includes community-based supports, psychosocial interventions, housing and employment support, and continuity of care mechanisms.

However, there was one area – acute inpatient care for crisis stabilization and intensive treatment – for which important divergences remain between stakeholders.

Although there is clear and unanimous recognition among stakeholders of the need for such services as a critical, but time-limited, part of the treatment continuum, three key points of disagreement were identified which were:

1. which organizational structures should be responsible for delivering acute inpatient services;
2. what financing mechanisms would ensure both equity and efficiency in the provision of inpatient care; and
3. how the roles and responsibilities for this care should be distributed between the inpatient and outpatient teams, including for treatment planning, referral, discharge and follow-up procedures.

However, the assessment team found that although these disagreements have often been amplified or presented as irreconcilable, in reality, these issues could be productively addressed. When each of the contested issues were examined separately and approached with constructive, neutral facilitation, stakeholders were open to dialogue and willing to identify feasible, consensus-based solutions.

Stakeholders affiliated with Type A CZPs, including representatives of the National Network of Community Mental Health Centres, service-user organizations, family caregiver associations and wider advocacy groups, have raised concerns about the prospect of excluding Type A CZPs from the model of services to be approved during the national scale-up of community care. They have expressed strong support for the continued operation of the existing Type A CZPs. They also advocate for the right to establish additional Type A CZPs during the national scale-up, where deemed locally appropriate and effective for service organization. In their view, this model enables integrated service delivery, particularly where inpatient care can be directly coordinated with outpatient and community-based services under a single organizational structure.

One of the options proposed over the last year for the national scale-up of the community-based model of mental health care has been to standardize future service provision through exclusively funding Type B CZPs nationwide. The rationale for this centres on the administrative and operational benefits of uniformity, and proposes that all community-based outpatient care should be delivered by Type B CZPs, while inpatient psychiatric care should be managed separately by distinct organizational entities.

However, the NFZ has observed that, although many Type B CZPs do perform well and provide high-quality care, many have found it difficult to establish effective collaborations with unaffiliated inpatient services. NFZ data on the Pilot Project implementation show the achievements of some of the current Type A CZPs:

- one Type A CZP had the highest level of coverage of the adult general population (6.4%), which was significantly above the national CZP average (3.2%); and
- another Type A CZP served as the main provider of mental health care for 93% of people with mental health conditions treated in the public system in its catchment area, which was well above the national CZP average of 65%.

Although the achievements of the CZPs vary, which is partly because different CZPs were started up at different times, meaning that some have years of experience, while others are relatively new, the achievements of the top ranking Type A CZPs, alongside the Type B CZPs, when they function in suitable local ecosystems, highlights the value that they can bring to the Polish mental health care system. Proponents of Type A CZPs are not advocating to convert existing Type B centres into Type A models, and they are not proposing that the national scale-up should be predominantly based on the Type A structure as the value and performance of Type B CZPs is recognized, but they do propose that decisions should be driven by local circumstances and needs.

In the process of validating the findings of this assessment, the NFZ stressed that it does not prefer the exclusive funding of Type B CZPs, and its position is that:

in order to ensure equal access to psychiatric care for patients and to implement the pilot programme immediately, it is necessary to first introduce CZPs based on widely available services, i.e. outpatient services (97% of patients use outpatient services).

It is essential that CZPs are linked to hospital services (access to which is uneven across Poland) in order to meet the objectives of the reform. At the same time, in the opinion of the Fund, the functionality/cooperation between hospital wards and health care providers implementing the CZP guidelines should be included in the organizational standards.

The NFZ also stressed that “the CZPs – regardless of type – should organize outpatient and community care, cooperating with hospital wards in a continuous and standardized manner” and noted that:

it is of fundamental importance for the National Health Fund that every CZP is linked to all psychiatric hospital wards in Poland, because:

- *emergency patients are admitted to the hospital according to the principle of the nearest available place – not necessarily the general psychiatric ward of their “own” CZP;*
- *it is necessary to ensure the exchange of information between the psychiatric hospital ward and the CZP with territorial jurisdiction – so that the CZP can provide further post-hospital care to the patient;*
- *only such a model improves coordination, ensuring continuity of treatment and community responsibility.*

In addition, every hospital psychiatric ward – regardless of its organizational affiliation – is required to provide separate 24-hour medical and nursing care. In the opinion of the Fund, this undermines the rationale for sharing hospital and outpatient care at the management level.

As highlighted in Box 4, international evidence underlines the importance of integrated and coordinated care across outpatient and inpatient services, while also showing that although national standards are essential, effective implementation must be adapted to local needs, capacities and health system contexts.

Box 4. Integrated and coordinated care for community-based outpatient and inpatient mental health care services

International evidence strongly supports the value of integrated and coordinated care across community-based outpatient and inpatient mental health care services, and highlights its role in improving continuity of care, treatment outcomes and service accessibility. The evidence acknowledges that there is no one-size-fits-all model for service organization.

Effective integration can be achieved through a range of structures, and the choice of where to base these functions – whether within stand-alone centres, hospital-affiliated units or broader primary care networks – should be guided by local needs, capacities and health system contexts. This applies equally to the shaping at the local level of stepped-care pathways, and the distribution of roles and responsibilities across inpatient and outpatient services to ensure best patient-centred quality of care and health outcomes.

The absence of standardized national clinical guidelines further complicates the creation of consistent, evidence-based pathways (see section 3.5). There is no common framework to guide the roles of the different teams or to define the expectations for engagement, crisis response, hospitalization, rehabilitation and reintegration.

Another important issue that emerged during site visits is the continued allowance of smoking in inpatient psychiatric facilities in Poland – a practice that stands in contrast to prevailing international evidence and contemporary public health standards. There is now robust evidence demonstrating that the continued allowance of smoking in acute psychiatric inpatient settings confers no clinical benefit and, in fact, undermines efforts to support recovery and reduce health inequalities. The long-held belief that banning smoking indoors exacerbates agitation or worsens psychiatric symptoms has been repeatedly challenged by empirical data. Multiple studies from high-income settings show that the implementation of comprehensive smoke-free policies in mental health services does not lead to increased aggression, seclusion or discharges against medical advice. In some cases, a reduction in violent incidents and an overall improvement in ward atmosphere have been observed following the introduction of smoking bans ((21, 22).

Smoking cessation is also associated with measurable improvements in mental health. Quitting smoking is linked with reductions in depression, anxiety and stress, with no evidence of harm to psychiatric stability (23). Many patients with severe mental illness want to stop smoking and can achieve cessation with the appropriate clinical support, including nicotine replacement therapy and behavioural interventions (24). Given that smoking remains a major contributor to the stark mortality gap faced by this population, maintaining indoor smoking in inpatient wards perpetuates avoidable harm. A transition to smoke-free mental health services is both evidence-based and ethically necessary.

Recommended actions

- Preserve and scale what works: expand the CZP model nationally, retaining its flexibility to adapt to local needs, avoiding a rigid, one-size-fits-all approach and maintaining the ability to set up both Type A and Type B CZPs. Selecting a suitable type of CZP within local contexts could be done based on formal criteria, although national service standards and performance benchmarks should be set.
- Document and promote good practices and locally developed solutions emerging from high-performing community-based centres across the country. CZPs can serve not only as a source of inspiration, but also as practical resource hubs for the wider mental health care network in Poland and beyond. Some CZPs already represent exemplary models of community-based mental health care, and their experiences should be systematically captured, shared and celebrated. Establishing mechanisms to identify, validate and disseminate these practices – both nationally and internationally – can help accelerate the shift towards community-based care and position Poland as a leader in mental health care system transformation.
- Establish dedicated specialist community mental health care teams within each CZP which would be tasked with care management for people with moderate-to-severe and severe conditions in the CZP's catchment area.
- Set clear accountability for territorial responsibility, ensuring that people with severe conditions are supported through proactive outreach, coordinated follow-up and ongoing psychosocial rehabilitation.
- Develop formalized care pathways, including roles and responsibilities across service levels, shared care planning processes and discharge protocols.
- Improved integration between CZPs and hospital-based care, supported by joint working protocols, data-sharing systems and financing mechanisms that reward

collaboration. Procedures to ensure continuity of care across all levels of the mental health care system should be formally embedded within the quality standards, both those governing inpatient services and those for community-based services.

- Resolve disagreements on acute inpatient care through facilitated dialogue and guidance on roles, financing and care continuity.
- Address equitable geographical coverage and adequate funding to build multidisciplinary teams and community-based services in currently underserved areas; this would entail the replacement or transformation of traditional outpatient clinics to ensure that these services are aligned with recovery-oriented, team-based models of care.
- Expand and update the CZP service package for this target group, with particular attention being paid to recovery-oriented and socially integrated services, including psychotherapy, psychosocial support and housing assistance.

3.4 Financing for a community-based model of mental health care

Mental health financing in Poland remains a core constraint in the transition to a comprehensive, community-based model of care. Despite important progress in implementing community-based mental health care services – most notably through the Pilot Project and the expansion of the CZPs – challenges persist, including fragmented funding streams, uneven implementation, and a lack of financial incentives linked to quality, integration and outcomes.

To enable consistent and equitable service delivery, financing models must support both structural integration and local adaptability. In this context, stakeholders, including the National Network of Community Mental Health Centres, service users, family caregivers and advocacy groups, have expressed strong support for preserving and expanding both types of CZPs in areas where they are effective. A flexible financing approach that allows for both CZP models – Type A and Type B – based on local needs and performance, and that is embedded within a framework of national standards and benchmarks, is essential. Such an approach would support the scale-up of high-performing, integrated service models while maintaining system coherence.

Mental health financing in Poland is a critical bottleneck in the transition towards a comprehensive, community-based model of care. Although gradual expansion of the CZPs represents a significant advance in implementing community-based mental health services, the fragmentation of financial streams and the lack of quality criteria-based incentives continue to undermine efforts to deliver accessible, equitable and recovery-oriented mental health care services. In this section, the current financing mechanisms are outlined, the key challenges identified and the strategic priorities for transformation are proposed.

3.4.1 Financial accessibility of services

Although mental health care services in the CZP model are free at the point of delivery, financial accessibility remains uneven throughout the country. For example, people with mental health conditions often face barriers to accessing early psychological support via public services, particularly in the areas that are not yet covered by CZPs. In addition, people with severe mental health conditions in need of community-based services, such as home-based care and crisis intervention, may find that they are unavailable in their area.

Hidden costs, such as transportation, medication co-payments or fees for non-reimbursed services (e.g. certain psychotherapies), are reported to disproportionately affect people living in rural areas and low-income populations. Although private services are widely used by higher-income groups, the challenge remains of how to guarantee high-quality care for all, regardless of socioeconomic status.

3.4.2 Structure of mental health expenditure

Mental health care expenditure in Poland is estimated to be approximately 4% of the total health budget. The primary source of financing is the NFZ, with additional contributions from the Ministry of Health, local governments and EU structural funds. However, spending remains fragmented and is inconsistently allocated across service types and regions.

Key funding streams include the following:

- public funding via the NFZ: covers the operation of CZPs, psychiatric hospitals and outpatient clinics;
- Ministry of Health allocations: support national programmes, NGO-contracted services and selected public salaries;

- EU funding: supports pilot initiatives, innovation and capacity-building projects, particularly in CZPs; and
- out-of-pocket payments: the exact magnitude of these payments is not systematically tracked, but these payments remain significant, particularly in private psychiatric and psychotherapeutic care.

3.4.3 Financing the CZPs

CZPs are financed through global budgets based on capitation (i.e. the catchment area population), and are intended to encourage prevention, continuity of care and local responsibility. The Opening Package defines the minimum services that should be offered, including psychiatric consultations, psychotherapy, rehabilitation and home- and community-based interventions.

However, there are challenges with regard to financing the CZPs.

- The package of services excludes some key recovery-oriented services, such as supported employment or structured psychosocial rehabilitation.
- Financing from municipal budgets is minimal and unsystematic, despite the community-based nature of CZP operations.
- There is a lack of integrated health and social care budgets, which limits the potential for coordinated service delivery and holistic recovery pathways.
- Financing for telehealth and blended e-health/AI solutions remains underdeveloped.

The division of inpatient and outpatient care financing continues to pose challenges, particularly in relation to the two organizational models of CZPs.

- Type A CZPs, which manage their own inpatient units, are able to flexibly pool resources across care levels, which improves continuity but raises concerns among some stakeholders about equity, as they operate under different financial rules than external inpatient units.
- Type B CZPs, which rely on external hospitals for inpatient care, lose funding when service users are hospitalized, leading to perceived disincentives for continuity and integration.

To enable consistent and equitable service delivery, financing models must support both structural integration and local adaptability. In this context, stakeholders, including the National Network of Community Mental Health Centres, service users, family caregivers and advocacy groups, have expressed strong support for

preserving and expanding both Type A and Type B CZP in areas where they are effective.

The views of the supporters of CZPs on maintaining global budgets based on capitation are so strong that it was suggested that “this method of financing should be included in the Mental Health Protection Act so that the National Health Fund cannot easily change it”.

A flexible financing approach that allows for both models of CZPs – Type A and Type B – based on local needs and performance, and that is embedded within a framework of national standards and benchmarks, is essential. Such an approach would support the scale-up of high-performing, integrated service models while maintaining system coherence.

Stakeholders also emphasized the need to define meaningful quantitative and qualitative indicators, which would be embedded within CZP financing mechanisms and aligned with quality standards and clinical guidelines, which would create financial incentives for compliance with the established requirements.

3.4.4 Contracting and performance-based financing

Currently, contracting procedures for mental health services – whether for public providers or NGOs – are largely based on historical allocations, with minimal linkage to performance or quality outcomes. Short contract durations and bureaucratic complexity create uncertainty for providers, particularly in the NGO sector. Although the CZP global budget model theoretically encourages long-term, preventive care, performance metrics and incentives have yet to be fully developed. Stakeholders have called for measures to:

- introduce financial mechanisms that embed quality criteria, with financial incentives for service providers to meet quality standards and achieve positive outcomes for service users;
- develop quality indicators linked to recovery and user satisfaction; and
- ensure transparency in procurement and contracting processes.

3.4.5 Fragmentation and cross-sectoral financing gaps

Mental health financing in Poland remains siloed across ministries and sectors. Although the Ministry of Health funds most direct care services, critical functions such as housing support, social reintegration and educational interventions fall under the remit of the municipalities, the Ministry of Family and Social Policy and the Ministry of Education.

There are no systemic mechanisms to pool funds across these entities, which results in:

- gaps in service continuity, especially for people with complex needs;
- underfunded community support services, such as assisted housing and supported employment; and
- limited collaboration between health and social sectors, despite mandates for coordination.

3.4.6 Recommended actions

Financing remains one of the central determinants of success in Poland's mental health reform. Although the CZP model has established a promising foundation for territorially based, community-oriented care, it requires a more coherent and equitable financing framework to become sustainable at scale. Addressing underinvestment, fragmentation and lack of outcome-oriented incentives will be essential to deliver on the promise of universal, high-quality mental health care for all. To strengthen the financial foundation of Poland's mental health care system, stakeholders have identified the following strategic priorities.

- Preserve and scale what works: finance the national scale-up of the CZP model while retaining the flexibility to adapt to local contexts. Maintain the recognition and funding of the scale-up using both Type A and Type B CZPs, with the selection of the type of CZP to fund in each location guided by formal criteria, and embed national service standards and performance benchmarks.
- Commission and conduct comprehensive economic analyses, including cost-effectiveness and cost-benefit evaluations, of the current CZPs and the broader range of mental health care services operating within the system. These analyses should inform priority-setting, resource allocation and planning for the national scale-up of community-based care.
- Increase overall mental health care funding, as needed, through a combination of measures: expanding the baseline mental health care budget within the statutory health insurance system, and allocating additional dedicated resources to establish new CZPs at the national level. This funding should also support the implementation of updated standards of care, the development and the roll-out of new clinical guidelines, and the system adaptations required to scale up the community-based model effectively.
- Ensure the scale-up maintains clear territorial accountability for the CZPs to ensure proactive outreach, coordinated follow-up and access to ongoing psychosocial rehabilitation. Set clear, measurable targets for population coverage by CZPs, both for their frontline mental health care teams and their specialist community mental health care teams, as well as for quality of care and cost-effectiveness measures in addressing this group's needs.
- Introduce quality-based financial incentives, rewarding service quality, continuity of care and outcomes, and use financing levers to promote coordination across service providers, with a focus on collaboration between providers of inpatient and outpatient care. Strengthen integration through joint working protocols and data-sharing systems, and through financing mechanisms that reward cooperation.
- Expand and update the CZP service package, with particular attention to recovery-oriented and socially integrated services.
- Develop financial models to support the delivery of digital and AI-based mental health care solutions as evidence-based, cost-effective and viable complements to face-to-face care, with a particular focus on blended models that integrate professional support with digital tools.
- Ensure public financing for the formal training of generalist health psychologists and clinical psychologists, integrating this training into the national education and health workforce system on a par with psychiatric residencies. This is key to equitable access to training and workforce scale-up.
- Consolidate fragmented funding streams to improve coordination between the health, social care and education sectors.

3.5 Clinical guidelines and standards of care for mental health

Clinical guidelines and standards of care are widely recognized as essential to ensuring high-quality, consistent and evidence-based mental health care. In Poland, however, the development, dissemination and implementation of clinical guidelines in psychiatry remain limited and uneven. At present, there is no comprehensive, officially sanctioned set of national clinical guidelines for mental health care endorsed by the Ministry of Health. Although professional bodies, such as the Polish Psychiatric Association, have issued advisory recommendations for specific conditions, these documents lack regulatory authority and are not integrated into national policy or accreditation frameworks. As a result, there is considerable variability in diagnostic and therapeutic practices across regions, institutions and, even, individual clinicians. This inconsistency is particularly pronounced in the context of community-based care, in which multidisciplinary teams require shared clinical frameworks to support coordinated, person-centred interventions. The 2017–2022 National Mental Health Protection Programme and the the Pilot Project have not mandated adherence to specific clinical pathways or evidence-based protocols. Consequently, many providers rely on local protocols, institutional experience or international literature, particularly when treating complex or less common disorders.

It is important to distinguish between clinical (medical) guidelines and organizational standards. The latter have been partially addressed through a draft organizational standard for CZPs, which outlines structural and operational expectations, such as minimum staffing, territorial coverage and service continuity. However, these standards do not contain guidance on clinical decision-making or therapeutic approaches, nor do they promote standardization across the spectrum of mental health conditions.

The absence of robust national clinical guidelines poses several systemic challenges. It complicates the training and supervision of new professionals, undermines efforts to assess service quality and limits the ability to benchmark performance across providers. Critically, it also hampers the transition to a recovery-oriented, community-based model of care by denying teams a unified evidence base from which to work.

Although a number of pilot CZPs have developed internal guidelines aligned with international best practices, widespread adoption remains limited and fragmented. Recent policy efforts under the new

iteration of the National Mental Health Protection Programme (2023–2030) have prioritized the finalization of national clinical guidelines and their integration into both service delivery and accreditation systems. However, the absence of a binding, system-wide framework remains a fundamental constraint on quality assurance, care consistency and meaningful transformation. Stakeholders consistently call for the urgent development and implementation of high-quality, evidence-based clinical guidelines, with legal requirements for their implementation.

3.5.1 Recommended actions

Develop and ensure the adoption of clinical guidelines that:

- are adapted to the Polish sociocultural and service context, while ensuring they are in line with the scientific base of evidence;
- carry professional endorsement from national clinical societies;
- are embedded in the education and continuing professional development of health workers;
- are supported by digital decision-support tools and clinical documentation systems;
- include outcome indicators to support monitoring and quality improvement; and
- offer accessible, parallel versions for different levels of care (e.g. primary care, specialist teams) and user-friendly formats for service users, families and informal caregivers.

3.6 Use of telecare and digital therapies in mental health care

The rapid digital transformation of health-care systems globally, which has been accelerated by the COVID-19 pandemic, has highlighted the transformative potential of telecare and digital therapies in mental health care. These technologies offer scalable, accessible solutions for prevention, early intervention and ongoing treatment, particularly in regions where traditional mental health care services are overstretched or inaccessible. E-mental health encompasses a wide range of tools, including telepsychiatry and telepsychology, mobile mental health apps, digital assessments, AI-powered chatbots and online peer-support platforms. These interventions can enhance patient engagement, enable earlier detection of mental health conditions and support personalized, continuous care. Telecare and digital mental health solutions should not be seen as a substitute for human

care but should be used as a means to enhance access to care, diversify support options, support task sharing and reduce bottlenecks in areas where workforce shortages are most acute.

In Poland, the adoption of telepsychiatry and telepsychology expanded significantly during the COVID-19 pandemic, allowing many providers – including the CZPs – to maintain service continuity through remote consultations and therapy sessions. Some CZPs have continued to integrate telecare into their routine operations, particularly for follow-up care and crisis intervention. Evidence from early pilot initiatives indicates that telecare can reduce missed appointments and improve patient satisfaction, particularly in underserved rural areas.

However, the integration of telecare into the mental health care system remains fragmented and underdeveloped. Although the pandemic accelerated initial adoption, most facilities lack dedicated digital platforms, or the standardized workflows and trained personnel that are needed to deliver remote mental health care effectively. Reimbursement for telepsychiatry remains limited, and regulatory frameworks have not yet evolved to provide clarity on key issues such as privacy, asynchronous care models and cross-border service provision. The absence of national protocols for telehealth delivery has led to significant variation in quality and scope across providers. Further barriers include:

- inadequate public financing models for care that blend face-to-face interventions with guided and unguided digital/AI solutions;
- digital literacy challenges among both service users and professionals;
- regulatory uncertainty related to data security and clinical responsibility; and
- limited access to appropriate technology in rural and socioeconomically disadvantaged populations.

Despite these constraints, there is considerable potential to scale up and systematize telecare and digital/AI solutions in Poland's mental health care system. Opportunities include the development of a national approach to telecare and digital/AI solutions, investment in secure digital infrastructure, and the integration of hybrid (in-person and online) models into routine care. Telemonitoring tools and digital assessments could also enhance care coordination, continuity and outcome tracking.

Stakeholders have expressed cautious optimism, and have highlighted ongoing innovations in blended service models and the pilot use of digital tools in some CZPs. Many stakeholders also emphasized the pressing need for structural measures, particularly in financing, regulation and training, to ensure that digital therapies are safe, equitable and effectively embedded within standard care pathways.

3.6.1 Recommended actions

- Establish national guidance and standards for the safe and ethical integration of digital tools into clinical pathways.
- Promote the adoption of evidence-based digital tools (e.g. guided self-help, digital cognitive behavioural therapy, online psychoeducation, AI-assisted triage or clinical decision support) as part of a stepped-care model to enable lower trained professionals to deliver effective low-intensity interventions with remote supervision.
- Scale up the use of telehealth and blended care models to improve access to care, narrow treatment gaps and extend the reach of existing mental health care professionals, particularly in underserved and rural areas.
- Invest in capacity-building and digital training for mental health care professionals to support the effective use of these technologies.

3.7 Recovery-oriented practice in mental health care

The findings of this rapid assessment indicate that the concept of recovery remains largely undefined and underused in the Polish mental health care system. Although international best practices, such as the EUCOMS consensus framework (25), positions recovery as the personal journey of the service user, supported but not directed by professionals, this perspective is yet to be meaningfully adopted in Poland. Recovery-oriented care entails more than clinical improvement; it involves supporting people to regain health, social functioning and a coherent sense of personal identity. Central to this approach is the principle that people can and do recover, even from the most serious mental health conditions, and that professionals must offer hope, focus on individual strengths and engage in shared decision-making.

In practice, however, recovery as a guiding principle is largely absent from national policy, clinical protocols and training curricula in Poland. Service delivery continues to prioritize medicalized interventions, often overlooking the social and personal dimensions of recovery. The

role of the service user as an expert by experience is rarely recognized, and structured opportunities for co-producing care plans or defining personal goals remain limited. Although some CZPs have introduced elements of recovery-oriented practice, such as peer support and strengths-based care, these efforts are fragmented and unsupported by a national framework or evaluation standards. Without this transformation, the broader goal of community-based, person-centred mental health care will remain incomplete.

3.7.1 Recommended actions

- Recovery-oriented practice in Poland should be reframed to emphasize the person, not the illness; to value subjective experience alongside clinical expertise; and to focus on what is strong rather than what is wrong.
- Achieving this shift will require investment in staff training, service redesign and embedding recovery across the three core domains of health, functioning and identity.

3.8 Civil society involvement in mental health care

3.8.1 Co-creation of mental health care with service users

Individual level: treatment plans, shared decision-making

In Poland, co-creation of care at the individual level is still unevenly practised. Interviewees highlighted that there is no national requirement mandating professionals to include the perspectives of service users in their treatment planning. Although there are some discussions between service users and professionals, this typically amounts to individual consultations rather than shared decision-making. In most centres, treatment plans are primarily shaped by professionals, with limited attention to the recovery goals or functional outcomes articulated by the users themselves. Service users and family members may speak with professionals – sometimes without breaching confidentiality – but this communication is often informal and does not translate into active participation in clinical decision-making.

System level: participating in mental health teams – the role of peer-support workers

The integration of service users at the system level is at a very early stage in Poland. The role of peer-support workers (recovery assistants) was introduced in 2017, yet it remains underdeveloped and inconsistently implemented. Interviewees described recovery assistants as providing essential emotional and practical support to service users, including assistance with returning to work, schooling and managing daily life. However, their professional role in multidisciplinary teams is still unclear and often not fully recognized. Their involvement is more symbolic than structural, and they are rarely integrated into clinical teams or decision-making processes. Nevertheless, their presence has been noted as inspiring, as they model recovery and offer hope to current service users.

Policy level: service design, participation in decision-making processes

At the policy level, service users and family caregivers, largely, are not involved. Despite earlier participation in the development of the pilot CZPs, service users and family caregivers are no longer actively involved in the ongoing process of transformation or the decision-making processes. Participants in the assessment expressed concern that recent policy directions from the Ministry of Health are not aligned with the principles of community-based care they support, particularly the integration of inpatient and outpatient services. They stressed the importance of continuity and of strengthening, rather than fragmenting, the existing model. Service users and caregivers called for legal protections to preserve the principles of the pilot CZPs and for policies that would ensure care is provided in the user's own environment with family involvement. The lack of infrastructure and communication from decision-makers further complicates meaningful participation in shaping mental health care.

Skills and competencies of service users and family caregivers

There is a growing interest in building the capacity of service users and family caregivers in Poland. Recent years have seen the introduction of training programmes aimed at empowering these groups to take a more active role in mental health care. In some centres, psychoeducation sessions are available for families and are delivered in part by peers. However, there is no standardized curriculum, and existing materials are often insufficient or not professionally produced. Interviewees underscored the need for high-quality educational resources and training materials – some even volunteered

to translate international guidelines into Polish. They also noted that greater reliance on psychologists (rather than only medical doctors) could improve care and communication.

Challenges and enabling factors

Key barriers to meaningful co-creation include hierarchical structures in the mental health care system, limited recognition of recovery-oriented practices among professionals and a lack of institutional support for peer roles. A cultural shift is also needed among clinicians – particularly psychiatrists and psychologists – towards believing in the potential for recovery rather than merely maintenance. Interviewees called for more education for professionals on teamwork, communication and effective delegation within multidisciplinary teams. Interviewees emphasized the importance of legislative support, stronger user organizations and better stakeholder communication. Although the path forward is challenging, service users and caregivers remain motivated and committed to contributing to a more inclusive and responsive mental health care system.

3.8.2 Engagement with family and other informal caregivers

Individual level: treatment plans, shared decision-making

The involvement of family caregivers at the individual level varies significantly across Poland. Stakeholders stressed the importance of taking a whole-family approach in mental health care. Assessment participants noted that the situation began to change in particular with the support of the Pilot Project. In areas where these pilot projects have been implemented, caregivers have more opportunities to be involved, and a team-based approach to mental health care has started to emerge. However, even in these regions, progress remains uneven. Although some CZPs actively involve families and emphasize collaboration, others continue to operate in a more traditional, individualistic model, with professionals unaccustomed to engaging family members in the care process.

Currently, there are no formal requirements for including families as part of the healing team. As a result, in areas outside the catchment areas for the pilot projects or where CZPs are not functioning optimally, caregivers often remain on the margins of care. Many professionals require additional training in team collaboration and in working effectively with families.

System level: participating in mental health teams – the role of peer-support workers

At the system level, the engagement of family caregivers also lacks structure. Participation is not mandated, and there are no national indicators or monitoring mechanisms to ensure quality collaboration with families. Some CZPs have begun to consult and involve caregivers more systematically, but this is not yet the norm.

Interviewees pointed out the absence of change management training, and the need for consistent models of good practice across centres. They advocated for exchange visits between CZPs to learn from those successfully implementing collaborative practices. The visibility of CZPs in the media also influences public perception, which varies depending on who presents the message. There is an urgent need for a structured approach to change management and communication.

Policy level: service design, participation in decision-making processes

At the policy level, family caregivers' participation remains limited and inconsistent. Between 2016 and 2022, caregivers were represented on the Mental Health Council. However, with the changes in administration, by 2023, caregivers were not included in the reconstituted Council. Interviewees suggest that this exclusion reflects a broader scepticism among policy-makers about the relevance of family input in shaping mental health care.

Despite being invited to contribute to earlier versions of the National Mental Health Programme, family representatives reported being excluded from the later stages of its development. Some officials – such as the Ombudsman – previously showed openness to caregiver involvement but these connections have not been sustained under the current administration. Interviewees highlighted the need for the Public Health Department to actively include family caregivers in policy-making processes, recognizing them as key partners in recovery.

Vision of family caregivers for community-based mental health care in Poland

Family caregivers envision a nationwide system of CZPs that integrates hospital and community services, akin to the Type A model. They emphasize early involvement of families, short hospital stays and treatment continuity within the community. They want their roles to be recognized as essential resources in the recovery process and advocate for more home-based care and supported living options to help people transition back to everyday life.

Caregivers also stress the importance of reducing stigma and ensuring that care begins promptly after the first symptoms appear. They call for closer collaboration between mental health and social services, clear standards of teamwork and proper remuneration for CZPs based on quality benchmarks.

Skills and competencies of family caregivers: what works well and additional needs

There is a significant need for training and capacity-building among family caregivers. Some CZPs offer psychoeducation and support activities, but access is uneven and content is not standardized. Family caregivers expressed a strong desire for structured, professional training programmes and highlighted the value of being equipped to support their loved ones' recovery more effectively. They also stressed the need for supervision and support structures for recovery assistants, advocating for their full integration into care teams.

Challenges, opportunities and priorities

Interviewees identified several challenges, including a lack of national standards for family involvement, limited recognition of caregivers at policy level, and inconsistent implementation of community-based care. Opportunities lie in building on the successes of the Pilot Project and fostering a cultural shift among professionals to view families as partners rather than outsiders.

A clear priority is to ensure that all CZPs – regardless of their type – operate with defined standards of cooperation and that family caregivers are systematically included in care, system design and policy-making. Interviewees also emphasized the need for supported housing options and continuity of care that bridges the gap between hospitals and communities.

3.8.3 Recommended actions

- Promote structured participation of service users and family caregivers by establishing formal mechanisms (e.g. advisory roles, consultation processes) that ensure their perspectives are consistently integrated into treatment planning, service design and policy-making.
- Clarify and strengthen the role of peer-support workers within multidisciplinary teams by developing role descriptions, training pathways and supervision structures, while maintaining the principle of complementarity with clinical staff.
- Encourage the development of standardized training and educational materials for service users and family caregivers, drawing on international guidance and

adapting it to the Polish context, to support their meaningful participation in care and recovery.

- Support exchange of good practices among CZPs in engaging service users and families, including peer involvement, family psychoeducation and co-design initiatives, to promote consistency across the country.
- Foster inclusive dialogue at national level by ensuring that civil society voices are represented in policy consultations, while balancing inputs from professional, user and caregiver perspectives.

3.9 Information systems and data monitoring in mental health care

3.9.1 Digital health and information integration in mental health care services

Poland has made substantial progress in the digitalization of health care in recent years, driven by national reforms, EU investment and the acceleration prompted by the COVID-19 pandemic (see section 3.7). Key milestones include the widespread implementation of electronic prescriptions, electronic health records, teleconsultations and the national P1 platform for digital health data exchange. These developments have enhanced access, transparency and efficiency, particularly in primary care. However, the mental health care sector continues to lag behind the broader health system in the adoption, integration and standardization of digital tools.

Although some CZPs and psychiatric hospitals have adopted basic electronic documentation systems and telepsychiatry services, the use of digital technologies in mental health remains uneven and underdeveloped. Many providers still rely on paper-based records, and interoperability between local systems and national platforms remains limited. Inconsistencies in data reporting, delayed integration with the Polish national e-health infrastructure, *Platforma P1* [P1 Platform], and the absence of a unified digital infrastructure hinder comprehensive care planning and system-wide coordination. These gaps are particularly acute in rural and under-resourced areas, where limited Internet access and information technology capacity further constrain adoption.

Efforts to enhance interoperability and expand digital tools for mental health care are being led by the National e-Health Centre, which has recognized the need to better integrate psychiatric services into national digital strategies. Nonetheless, challenges persist. Data protection regulations, such as the General Data

Protection Regulation⁸ and Poland's Patient Rights Act,⁹ introduce additional complexity when handling sensitive mental health data, particularly in the context of intersectoral collaboration. Ethical concerns, technical limitations and the lack of standardized legal protocols for data exchange between sectors impede the development of integrated, person-centred digital care pathways.

The legal framework for intersectoral cooperation, including legislation such as the acts on Social Assistance, Local Government and Public Health, provides a general mandate for collaboration among public, private services and NGOs. However, in practice, these frameworks are inconsistently implemented. Coordination is often hampered by fragmented regulation, unclear responsibilities between institutions and bureaucratic obstacles. Intra-sectoral collaboration – for example, between physicians – is more straightforward than cooperation between health-care providers as legal entities, which often requires separate legal agreements.

Mental health care services are particularly affected by these limitations, as no single sector – health, social care or justice – can independently respond to the complex needs associated with mental health crises. The secure exchange of information across sectors remains a critical bottleneck in enabling coordinated care. Despite ongoing reforms, the implementation of digital health solutions in mental health remains fragmented, underfunded and largely confined to pilot initiatives.

Nonetheless, the potential of digital tools and information systems remains substantial. Stakeholders recognize that integrated digital tools, such as shared care plans, interoperable health records and outcome tracking platforms, could significantly strengthen interdisciplinary collaboration and improve both the continuity and quality of care. Ensuring the development and implementation of secure, scalable and context-appropriate digital infrastructure in mental health care should be prioritized in Poland's broader digital health strategy.

3.9.2 Performance monitoring and evaluation

Performance monitoring in Poland's mental health care system remains at an early stage, with significant limitations in the scope, quality and utility of existing data. At present, the NFZ collects administrative and activity-based data from contracted providers, including service volumes, staffing numbers and the number of patients seen. However, there is no nationally standardized set

of mental health-specific quality indicators to support routine assessment of service effectiveness, user experience or recovery outcomes.

The Pilot Project introduced basic performance reporting requirements, which have improved transparency in service activity. Nevertheless, these data remain largely quantitative and are focused on structural and procedural indicators rather than clinical outcomes, functional improvements or patient-reported experiences. Initial evaluations of the Pilot Project, which were conducted by the Ministry of Health and academic institutions, have noted improvements in accessibility and user satisfaction. However, these findings are constrained by methodological limitations, including the absence of baseline data, standardized outcome measures and control comparisons.

Some stakeholders underscore the progress made in establishing the foundations for a national performance framework, although others emphasize that current monitoring remains overly basic, with limited integration of validated tools or outcomes that reflect service-user priorities.

Robust monitoring and evaluation of the mental health care system are hindered by fragmented data systems, undefined indicators and limited performance oversight and treatment effectiveness. Fundamental services – such as psychoeducation, social prescribing or recovery support – are not adequately tracked. A national mental health care information system must be developed to support transparency, learning and strategic decision-making.

Recognizing these gaps, national stakeholders have initiated efforts to develop a comprehensive set of quality indicators for mental health care services. These would include metrics on accessibility, continuity of care, patient satisfaction, functional recovery and clinical outcomes and may be linked to future service contracting and funding mechanisms. Plans are also underway to build digital infrastructure, including real-time dashboards and public reporting platforms, that would enable timely decision-making and accountability.

3.9.3 Recommended actions

- Establish system-wide quality assurance by:
 - embedding clinical and organizational standards into contracting, financing and service accreditation; and

⁸ European Union. Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation). Official Journal of the European Union. 2016;L119:1–88.

⁹ Poland. Act of 6 November 2008 on Patients' Rights and the Patient's Rights Ombudsman. Journal of Laws. 2009;52(417).

- aligning monitoring systems with service delivery realities, including indicators for user experience, recovery outcomes and cross-sector coordination.
- Strengthening the performance evaluation by:
 - incorporating mental health-specific indicators, including measures of recovery, quality of life and service-user experience;
 - promoting transparent public reporting to facilitate peer learning and accountability;
 - leverage digital tools and analytics for real-time monitoring and service improvement;
 - involving service users, families and caregivers in co-producing indicators and evaluation strategies; and
 - supporting independent evaluation through collaboration with academic institutions and civil society organizations.

4. Conclusion

Poland is at a critical stage in transforming its mental health care system, driven by the commitment of national and local stakeholders, alongside policy support and backing from the public. The national leadership for health and mental health, along with key stakeholders from other governmental sectors and local authorities, experts, professionals and advocacy groups, are unified in their commitment to transformative change. Importantly, people with lived experience of mental health challenges and their families are strongly supporting this reform.

The launch of the National Mental Health Protection Programme 2023–2030, which was accompanied by a public investment of 4 billion polski złoty (PLN) [Polish złoty] and the expansion of the CZPs to cover over half of the adult population, reflects clear momentum and vision. This assessment provides a comprehensive and pragmatic appraisal of the system's current status and outlines the next steps to be taken to achieve the following stage of reform.

The assessment confirms the widespread consensus on the overarching goal for mental health care in Poland: to build a universal, person-centred, community-based mental health care system with territorial responsibility and equitable access. The CZP model forms the core of this transformation, offering a territorially defined structure designed to deliver integrated care across outpatient, inpatient, day care and home-based care. However, although CZPs are central to mental health care in Poland, they are only part of the system. The broader mental health care system architecture also includes

traditional outpatient clinics and psychiatric hospitals, which requires coordinated transformation and alignment of care across all components of the mental health care system.

Stakeholders agree on the “what” of transformation – the vision, goals and essential services – but challenges persist in how to achieve this, in particular regarding governance, financing, roles and responsibilities, and system integration. Diverging views on the organization of inpatient care, the structure of the CZPs and the role of lower trained providers are not irreconcilable but require structured, facilitated dialogue and shared problem-solving. The assessment found that the path forward is not about enforcing a one-size-fits-all approach, but will involve preserving and scaling up what works, embedding national standards and supporting locally adapted solutions. The recommendations in this report offer a realistic and actionable path for turning the promise of reform into reality, and ensuring that high-quality mental health care becomes a guaranteed public good for all.

Overall, the assessment underscores the importance of differentiating between population groups with varying levels of mental health need, particularly those with mild-to-moderate and moderate-to-severe conditions. Addressing these differences requires proportionate, needs-based service packages and aligned workforce allocation.

Throughout the system, implementation challenges include fragmented governance, opaque care pathways, gaps in intersectoral coordination, persistent workforce shortages and insufficient financing mechanisms. Yet, these challenges are surmountable by applying the recommended next steps, many of which fall within the existing authority and operational reach of the Ministry of Health, and by leveraging the substantial expertise in mental health care that Poland possesses.

Drawing from the assessment findings, Fig. 6 shows the strengths, weakness, opportunities and threats (SWOT) analysis of the current status of Poland's mental health care system and its readiness for further transformation.

Fig. 6 SWOT analysis of the current status and readiness of the Polish mental health care system for nationally scaled transformation

STRENGTHS

- Strong enabling policy context, including the National Mental Health Protection Programme 2023–2030 and sustained political support.
- Unprecedented alignment among national and local stakeholders in pursuing the national scale-up of community-based care.
- Community-based services (CZPs) currently provide coverage for approximately 50% of the adult population.
- Substantial national expertise in mental health, including proven capabilities in delivering community-based care.
- Existing pilot experience with flexible service models (e.g. Type A and Type B CZPs) provides a practical foundation for further scale up.

WEAKNESSES

- Lack of a unified and operationalized model for stepped, needs-based care pathways at the provider level.
- Uneven geographical distribution of qualified mental health professionals and limited interdisciplinary training to support collaborative practice.
- Structured intersectoral collaboration remains underdeveloped; incentives and mechanisms to engage sectors beyond health are weak or absent.
- Services remain insufficiently adapted to the specific needs of vulnerable populations – including refugees, older adults and forensic patients.

OPPORTUNITIES

Expressed openness across stakeholders to:

- Finalize and implement a comprehensive, stepwise and network-based model of community care that integrates legal, policy and financing mechanisms aligned with both international standards and local needs.
- Assign an intermediate coordination and facilitation team that will further build the national and regional capacity, facilitate the definition of clear governance frameworks and build institutional capacity at all levels to oversee and sustain the transformation.
- Develop and roll out national competency standards for community-based mental health care, alongside scalable training packages for professionals across sectors and disciplines.
- Design and implement a unified monitoring and evaluation framework, supported by national standards and consistent data collection, to guide evidence-based planning and policy.

THREATS

- Absence of consolidated coordination capacity to manage and facilitate a complex, large-scale transformation and build capacity for sustainable national and regional coordination mechanism, risking fragmentation and reform fatigue.
- Lack of cross-sectoral data systems and agreed indicators for service quality, cost and outcomes limiting oversight and the ability to ground decisions in reliable evidence.
- Persistently high levels of unmet mental health care needs, accounting for over a quarter of all reported unmet health care needs in Poland, which could overwhelm services if not addressed strategically.

4.1 Strategic directions for action drawn from the findings of the rapid assessment

1. Ensure with immediate effect the smooth coordination of the implementation of the community-based model of mental health care and stepped care pathways at the national and regional levels to transform mental health care services, and align and integrate the efforts of different stakeholders across multiple components of the mental health care services and sectors. As this capacity does not yet fully exist, an intermediary coordination mechanism should be established in the short term to guide implementation, build institutional readiness and ensure consistency across regions during the transition phase.
2. Implement a nationally integrated model of community-based mental health care services across the life course. A comprehensive model of care – anchored in territorial responsibility – should be fully operationalized nationwide to ensure service availability for all age groups. This will require a harmonized legal, policy and governance framework, along with financing mechanisms aligned with population needs and which are flexible enough to support locally adapted solutions.
3. Build workforce capacity to deliver person-centred, community-based mental health care by coordinating with other capacity-building projects and initiatives, developing national competency standards for the new model of care and delivering targeted training sessions. Competencies for interdisciplinary collaboration must be expanded across health, education, social care and other relevant sectors.
4. Operationalize intersectoral collaboration for mental health care and well-being at all levels through clear governance arrangements, shared responsibilities and sustainable resources.
5. Ensure the system-wise transformation of the mental health care system addresses the needs of vulnerable populations, with particular attention being paid to groups such as refugees, people receiving forensic mental health care in the criminal justice system, children and older adults.
6. Develop and institutionalize a national system for monitoring, evaluation and data use with a comprehensive monitoring and evaluation system, with clear indicators, cross-sectoral data integration and regular analysis, should be established to inform continuous improvement and accountability.
7. The assessment findings have laid out a realistic and actionable path for completing Poland's transition to a modern, community-based mental health care system. The strategic directions for action reflect a high degree of stakeholder consensus, alignment with international standards and a strong policy foundation that is already in place. However, realizing this vision will require more than merely policy intent as it will not merely be a case of continuing "business as usual", but will call for a coordinated and sustained effort across sectors and levels of government, supported by dedicated capacity, clear governance and targeted investment that will not be achieved through routine measures or fragmented actions. The next phase of transformation demands a structured and deliberate approach to ensure that what is now possible in principle becomes fully operational in practice.
8. The opportunity to complete the transition to a comprehensive, community-based mental health care system in Poland is within reach, but it must be actively grasped. Allowing the rare and powerful momentum that is currently present to dissipate risks stalling the progress that has already been made. Now is the time to consolidate gains, act with purpose and commit the necessary resources and coordination to ensure that this transformation becomes not just a vision, but a sustained and lasting reality for the people of Poland.

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