# ***COMMUNITY MENTAL HEALTH CENTRE***

In the last decades institutions of mental health (e.g. mental hospitals) have been regarded by the authorities and society as the best solution and form of taking care of people with psychiatric disorders. Yet, is it the best way to provide aid to these people in a well-developed society and an EU country in the XXI century? Nowadays, when non-materialistic aspects of life such as human dignity, autonomy and integrity are recognized more and more commonly as the most crucial social values in a country, we should strive to a more humanistic model of treating mental disorders, which will allow us to focus on individual needs and rights of each person and patient in the process of treatment and on their way back to self-determination. People, who have been experienced by mental disorders and their families, should become partners and take part in the process of decision -making in their treatment, therapy and social support. Each person has the right to fulfil their potential.

Community Mental Health Centre (CMHC), which is based on the ideas of personalistic axiology (human dignity and human rights) aims at improving the quality of life and health of people, who have been experienced by a psychological crisis acting in the place near their place of living (district, city, town). Thanks to the new approach to a patient, now regarded as a partner in the relation, and thanks to the innovative organizational solutions these people will stand a chance to gain support in achieving a satisfactory level of life and to get back the feeling of their autonomy and integration with the society.

If we expect measureable effects of deinstitutionalization and bringing the psychiatric treatment and social support to services organized in the living environment of the patient, it is to important to plan the process of changes in such a way that it concerns both the organizational change and the attitude change towards people experienced by psychological crises. Both processes should be complimentary to each other, as they have distinct meaning for achieving the state of well-being of isolated and passive, because of their psychological crises, people .

The first planned steps to deinstitutionalization are based on raising social awareness particularly among people carrying out tasks of Community Mental Health Centre towards people experienced by psychological crises. We assume that only the attitude change can push the organizational change into better solutions, more adequate for the needs of beneficiaries. Attitude change is possible only by the joint commitment of stakeholders and beneficiaries of the new model, as it requires good will from all participants involved in the mental health protection system. The change manifests itself in the approach to another man, both to the co worker and to the

beneficiary. Since it concerns the attitude change (one's attitude to personal values) and not the change of elements or strucures of the system, it involves self-awareness, ability to speak to a person at the stage of their own autonomy.

CMHC, basing on personalistic axiology, places the person with disorders in the centre stage - emphasizing their dignity and rights. Educating mental health protection workers has the goal to prepare for building up therapeutic relation with regard to the autonomy of people experienced by psychological crises. It is the first stage towards change. At the further stage, the humanistic approach to people with disorders should be considered not only among the workers of CMHC but in the whole society, which has to cope with the rising number of people experienced by psychological crises. Campaigns and various educational actions which are involved in CMHC activity are to orientate the awareness process of the society in so people are not longer identified as "different", socially deviant or even dangerous, but first of all as the ones who can and should participate in creating social prosperity and culture.

We should be particularly careful so that organizational and institutional purposes do not dominate the individual needs and of a patient. We should work on the relation between professionals and patients so it does not create the distance due to which the patient feels inferior, weaker or dependent. It should allow the patient to get back the influence on their treatment process, encourage them to take decisions and use all their resources to recover. Considering the positive effects in the attitude focused on the needs of a patient and their support network it is advisable to implement the tested European practices for our needs. Here is the attempt to adapt them to the Polish ground.

## SPECIFICATIONS OF MENTAL HEALTH COMMUNITY SERVICE

Model solutions concentrate on two objectives, which are defined from the perspective of benefits of the system user:

1. regaining self-steerability in the different areas of life by people with the experience of mental disorder
2. reconstruction of satisfactory interpersonal relations by a person with the experience of mental disorder

Actions taken by are CMHC concerning substantial and organizational matters are subject to these objectives. The subsequent targets include organizing and coordinating preventive and educational actions and also medical and social support network for people going though and recovered from psychological crises in a way which ensures treatment and support for all recovering patients in the region, city or district - with the exception of cases which definitely require hospitalization.

The Centre is a place, where aid and treatment for patients going through and recovered from psychological crises is organized. It means that it provides basic services of treatment in the area. It is a hub, which connects preventive, medical and aid on one hand and functions coordinating actions taken for patients on the other hand. It also serves as a round-the-clock help line, whose aim is to start cooperation with the patient or organization in order to take external intervention (e.g. emergency, hospital, etc.) in case of a threat to life or health. Coordinating cooperation of the patient in the medical and aid actions, the centre plays the role which has not been performed yet. It helps the patients from the moment of the first crisis to the recovery and playing social roles. It accompanies patients in all symptoms and forms of his psychological crises and life: in the family, at school, at work, in offices, medical and social aid centres, labour market institutions.

One of the most important features of CMHC is to combine three basic functions: prevention and education, treatment and social support. These tasks are funded from different departments, but only when carried out in a complimentary way, they support the patient from the first crisis back to reintroducing them into their social roles, ensuring the whole range of medical and rehabilitation treatments preserving the therapeutic continuity. Therefore the activities of the centre should cover:

1. preventive and educational actions
2. medical treatment in the form of Integrated Medical Services
3. social influence in the form of Integrated Social Support Services

<u>To accomplish the above tasks the centre should follow the following rules:</u>

1. **immediate aid –** the first meeting takes place within 24 hours after information about the crisis no matter who get into touch first. Its purpose is to avoid hospitalization and to enable the patient to express their extreme experiences, often triggered by factual events, terrifying for the patient and unnoticed by their relatives. A quick reaction allows creating a safe atmosphere to talk about these experiences, which have not been unaccepted by the family and there has not been discovered the way to discuss them.

2. **inclusion of social network** - besides the patient also the family, the key members of their social network such as friends, neighbors, colleagues or doctors so all people who have been involved in the situation are invited to participate in the first meeting. The support network allows defining the problem in the correct way;

3. **flexibility and mobility**– treatment should respond to the specific and changing needs of the patient and his family and include methods of therapy which are appropriate for them, their language and lifestyle. The best place for meetings is at the patient's, because of the availability of the family resources, which helps to avoid unnecessary hospitalization;

4. **responsibility** – the person, who has been contacted first is responsible for organizing the first meeting and ensuring the family that they will get the help needed. The team including experts in different fields dependably on the number and sort of problems is responsible for the analysis of the problem and planning the treatment. In case of differences in opinion alternatives are discussed in presence of the patient and his family, which increases their part in decision-making;

5. **ensuring the therapeutic continuity** – the team is responsible for the whole process of treatment as long as it is necessary, in the case of treatment at an outpatients' clinic and in hospital. It allows to avoid situations, in which the change of therapists causes too much concentration on the actions, which need to be taken instead on the treatment process itself. It also means combining different therapeutic methods in such a way, to make them complimentary creating the consistent treatment process;

6. **insecurity tolerance –** is denial of the approach which concentrates on the illness and aims at relieving symptoms by means of medications. This approach builds up the feeling of safety in a patient, and consequently mobilizes his and his family psychological resources to make it possible to share difficult experiences. The time which is gained to analyze the problem allows to avoid premature decisions and erroneous appliance of neuroleptic medications.

7. **dialogicality** – the biggest emphasis is placed on the dialogue and subsequently on the change. The dialogue is a means which allows patients and their families to gain bigger influence on their lives and take control of them. The task of the therapists is to animate an open dialogue basing on the statements of the patient and his relatives in a way which allows to apply their professional knowledge .

## SHAPE OF THE MODEL OF THE COMMUNITY MENTAL HEALTH CENTRE

### I. The Centre of Coordination and 24 Hour Hotline

The Centre of Coordination and 24 Hour Hotline are the flow-in place of information about

patients, actions and the current form of cooperation with the ill. The Centre is also the place of coordination between recovering patients and different institutions and coordinator of preventive and educational actions, campaigns and social information in the district. It coordinates the way the patient benefits from the medical service / social service which has already existed in the area and newly established ones within the model. 24 Hour Helpline which Crises Phone Line is also located there. As a target all inhabitants of a district should know about the existence of such a phone number and its availability. Duty hours at the helpline are staffed by the members of a mobile team with a reservation that it is always a competent person with experience in the clinic work. It can be a nurse, a psychologist, a community therapist etc.. The person taking the call is responsible for organizing the first contact with the patient within 24 hours. A two-member mobile team is sent in case the patient needs it. The team consists of a psychiatrist, a psychiatric nurse, a psychologist, a community therapist or a social worker. The conversation between the mobile team and his family is to plan next steps, which are appropriate to the state of health of the person.

The second task of the Coordination Centre is to collect and process medical and social documentation of a patient on the basis of the regulations concerning professional secrecy or personal data protection. (legal opinion attached to the description of the model) Coordination of the documentation will be gathered in the centre of medical and for a person who has experienced a psychological crisis. The present documentation will serve for the objectivisation of information and will be used to build Individual Recovery Plan. Documentation will be run in the electronic and mobile version. It means that at the implementation state an IT program will be created with a database and files of patients with the applications which will enable the contact by means of the Internet. The program will also be compatible with other more popular programs for running medical documentation or social services in order to integrate data from different IT systems. Coordination Centre of the described program has the third function - coordination of the medical and social services in the working area of the Centre. It should distinguish the sort and number of services and units acting and supporting actions for the mental health state in the area. It should strive to cooperation with all of them and coordinate using the services by the users od CMHC. For example, if a person after psychological crises is entitled for using the services of a centre for people with special needs, a supervised apartment, a day ward or another method of treatment or social support workers should prepare such a solution and fix an appointment and accompany them if needed. (IT program specifications will be attached to the model)

The services in the coordination centre will be provided by members of mobile teams, workers responsible for coordination and keeping in touch with units acting in the area for mental health, workers responsible for preventive and educational actions, IT staff and staff

accommodation and other specialists necessary for reaching targets of the centre. Actions of Coordination Centre will also be supported by recovery instructors (EX-IN).

## II. Informational and Prevention Educational Interventions

Regardless the fact if it is a universal, selective or indicated prevention, the aim of modern prevention programmes is to develop and/or strengthen the individual potential of a person through:

- enabling him/her to gain everyday life skills,
- improving his/her relationships with a family or other important people,
- creating a friendly social environment (family, school, university, work, local community) which will foster personal development. In defining prevention carefully, it is also important to take into account health promotion actions in the modern programmes, including mental health ones.

Information and prevention actions targeted at the greatest possible number of people will help consolidate knowledge about mental disorders, which in turn will serve to maintain one's mental health and to create a friendly, stereotype-free and understanding community, providing support to both healthy and ill individuals.

Prevention and education actions encompass preparing inhabitants and public administration employees of the region (*powiat*) to acquire basic knowledge of mental disorders, to run prevention for various types of beneficiaries and to build the right image of people suffering from mental disorders. The first group to consider is public administration employees who have a direct contact with the client. They shall be prepared to work with people who experienced a mental health crisis, but also to recognize the first symptoms of disease. The training shall be offered to GP's, social services workers, teachers, officers of employment, police, municipal police, court and probation officers, case workers, priests and others. What seems especially crucial is a training for GP's, who often are the first to consult the patient presenting with mental illness symptoms. GP's constitute a present structure to consult the patients presenting with benign symptoms, who do not need a specialized consultation. GP's can also consult patients after treatment in a Community Mental Health Centre (CMHC), it means that they can prescribe necessary medication given in maintenance therapy or control the mental condition of the patient. Therefore, their training in prevention, but also in general dealing with patients presenting with symptoms of mental disorders, is indispensable to create a comprehensive solution. Prevention and education actions should furthermore include employees of a CMHC and supporting them Experts by Experience (EX-IN) –

Instructors in Recovery. Students from high schools and junior highs schools are a very important target group. The model offers them developmental trainings on how to build their self esteem and the sense of responsibility for themselves, and it also provides workshops on mental illnesses. Beside trainings, there should be social campaigns conducted in the region (*powiat*), aiming at building the right image of people with experience of a mental illness. Finally, a written notice informing about help organized in a Community Mental Health Centre and the opening hours of the facility should be distributed to every household.

## III. The Project of Integrated Medical Service (IMS)

The model of CMHC consists of creating the Integrated Medical Service which is a combination of basic medical tasks in the field of mental health, i.e. emergency aid, community, out-patient, day-care and in-patient treatments, specified in Article 5 and 5a of the Act of 19 August 1994 on the protection of mental health. Now, these services are provided by the following health care organizational units: the Outpatient Mental Health Service, Community Treatment Team, Day-care Psychiatric Unit, Hospital, Admissions Unit and hostel. But, what is missing is organizational units providing emergency services. Today's practice does not define the organizational units that should be in charge of such services (maybe except for a hospital admissions unit).

For the needs of the model, the **innovative** solution will be set up, consisting of the Mobile Team Intervention Services and Crisis Intervention Points. The newly-formulated Integrated Medical Service shall bring all the services together into one organizational unit, by combining tasks of different already existing units. The organization of medical service in every case shall be designed individually (tailored-made) with regard to the needs of the patient and defined in the Individual Recovery Plan. As a result of such a combination of tasks in only one organizational unit, the service provider has a possibility to adjust services to the needs of the patient in a flexible way. Thus, it is the service provider who, depending on the needs of the patients, will decide on how many hospital beds and out-patient, day-care, community or emergency services are needed. The needs of the patient, and not of the institution (as in a case when every organizational unit needs to perform the contract), will regulate the number of services provided. In order to implement such a solution, the methods of financing and settling medical services have to be changed. The change should be about the settlement of effects (indicators) and about freedom how to spend funds to organize a given service. The regional budget, calculated according to NHS expenditure per capita in a given region, seems to be an optimal financing solution. However, it is not a perfect model and it also entails a risk of providing low-quality services. Because the client in the system generates

costs, there is a temptation to provide the least cost-consuming services. The risk mentioned here was anticipated and will further be discussed later. The Integrated Medical Service is a universal, and need-adapted type of service, flexible in time. The form of the service will differ depending on the patient at a given time. The core of IMS is the Mobile Team which accompanies the patient, providing therapeutic continuity, from the first episode of crisis till the moment of regaining by him/her social and professional stability.

***Care provided by the Integrated Medical Service***

The IMS provides as follows:

1. Out-patient care,
2. Community services,
3. Day care services,
4. In-patient services,
5. Acute care services.

**<u>Out-patient care:</u>**

*Tasks*

In the field of out-patient care, the IMS provides a comprehensive diagnosis: medical and psychiatric, psychosocial and community-based social ones, together with evaluation of the patient’s functioning. The services also include a medical history, specialized consultations and additional tests (scans, EEG, laboratory tests). The Individual Recovery Plan is also set up, including a pharmacotherapy, psychoeducation, psychological care, psychotherapy, and the scope of social interventions of the integrated social support service is defined. The follow-up meetings help monitor and evaluate the progress of therapy. If necessary, the elements of the therapeutic plan can be discussed together by the team, patient and his/her social network. The frequency of the meetings depends on the patient’s needs and health condition.

*Type of services:*

1. diagnostic, therapeutic and follow-up medical visits,
2. psychological counseling and diagnosis,
3. individual, group, and family therapy sessions,

4. psychosocial support sessions,
5. home and community visits made by a physician, psychologist or a nurse

**Community Treatment Services**

*Tasks:*

Community treatment services are classified as an out-patient care. That is also why, the tasks to fulfill by the community treatment services are similar to the out-patient ones.

In the field of community services, medical care is provided to individuals requiring an intensive treatment in chronic and recurrent mental disorders which severely impede their functioning in everyday life and in the sphere of contacts with other community members. The treatment takes place at the patient's home and also during regular visits in the out-patient facility (1-3 visits per week).

The community treatment services are provided to the patients diagnosed with some organic mental conditions, including symptomatic disorders (F06–F09), with schizophrenia, schizotypal and delusional disorders (F20–F29), mood disorders (affective F30–F39), pervasive developmental disorders (F84) and, sometimes, other mental disorders (F00–F99) requiring community care due to a significant degree of social dysfunction.

*Type of services:*

6. diagnostic, therapeutic and follow-up medical visits,
7. psychological counseling and diagnosis,
1. individual, group, and family therapy sessions,
2. psychosocial support sessions,
3. home and community visits made by a physician, psychologist or a nurse

**Day care services**

The indication for day care treatment is when the patient's health condition requires an intensive medical care, strong psychological and psychotherapeutic support or nursing services, which cannot be provided in an out-patient facility, but there is no absolute indications for hospitalization.

The services are provided everyday during the course of the patient's stay in the unit, from 8 a.m. to 3 p.m. During the rest of the day and at the weekends the patient stays at home.

The day care treatment is intended for the mentally ill falling under the classification ICD-10 (F00

to F99), except for individuals with disorders due to psychoactive substance use (F10,0 – F19,9) and those with mental retardation (F71-F79). The discharge from a day care unit falls after the end of therapeutic process, the further realization of the Individual Recovery Plan is discussed by the mobile team with the patient.

**Hospital in-patient services (around-the-clock)**

*Tasks*

The in-patient mental health treatment takes place either in specialized psychiatric hospitals or in psychiatric units of general and multi-disciplinary hospitals. The treatment in psychiatric unit is provided to the patients diagnosed with all sort of mental conditions falling under the classification ICD-10 (from F00,0 to F99,0), but also those admitted for an observation and evaluation of suspected diseases and conditions (Z03).

The indication for being admitted to hospital is an exacerbation of symptoms, dangerous behaviour, a risk of pharmacotherapy or a need for specialized diagnosis and therapy which are available only in hospital. In the psychiatric unit there should be no more than 30-40 beds in rooms of 1-4 people. The unit should be protected in case the patient wants to leave while being in a health condition threatening his/her or other people's safety. The unit should have a dining room, therapy and occupational therapy rooms, a treatment room, observation room, admissions area and isolation room.

*The rules of hospital admission*

The rules of hospital admission of patients with mental health disorders are regulated by the Act of 1994 on the protection of mental health[1] and by the ordinance of the Minister of Health of 2012 on the detailed procedures of psychiatric hospital admission and discharge. [2] In order to fulfill the criteria for hospital admission, it is necessary to find out together if there is a need for hospital treatment – through medical indications and also by defining a need for treatment with the patient and his/her social network. Then, a written referral is given by a psychiatrist or a physician from the admissions unit and the patient signs a written agreement for treatment. In urgent cases, the patient can be admitted to hospital without a referral. If the patient disagrees, he/she can be subjected to compulsory treatment under Article 23 and 24, or 22.2a of the Mental Health Protection Act. [3] The

1 The Act of 19August 1994 on the protection of mental health (Journal of Laws of 1994, No. 111. item 535).

2 The Regulation of the Minister of Health of 13 July 2012 on the detailed procedures of psychiatric hospital admission and discharge (Journal of Laws of 2012, No., item 854) (Dz.U. 2012 Nr poz. 854).

3 The Act of 19August 1994 on the protection of mental health (Journal of Laws of 1994, No. 111. item 535.

hospital director shall inform the competent court about the involuntary admission within 72 hours. The patient can also be admitted to hospital upon request of the court (Article 29 of the abovementioned Act). During the patient's stay in the psychiatric unit, he/she is subjected to a thorough diagnosis, of medical, psychosocial and nursing character, which is made with participation of a psychiatrist, social worker and nurse. There are also other specialized consultations and diagnostics tests provided. On the basis of a given diagnosis, the Individual Recovery Plan is set up, defining the right pharmacotherapy, nursing care and psychosocial interventions (a psychoeducation and support of the patient and his/her family, occupational therapy, psychotherapy, community and social interventions, trainings, leisure time activities).

The patient's rights are ensured, allowing him/her to have a free contact with his/her family and close people (via letters, phone calls, visits etc.), to have an access to the patient ombundsman in hospital and to leave the unit if his/her health condition is good enough.

If the treatment brings positive effects and the health condition of the patient improves, he/she can be discharged from hospital. However, it is necessary to reassure if his/her mental condition is good enough and to check if he/she does not threaten his/her and other people's safety. Before being discharged, the patient discusses with the Mobile Team the rules of further treatment and the way of rehabilitation and social support.

***Acute care services***

**Admissions unit**

*Tasks*

In the admissions unit, the diagnostic and therapeutic services are mostly provided. This is a around-the-clock service, operating 24 hours, 7 days a week. Its main task is to react in urgent situations. In some cases, it can end up with hospitalization. But, it can also entail a short-term intervention on site and the patient is sent home or referred to other specialized health care facility. The service offers medications, dressings and other medical supplies and, if required, a hospital transportation.

The treatment in admissions unit is provided to the patients with mental conditions falling under the classification ICD-10 (from F00 to F99), but also those who need an observation of suspected diseases and conditions (Z03).

**Mobile Team Intervention Services:**

*Tasks*

The Mobile Team offers acute care services. It is an **innovative** solution in the model. It provides

the patients with an acute care delivered during an intervention by a team of professionals in the case of an exacerbated mental health crisis. When informed about a person in a severe mental health crisis, a physician accompanied by other member of the team reaches out the person in need of help. Being at the patient's home, a physician assess, together with the patient and his/her family (social network), if the health condition is good enough for the patient to stay in the community or if he/she needs a hospitalization. If the patient stays at home, it is defined what type of further treatment and care he/she needs from the part of the mobile team centre.

*Specialists in charge of services:*

- a certified psychiatrist or psychiatrist in training,
- a clinical psychologist or nurse or community therapist.

**Intervention overnight accommodations:**

*Tasks*

The Intervention overnight accommodations are located on the premises of the Community Mental Health Centre. They provide care to patients who cannot deal with a crisis on their own, being at home, and who do not require hospitalization. In the Community Mental Health Centre there are rooms of 2-4 people, prepared for individuals in crisis. The CMHC provides care, support and necessary medical and therapeutic interventions 24 hours a day, 7 days a week. It is designed to help patients in the situation of deteriorating mental health and well-being, when there are no absolute indications for hospitalization. The average length of stay in the CMHC should be up to 10 days. The decision of admission to the hostel is taken on the basis of an agreement between the Mobile Team, the patient and his/her social network and with the support of healthcare professionals. The decision to discharge the patient from the CMHC is taken in the same way. In the case of an individual who is not supported by any social network, the decision is taken by the individual together with the Mobile Team and specialists accompanying them.

*Specialists in charge of services:*

- a nurse,
- a psychologist or community therapist, instructor in recovery or other specialist from the health care centre.

The services are provided only after the user's consent.

This catalogue of services presents the scope of interventions of the Integrated Medical Service (IMS). The Mobile Team cooperates with the patient and his/her social network in creating the Individual Recovery Plan. The Mobile Team selects services offered in the IMS catalogue and

adapts them to meet the recovery goals defined in the Individual Recovery Plan.

## IV. Integrated Social Support Service Project

The main premise of the Integrated Social Support Service is the possibility of flexible and comprehensive selection of services in a manner tailored to the needs of a given system user.
The integrated social service designed for the purposes of the Model combines the following tasks:

1. specialised care services,
2. community self-help centre,
3. self-help club,
4. sheltered accommodation.

The substantive scope of these tasks provides comprehensive support to persons with mental disorders in many aspects of their functioning in the environment. The offer contained in the Integrated Social Support Service comprises all the services mentioned in the tasks above.

**Service catalogue:**

1. Learning and developing skills necessary for living independently and training in day-to-day functioning, includes:

- training in personal hygiene and taking care of one's looks
- training in practical skills
- training in the management of financial resources (budget planning, assistance in making expenditures, improving personal budget management and financial independence)
- training in cooking
- training in interpersonal skills (maintaining contacts with members of the household, peers, work or school mates, local community)
- training in problem solving (including healthy methods of stress management)
- training in spending leisure time (including facilitating access to education, culture and sport, developing interests, individual talent development)
- intervention and assistance in family life,
- cooperation with the family – shaping adequate attitudes to the sick person,

- assistance in official business

2. Support and assistance in employment, including:
   - assistance in completing documents necessary for employment,
   - preparation for the interview,
   - support and assistance in contacts with the employer,
   - solving mental problems resulting from employment or its lack,
   - possibility of consulting employment specialists.
3. Care understood as the facilitation of the treatment process, including:
   - assistance in gaining access to health services,
   - arrangement and monitoring of the attendance of doctor appointments and diagnostic tests,
   - assistance in buying and ordering medication at a pharmacy,
   - monitoring of medicine taking and observing the possible side effects,
   - assistance in using medical equipment and aids, orthopedic aids and maintaining hygiene,
4. Physical rehabilitation and improvement of disturbed functions of the body,
   - compliant with the recommendations of rehabilitation and physiotherapy specialists,
   - exercise therapy,
   - cooperation with specialists in psychological-pedagogical and educational-therapeutic support aiming at versatile activation of the service user.
5. Accommodation support, including:
   - assistance in applying for a flat, negotiating and making payments,
   - specialised counseling in the field of law, psychology, etc.
   - organisation of minor renovations, adjustments, repairs, removal of architectural barriers,
   - shaping adequate relationships between the assisted person and his/her neighbours and housekeeper,
   - temporary around-the-clock assistance in a support centre
6. Other forms of indispensable care

For the purpose of rendering the aforementioned services, the Integrated Social Support Service employs qualified personnel composing the basic team of professionals, but with the possibility to expand the offer with optional professions, if required.

| **Basic Team Members** | **Optional Team Members** |
|---|---|
| Manager of the Integrated Social Support Service | Specjalist in medical rehabilitation |
| Psychologist/Psychotherapist | Physiotherapist |
| Occupational Therapist | Supervisor |
| Community Therapist | Speech Therapist |
| Social Worker | Pedagogist |
| Instructor in Recovery | Other specialists depending on user need |
| Nurse | |
| Disabled Person Assistant | The staff may also comprise employees rendering health care services, especially in the field of rehabilitation and nursing depending on user need. |
| Community Support Worker | |

The tasks of the Integrated Social Support Service are carried out:

1. in a user's home,
2. in the seat of the centre,
1. in any place necessary for the achievement of the objectives of the Individual Recovery Plan,

**<u>Features of the Integrated Social Support Service</u>**

1. The Integrated Social Support Service is created based on the Community Self-Help Centre of A or B type, where mentally ill persons are the dominant group. The newly created structure is called Community Self-Help Centre - A Plus.
2. The seat of the Community Self-Help Centre - A Plus is the base for the Integrated Social Support Service.
3. The Community Self-Help Centre - A Plus may be established as an entity co-forming a Community Mental Health Centre.
4. An Integrated Social Support Service user receives services in the scope and quantity determined in the Individual Recovery Plan, without the obligation of permanent stay in the facility.
5. Settlement of the cost of the service is conducted based on activities documented in the Individual Recovery Plan, on account of administrative decisions issued, not the participants'

attendance.

6. The Integrated Social Support Service renders around-the-clock, day care, mobile and emergency services,
7. Owing to the flexibility of influences the number of persons benefitting from the service will be increased.
8. The Community Self-Help Centre - A Plus shall be exempt from the requirement of 8m2 of floor area per one participant.

**Medical and Social Services Integration**

The real integration of medical and social services in the functioning of the Community Mental Health Centre takes place owing to the Mobile Team and the Individual Recovery Plan tool. The Mobile Team coordinates social and medical services in practice, while the Individual Recovery Plan describes the way in which such integration is to be achieved.

**Mobile Team:**

The Mobile Team has a leading role in the process of patient recovery, but it is also emergency in character – intervention in need. It is a team which performs its task in the patient's home, in the Community Mental Health Centre and any locations necessary for the achievement of the goals contained in the Individual Recovery Plan. It is a point of permanent contact with the patient and the main form of work at the initial stage of treatment and support, as well as at the further stages. The first therapeutic intervention in the patient's home should take place within 24 hours from the obtaining knowledge about a patient seeking help. The team's task is to show initiative and take interest in the further course of the patient's treatment, keeping in touch with him/her irrespective of the structure whose services the patient is currently a beneficiary. In the case of information about an exacerbation of the crisis (acute psychotic symptoms, a situation threatening to the life and health of the patient or his/her family and friends) a psychiatrist is added to the mobile team, who assesses the patient's condition on the spot. The psychiatrist decides whether hospitalisation is recommended, or the person can use community treatment. The form of treatment and further contacts with the Community Mental Health Centre is always agreed on. The Mobile Team can also take over the role of out-patients care. In the model functioning, the Mobile Team is the real integrator of medical and social services. Each Mobile Team comprises of at least two persons, one competent in rendering medical services and the other competent in social services. The Mobile Team is responsible for the creation of the Individual Recovery Plan, together with the person in crisis and the person's social network. Coordinating the process of the Individual Recovery Plan and its evaluation is also within its scope of activity. Depending on the patient's current health and

social condition, as well as the needs and goals defined in IRP, the Mobile Team selects specialists from medical and social care structures. It has a wide range of specialists to choose from: a physician, psychologist, psychotherapist, nurse, community therapist, specialists in vocational activation and many others. Also, the character of interventions may take on various forms, of services rendered: around-the-clock, daily, individually, in group, at home, at a health care or social care facility, etc.

**Individual Recovery Plan:**

The Individual Recovery Plan is an integrator and monitor of medical and social services rendered within the model. It is the main document describing the scope of changes in the patient's recovery process.

The Individual Recovery Plan is created by the Mobile Team with the person in crisis and his/her social support network and, if necessary, in cooperation with (counseled by) other specialists, such as a psychiatrist. The document comprises of several sections.

**Section I – Diagnosis**

It is a functional diagnosis based on ICF and resource examination, combined with medical diagnosis based on ICD-10 and a psychological one.

**Section II - Crisis Plan**

A crisis plan is created on the foundation of diagnostic knowledge and with the patient's participation, an instruction of steps taken in case of mental health deterioration.

**Section III – Therapeutic Plan**

Another element is the determination of short-term and long-term goals, together with a path to achieving them, that is, a selection of forms (elements, single services) of the Integrated Medical Service and Integrated Social Service for a given patient.

**Section IV – Course of Recovery Process**

This section of the Individual Recovery Plan is a description of the implementation of medical and social interventions. Based on Section IV of the Individual Recovery Plan, it will be possible to determine what services were rendered to a patient and the budget from which they were financed. In the scope of medical interventions, these are: social support sessions, individual and group, emergency, out-patient, community, day and around-the-clock interventions.

In the scope of social interventions these are: social support network meetings, individual and group interventions, cooperation in interventions (emergency, non-medical ones), basic life needs, social rehabilitation, functioning is the family environment, obtaining and maintaining employment and accommodation assistance.

**Section V – Evaluation**

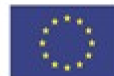
Each implementation of the Individual Recovery Plan is to be evaluated. IRP implementation will be assessed and, possibly, modified, every 6 months, or when a need arises to do so. The assessment will be conducted by an Interdisciplinary Team including the Mobile Team, in the presence of the sufferer and his/her support network.

**Initiation of cooperation with the Community Mental Health Centre**

The system may be entered by various forms of contact: the helpline, the patient's personal visit to the Coordination Centre, notification made by a family member, etc.

- Having received information about the patient seeking help by means of helpline or appearance in person, the patient participates in an initial conversation with the person accepting the notification about the problem. After the initial conversation, the person is directed to the Mobile Team, who start to construct the Individual Recovery Plan.

- In the case of crisis exacerbation, a patient receives a doctor appointment. Together with the patient, the doctor and other team members decide whether the patient can be treated in the out-patient care, or must be referred for an in-patient treatment. After hospitalisation the patient returns to the Mobile Team, who commence work with the use of IRP.
- If the helpline dispatcher assesses that a patient's situation is serious, a decision will be taken about sending the Mobile Team to the spot, assisted by a psychiatrist. During such an intervention visit at the patient's home, the doctor, together with the team, the patient and the family decides whether the patient can be treated in the community or requires hospitalisation. If there is risk to the patient's health and life, the team call emergency medical services.
- If, in a conversation with an helpline dispatcher, a patient calling the centre states that the problems requiring solution require social intervention, he or she is directed to the Mobile Team and work on IRP begins.
- Well adjusted patients who only require a check-up doctor appointment and do not need more profound support, will be directed to the doctor, to await their visit.
- A variation of the entry into the model services is also a situation in which during a call to the helpline the problem is estimated not to require an emergency intervention, a date will be set for the Mobile Team visit at the patient's home or at the CMHC. Since this moment, following the patient's consent, the work commences in compliance with the IRP



procedure.