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From Institutional Walls to Community-Based Treatment – the Changing Forms of Support for People in Mental Health Crises

According to the epidemiological study – EZOP II (2021), approximately 9 million Poles suffer from mental disorders. The statistics concerning the number of suicide attempts, as well as the scale of serious mental health crises among children and young people are increasingly worrying. The broadly understood support system faces the challenge of organising professional help for an increasing number of people who are at different stages of illness and therefore have different needs. The aim of this paper is to describe the process of changes in the approach to supporting people in mental health crises, with a particular focus on the transition from an asylum model geared towards inpatient treatment to a community-based model enabling people to receive support provided in a form as open as possible. The lack of long-term isolation is thought to counteract the phenomenon of stigma and to accelerate recovery from the deviant social role of the patient. The article presents specific community-based forms of support: Mental Health Centres, day wards, sheltered housing, and NGO activities. The impact of the community-based model on the wellbeing of not only the persons suffering, but also their loved ones and society as a whole, is assessed. Questions are raised concerning the future of the community-based model. The paper, apart from an attempt to diagnose the current situation, refers to sociological concepts, primarily from the sociology of medicine and the sociology of the family.

Keywords: community psychiatry, forms of support, mental health crisis, mental illness

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Introduction

Mental health constitutes an increasingly significant social problem. According to an epidemiological study (EZOP II 2021), 26.5% of Poles suffer from at least one mental disorder, which translates into nearly 9 million people. Over the course of a decade (since the first EZOP survey carried out in 2011), we have seen an increase of more than 3 percentage points in this respect. The most common mental health conditions are anxiety disorders and affective disorders. We report high (above the European average) suicide rates of 2.9 per 100 000 people in women and as many as 21.4 in men (WHO 2020). This translates into around 12,000 suicide attempts per year, of which around 5,000 end in death (Police Headquarters 2022). The increase in the incidence of serious mental disorders among children and young people is of particular concern. Data from the National Health Service (NFZ) indicate that between 150,000 and 200,000 minor patients receive psychiatric care each year, with around 13,000 requiring hospitalisation. The psychiatric care system is already failing to keep up with the exponentially increasing demand to provide professional help to this group of patients. As a result, we have overcrowded hospital wards and very long waiting times for specialists – psychiatrists and child psychologists. The pandemic, which isolated young people from their peers for several months, had its share of impact on the negative consequences[2].

Mental health problems can hardly be expected to decrease in severity in the future. On the contrary, the available data and experience from other European countries lead us to assume that the following years will show increases in the incidence of mental disorders among both adults and minors. Therefore, the broadly understood support system faces the daunting challenge of providing professional and comprehensive assistance to the millions of Poles struggling with mental health crises[3]. The main part of the article will be devoted to describing specific forms of support (increasingly often referred to as support practices), understood as "professional activities and services implemented by the mental health care system, the social welfare system, as well as non-governmental organisations and other entities" (Rymsza 2023: 7)[4].

[2] The negative impact of the pandemic on mental health is confirmed by reports from the World Health Organization. According to the 2022 data, the global prevalence of anxiety disorders and depression increased by 25% during this time. One of the main reasons for this was the stress caused by isolation. Fear of infection, suffering, death of loved ones, and financial worries were also significant (Szczepaniak 2021). According to a survey conducted by UCE Research – 38.5% of respondents rated their mental health as having deteriorated during the pandemic. Symptoms that respondents observed in themselves included stress, lowered mood, sleep disturbances, frequent feelings of anxiety, activity disorders, and lack of energy (Stelmach 2022).

[3] The phrase "people in mental health crises" will be used throughout the article. It is a phrase that is less stigmatising than a person suffering from a mental disorder.

[4] Due to its different character, the text will not address the issue of treating addiction or forms of support for people with intellectual disabilities.

From an asylum model to a community-based model

Mental crises have always been with us. However, the approach to those affected varied significantly depending on the region and the historical period. Sick people could count on kindness and support or they were isolated and, in extreme cases, even eliminated from society (Brodniak 2000). Until the middle of the 20th century, the predominant model was the so-called "asylum model", which on the one hand provided patients with care and treatment methods adapted to the possibilities of the given time, and on the other hand consisted in separating them from society. Unfriendly, located on the outskirts of cities, and completely closed psychiatric hospitals, ineffective and full of side effects pharmacotherapy, limited therapeutic forms, failure to respect the basic rights of patients – this was the reality of psychiatric care at the time. Hospitals often took the form of Goffmanian total institutions[5], and patients stayed in them for very long periods of time (often years) with no apparent improvement in their health[6]. Much has changed in the 1950s, when the anti-psychiatry movement began to develop in the United States. Its representatives not only fought for the basic rights of people in psychiatric hospitals to be respected, but also called for treatment to take place to a much greater extent in the community and with the involvement of local communities. The example of the United States was also followed by other countries, primarily European, where representatives of the anti-psychiatry movement began to make their voices heard more and more. In places, their ideas were becoming highly radical. This was the case, for example, in Italy, where decisions were made in the 1970s to stop admissions to psychiatric hospitals, resulting in closing them. This ill-conceived decision has done more harm than good, but in the vast majority of locations, the switch from an asylum model to a community-based model proved to be a turning point and has contributed to significant improvements for people experiencing mental health crises. What was already becoming the norm in the 1970s in the United States, Scandinavia, or Western European countries, we had to wait much longer for in our country. The first attempts to implement the community-based model in Poland took place in the 1990s, but they were highly limited and did not yield the expected results. The first tangible movement in this direction was made in 2010 with the attempt to implement the National Programme for Mental Health Protection (NPOZP) for 2011–2015 (Journal of Laws

[5] The concept of total institutions was described by Erving Goffman in 1961, who defined them as social organisations within which a closed group of people, formally controlled by its staff, live. Examples of total institutions include concentration camps, prisons, military barracks, boarding schools, monasteries, and psychiatric hospitals (Goffman 2011).

[6] The situation of people in psychiatric hospitals in the asylum model is very well illustrated in *One Flew Over the Cuckoo's Nest*. This 1975 Oscar-winning film by Milos Forman became one of the symbols of the anti-psychiatry movement and has helped to improve the situation of people with mental illness.

of 2011, no. 24, item 128), which was the result of the joint work of many involved communities and which was considered one of the best designed and most comprehensive documents of its kind in Europe. Unfortunately, the NPOZP turned out to be a complete failure. This is confirmed by a report by the Supreme Audit Office (NIK 2016) indicating a great scale of neglect and omission. It is enough to mention that at that time the Minister of Health failed to complete 29 out of 32 tasks, and the performance of other governmental units can be assessed only slightly better. Therefore, it is not surprising that the vast majority of the Programme's objectives have not been met. Another significant moment came in 2017 with the new edition of the NPOZP, this time scheduled for 2017–2022 (Journal of Laws of 2017, item 458). It appears to have been taken more seriously, with appropriate legislation and funding secured in its implementation. In 2018, a pilot of Mental Health Centres (CZP) was launched, scheduled to end in 2022 (Journal of Laws of 2020, item 2086 and 2364 as well as 2021, item 1976, 2012, and 2491). It was eventually decided to extend it until the end of 2024 (Journal of Laws of 2020, item 2086 and 2364 as well as 2021, item 1976, 2012, and 2491). The CZP, intended to constitute the basis of the community-based model, will be described in more detail later in the chapter.

The process of transition from an asylum model to a community-based model can be summarised as follows. The vast majority of countries where psychiatry is at a high level already have this reform long behind them. In such countries, the community-based model constitutes the primary form of care for people in mental health crises. In the case of Poland, we are at least 20–30 years behind and are now making up for lost time. We are – maybe not at the beginning – but somewhere in the middle of a path from which we can no longer turn back. It is important that the following decades (because that is probably how long it will take to complete the process) bring more decisive and consistent action that will actually bring us closer to the goal of implementing the community-based model. This would certainly constitute a qualitative change extending universal and comprehensive support to people in mental health crises.

The community-based model in practice

What is the much-talked-about community-based model in practice and what opportunities does it offer to replace the asylum model for good? It is an example of deinstitutionalisation activities that cover many areas of our lives[7]. Deinstitutionalisation

[7] The issue of deinstitutionalisation is dealt with, among others, by the University Observatory for the Deinstitutionalisation of Support Practices (UODI), which has produced expert reports concerning people experiencing mental health crises, addicts, people in the crisis of homelessness, people with disabilities and people in foster care. They are all available at UODI website.

is "a process of transition from organising support based on institutional solutions – where the primary role is played by 24-hour long-stay institutions – to organising support in a community-based way, using social service infrastructure and local community resources" (Rymsza 2023: 7).

Thanks to the community-based model, patients can count on various forms of support tailored to their current needs. The only thing that was offered to them before was closed treatment. Even if it turned out to be necessary and had the intended effect, the patient did not have the option of continuing it in an open formula. Due to a lack of options, patients with less severe symptoms who did not require such a radical form of support at all were also admitted to hospitals. Thanks to the community-based model, people in mental health crises now have an entire range of solutions – from strictly institutional (24-hour wards) to intermediate forms (day wards), up to community-based solutions (e.g. sheltered housing). Importantly, they are not alternatives to each other and patients can benefit from all of them. This is very important, for example, for people with serious mental illnesses (e.g. schizophrenia), which cause a range of not only medical consequences but also social ones. In their case, a step-by-step progression through all forms of support is recommended – from the 24-hour ward in the acute phase of the illness, to day wards when the condition becomes clearly stabilised but the patient still needs constant assistance, up to fully community-based solutions that motivate independence and a return to an active social life.

Day wards and sheltered housing

Day wards are facilities run by psychiatric institutions that can be described as an intermediate form between inpatient and community-based treatment. Patients stay in the day ward for a given period of time (12 weeks), participate in activities and therapy during the day (minimum 5 hours), and return to their homes for nights and weekends. During their stay, they remain under constant medical and therapeutic care, have a structured daily schedule, participate in various activities and trainings, and actively participate in group life. The offer of day wards is primarily aimed at two groups of patients. Firstly, to people who have completed their stays in 24-hour wards, but whose condition requires continued treatment in an inpatient setting. Secondly, for people who are experiencing relatively severe mental health crises, but whose symptoms are not as acute and threatening that closed treatment is necessary. Thus, day wards counteract social isolation and

allow patients to continue the treatment process in their own homes, surrounded by people close to them, in a friendly and safe environment[8].

One step further in the community-based direction consists in sheltered housing, where people with a serious mental health crisis seek to become independent, active, and acquire a range of skills to function outside the psychiatric care system. This is particularly important for people who become ill at a young age and have not had time to develop these abilities, or for people who have a chronic illness and have therefore withdrawn from active social life for a long time. Stays in sheltered housing last on average 6–12 months, and during this time participants are supported by professional staff and take part in an extensive programme of activities and training (preparing them for independence, including cooking, housekeeping, job-seeking, and social skills). No less important is the very fact of living with a group of people with similar problems. It is the daily interaction with people, the support provided to each other, and the friendships formed during the time spent together that lead to a significant improvement in the functioning of most participants at the end of their stay, especially in terms of independence, activity, and social skills. Sheltered housing constitutes housing located in ordinary residential areas, where neighbours usually do not even know that such a project is taking place. Participants go to work or school, shop, run all sorts of errands – they are full-fledged members of the local community. This constitutes the essence of community-based thinking. Thanks to sheltered housing, even people with more severe and chronic illnesses can remain in the community, be its active part, and gradually acquire the skills necessary to become independent. Sheltered housing constitutes a form of support on which psychiatric treatment is largely based in Western European and Scandinavian countries. They have been operating in Poland for several years and their number is steadily increasing[9]. In many cases, sheltered housing is an example of proper cooperation between medical institutions (which provide professional staff), social workers (who carry out the formal process of referring a person to a sheltered housing unit), and non-governmental organisations which, by entering competitions to run such places, constitute partners for local governments and take on the organisational burden.

[8] A similar task to day wards is carried out by the Community Self-Help Centres (ŚDSs), which are run as part of the social welfare system. People in mental health crises can stay there during the day, taking part in a diverse programme of activities. Such facilities aim to activate and counteract the social exclusion of chronically ill people whose health condition is not significantly improving and does not allow them to be socially active (e.g. professionally).

[9] Currently, there are nearly 1,500 sheltered housing units with places for 4,500 people with disabilities and various mental disorders. Importantly, they are being established not only in large cities but also in smaller centres where this type of support is also badly needed (*Nowe mieszkania* 2023).

Mental Health Centres

Undoubtedly, day wards and sheltered housing constitute an important part of the community-based model. Due to the specific nature of the assistance provided and accessibility, a limited number of people can benefit from their services[10]. The most important and widespread element of the support system for people in mental health crises is to be the Mental Health Centres, which will be established in each county or district of a large city and in territorial terms cover no more than 200,000 people. Regulation of the Council of Ministers of 8 February 2017 (Journal of Laws of 2017, item 458) specifies what elements a single CZP consists of: an outpatient team (clinic) providing specialised advice (psychiatrist, psychologist, psychotherapist, nurse, and social worker), a community team (mobile) providing, among other things, home visits, a day ward, and a hospital team that provides 24-hour hospital care in the event of severe symptoms. Importantly, the CZP offers a variety of forms of support, tailored to the needs of the individual patient. When necessary – hospital wards and day wards are available. Mobile teams capable of providing home treatment are in place. However, a great part of assistance is provided in the form of outpatient specialist advice. The most important advantage of CZP is their accessibility. They offer free support available 24 hours a day, without a referral or the need to sign up for an appointment. The first contact takes place at the application-coordination points, where, after a conversation with a specialist, specific forms of assistance are proposed, adapted to current needs.

As part of the pilot conducted since 2017, approximately 100 CZP have been established so far (data from the NPOZP Pilot Office). The problem is that they are distributed unevenly – they are established primarily in large and medium-sized urban centres, where there was already a well-organised support network[11]. We still have more than a year of the pilot period ahead of us, as it has been extended until the end of 2024. During this time, additional CZP will probably be established, although it will be a very long time before we can say that they cover the majority of Poles. However, the direction is definitely right and should be continued. Organising a network of CZP across the country would provide people experiencing mental health crises with a variety of forms of support tailored to their current needs, a great part of which could be provided in a community-based model.

[10] Day wards constitute a continuation or substitute for 24-hour treatment, so they involve people with more severe illnesses. Whereas, sheltered housing is too scarce in our country to speak of its universality.

[11] This is due, among other things, to the requirement for a CZP to include a 24-hour ward. As a result, following CZP can only be created where psychiatric hospitals are still operating or, alternatively, where it is possible to organise an inpatient unit in general hospitals.

The activity of NGOs

In the asylum model, virtually all responsibility for organising forms of support lays with the mental health system. Whereas, in the community-based model the third sector plays a very important role and is perceived as a partner of the health and welfare system. NGOs operating within the area of mental health are involved in implementing certain forms of support (e.g. sheltered housing), often playing a key role in them. Their important activity also consists in carrying out various social actions of a preventive or educational nature. This type of activity has a tangible effect – it impacts public awareness, develops proper attitudes, and makes the public start to care about their health and respond appropriately to emerging problems. NGOs can successfully do what medical institutions do not usually have the time or resources to do. A number of campaigns concerning mental health issues have been developed and successfully implemented in recent years, including those in terms of depression and autism: "Twarze depresji – nie oceniam. Akceptuję"[12], „Nastoletnia depresja. Nie pozwól dziecku wylogować się z życia"[13], or „Autyzm wprowadza zmysły w błąd"[14].

An important part of the third sector's activities is carrying out initiatives of a supportive nature. More and more self-help groups are being established, both for those suffering from mental condition and their relatives, "clubs" are being operated to activate chronically ill people who are unable to work or study, and so-called "helplines" are being organised. Thanks to these, people experiencing mental health crises have the opportunity to receive support "here and now" as well as information on what they should do next in terms of their problem and whose help they can take advantage of. The helplines constitute a form of prevention against the great tragedy of suicide attempts.

One of the most important principles of the community-based model consists in inclusion and social activation. It is not just a matter of getting people in mental health crisis back to work and other pre-sickness tasks as quickly as possible, but also of taking advantage of their knowledge and experience. This is the nature of, among other things, the currently developed project named Recovery Assistants – persons with experience of their own mental health crisis who, after appropriate training and with the support of professionals, can be employed in facilities and support patients in their recovery process. A person who has personally gone

[12] A campaign in which well-known figures from the world of popular culture talk about their experience of battling depression.

[13] A campaign aimed at parents and teachers drawing attention to the problem of depression among children and young people.

[14] A campaign in which actor Bartosz Topa acted out scenes from the everyday life of a person affected by autism spectrum disorder.

through a mental health crisis is activated and encouraged to help others. This allows that person to feel needed, to gain self-confidence and to have a feeling of doing something really valuable. In turn, patients who are currently facing a mental health crisis have the opportunity to take advantage not only of the support of professionals (doctors or therapists), but also to draw on the experience of people who understand perfectly well the problems they are experiencing.

Assessment of the community-based model from the point of view of a person in a mental health crisis

Research indicates that the initial hospitalisation is considered – next to the onset of the illness – to be the most difficult moment of the entire illness process. The element most difficult to deal with consists in isolation from relatives, poor social conditions, and the presence on the same ward of patients experiencing different difficulties and at different stages of the recovery process[15]. Treatment in the community-based model is perceived to be far more friendly. There is talk of non-isolation, subjective treatment, a sense of being free and not being deprived of causative capabilities and self-determination. The "homely" atmosphere that prevails in day wards or sheltered housing is also emphasised (Glinowiecki 2014)[16].

It is very important that the community-based model does not leave the patient without the professional care that in the asylum model was provided by psychiatric hospitals (pharmacotherapy, psychotherapy, social support). This type of support is available but is adapted to current needs. Primarily, long-term "detention" in psychiatric institutions is avoided. Instead, community-based solutions are offered in a completely open formula. This is extremely important, as some patients, after years in psychiatric institutions, become "addicted" to the support they receive there and are unable to function normally. At this point we touch upon the extremely important – from a sociologist's point of view – topic of social roles. Talcott Parsons – the most prominent representative of functionalism believed that illness could become a deviant social role. An individual fulfilling certain social roles is forced to take on a completely new role as a patient, with all its consequences, when serious health problems arise. These are both positive and

[15] For example, in one room there is a depressed person – in need of peace and quiet – with a psychotic person who behaves very loudly.

[16] Research concerning the social and family aspects of functioning of people with schizophrenia was conducted in the form of interviews between 2012 and 2016 at the Institute of Psychiatry and Neurology in Warsaw. The respondents (90) were people suffering from schizophrenia (50), family members of people suffering from schizophrenia (20), and professionals working with people with schizophrenia (20).

negative. The former relate to the sanctioned temporary exemption of a unit from certain tasks (e.g. professional – sick leave) and the fact that the person is subject to state care during illness. However, the negative consequences appear to be more significant. The patient "falls out" from the normal social roles, ceasing to be an active member of society. During the illness, that person relies on others, including, primarily, the medical institutions, to which Parsons attributed a very important role (Parsons 2009). They determine who is granted the status of a sick person and who does not deserve it. This is particularly the case for people experiencing mental health crises, where objective criteria are often hard to come by while the diagnosis and prescribed treatments are often the result of the subjective feelings of doctors.

Due to the fact that the patient's social role is regarded as deviant, the affected individual is expected to end it as soon as possible and return to more desirable social roles. Long-term hospitalisations, characteristic of the asylum model isolated the individual and "forced" that person into psychiatric institutions for long periods of time, which became increasingly difficult to leave (not only literally, but to a large extent also mentally). Even when it was possible to leave the hospital ward and get better – further support was lacking. The patient would return home and have to deal with the situation individually, not always ready to function at their pre-sickness level. The community-based model has much more to offer in this regard. First of all, a person in a mental crisis either does not go to a psychiatric hospital at all or, if necessary, returns from it relatively quickly. At that point, the person can continue treatment in day wards, sheltered housing, or in an outpatient form in terms of the Mental Health Centres (or a growing network of private facilities, the number of which exceeds the public ones many times over). If health allows for it – the individual can work normally. When returning to the open labour market is not possible for objective medical reasons, the social assistance system offers appropriate benefits (e.g. a pension) and the patient has the opportunity to gain work experience in sheltered workshops[17]. Thanks to the activities of the third sector, which in the community model participates significantly in supporting people in mental health crises, they can actively participate in specific projects and initiatives, playing an important role in them. Working as a Recovery Assistant constitutes an opportunity to take advantage of one's knowledge and experience to support others, thus overcoming one's own barriers and eventually gradually returning to other social activities.

The community-based model counteracts isolation and exclusion, allows for treatment in an environment that makes patients feel safe, is inclusive and activating. All this means that a person in a mental health crisis can avoid entering the

[17] Protected workplaces are entities with special legal status (granted by the provincial governor) which, according to the regulations, must employ at least 30% of blind, mentally ill, or mentally handicapped persons classified as having a significant or moderate degree of disability.

Parsonian role of a sick person and instead realise other social roles from which they will derive satisfaction. It has been known for a long time that the healing process goes better when we are active and have a support network constructed around us. In the community-based model, the person experiencing a mental health crisis is surrounded by other people – he or she lives in his or her own home, has contact with his or her family, friends, neighbours. By participating in structured forms of treatment, that person receives support not only from professionals (primarily doctors and therapists), but also from fellow patients. It is precisely this type of relationship – of people united by this experience of battling an illness and experiencing similar problems – that is recognised as being of vital importance in the healing process (Glinowiecki 2014).

Evaluation of the community-based model from the perspective of the relatives of a person in mental health crisis

The experienced mental crises can disrupt the family system and result in a range of negative consequences in the family – the emergence of bad emotions, conflicts, communication problems, blaming each other and, in extreme cases, can even lead to the family breaking up. On the other hand, the patient's relatives play a great role in the recovery process. They are usually the first and primary support group for that person, organising the treatment, supporting the patient, and helping to solve the patient's daily problems. The onset of a mental illness is particularly difficult. This is the moment when acute symptoms appear, when the family does not understand what is happening to their loved one and does not know how to help. It can also happen that the patient starts to endanger themselves or their fellow residents, who are faced with a very difficult decision: to call an ambulance (which can be traumatic in itself) or to try to deal with the situation on their own (Glinowiecki 2019). Critics of the community-based model argue that, as it develops, relatives of sufferers will increasingly face such situations. The assumption that hospitalisation is a last resort, and that other, open-ended treatments should be considered first – places a heavy responsibility on the family. It is precisely the relatives of the person in mental health crisis who are supposed to be one of the pillars of support, keeping them safe, arranging treatment, or supporting them in their daily difficulties. Many families are unable to cope with such a burden. Usually not because they do not want to show support, but because they do not have the right resources, do not understand what is happening, and lack the practical knowledge of how to deal with the situation they are facing. For these reasons, it is of the utmost importance that those who are assigned such a responsible role are not left alone with this but are properly looked after. The

community-based model offers them the opportunity to undertake their own therapy and pharmacological treatment, take part in dedicated support groups or enhance their knowledge through educational activities. However, it seems that there is still not enough of this type of action and that relatives are too often left alone with the problem. When planning new changes, it is important to bear in mind that it is not only the patient who needs help, but also the entire family system, and that the patient's relatives will only be able to support the patient if they are equipped with the right knowledge and can count on specialist help themselves.

Evaluation of the community-based model from a societal perspective

Long-term mental crises that prevent an individual from fulfilling basic social roles result in high costs for the state. They are currently estimated to be in the tens of billions, which includes the need to organise medical and social support. Disturbing data is presented by the Social Insurance Institution, whose analyses show that mental disorders constitute one of the most common reasons for sick leave in our country. In 2023, this was 9.8% of all sick leave. This translated into 26 million days off (*Coraz więcej zwolnień lekarskich* 2024). A mental crisis triggers an entire avalanche of further costly events. The patient is forced to undergo treatment, which often lasts many months. During this time, that person cannot work, which translates into the need to provide him or her with adequate benefits. In the case of serious health problems, it sometimes happens that the patient – despite his or her young age – never returns to work again, and for many years draws a pension and receives support from specialist facilities. Precisely for these reasons, it is extremely important to implement a community-based model, which initially allows mental health problems to be diagnosed at an early stage and appropriate treatment to be implemented in time (thanks to the availability of specialists and the strong role of prevention); secondly, it provides support, an important element of which consists in motivation and providing tools for being active. As already stated – patients are supposed to stay in isolation for as short as possible and then continue their treatment in an open form, which does not prevent them from returning to work or school. As a result, treatment in a community-based model is less expensive and ensures that the vast majority of people experiencing mental health crises will not burden the state budget in the long term.

In addition to the financial dimension, the one related to the shaping of social attitudes seems even more important. Mental health, despite the many positive changes that have taken place in Polish society in recent years, still constitutes a taboo for many people, which is not spoken about loudly. There are still many

myths and stereotypes about mental illness and those affected by it, and there is low awareness of mental health hygiene. One of the fundamental reasons for the distrust of Poles towards people experiencing mental crises is social isolation and the lack of presence of this group in the media space[18]. We are afraid primarily of what we do not know – the lack of daily contact with people in mental crises leads to stereotypical thinking, which then translates into concrete negative social attitudes. In extreme cases, the phenomenon of stigma described by Erving Goffman can occur. The stigmatised person possesses (at least in the opinion of others) a certain attribute or characteristic that devalues that person in a particular social context (Crocer et al. 1998). In the case of mental illness, stigma stems primarily from perceiving the patient as having personality and behavioural deficits, which to a large extent results from the label given rather than the patient's own experiences (Goffman 2005). The community-based model prevents this by activating and integrating people experiencing such problems into society. It will probably take some time to create a sense in the society that mental illnesses are not unique or different from other conditions, and that people experiencing them do not need special treatment at all. However, in recent years much has been achieved in this regard, in which initiatives implemented by NGOs in particular have played a crucial role. Educational and media campaigns, activation activities – all of these bring people in mental health crises much closer to society, becoming "familiar" rather than "strangers".

What lies ahead? The future of the community-based model

Deinstitutionalisation and community-based forms of support for people in mental crises are global standards, which we are also slowly moving towards in our country. We have already lost a great deal of time, which means that we are only in the middle of a process that others are long behind[19]. On the one hand, it provides us the opportunity to learn from their experience and avoid incorrect decisions. On the other hand, given the current situation and the great need to provide professional support – we cannot afford to take apparent action and waste any more time. Bold decisions at government level, proper legislation

[18] At this point, it should be noted that society's attitude varies depending on the disease entity. While in Poland, thanks to, for example, successful media campaigns, depression has been "disenchanted", the situation is far worse for people suffering from, for example, schizophrenia. It is still a disease that evokes negative social reactions, which translates into the daily lives of those suffering from it.

[19] In the case of our country, we can currently speak of an institutional change in the psychiatric care system rather than complete deinstitutionalisation. This is because there has not yet been a sufficiently advanced process of transferring psychiatric care to the community and there is too little community involvement in supporting people in mental health crises.

and securing funding are needed, as well as a great determination from the community itself to create specific services and solutions for people in mental health crises. There are many specific challenges ahead. Firstly, covering the entire country with the community-based model, and not, as before, a few dozen cities and counties where pilot CZP have been successfully organised. Secondly, dealing with the collapse of child psychiatry, the main problem of which consists in the lack of specialists, which translates into an insufficient number of facilities, as well as very long waiting times for appointments. Thirdly, further education and striving to change social attitudes towards people experiencing mental crises, as they are still full of stereotypical thinking. Fourthly, providing more support to the relatives of sick people than is currently the case, bearing in mind that the illness affects the entire family system.

At this point, it is still worth answering the fundamental question – to what extent should the deinstitutionalisation be carried out? Can the community-based model replace the company forms in every aspect? Can the latter be completely eliminated? The Italian experience should be a lesson for us. The protests that erupted there in the 1970s, following the populist but ill-considered decision to close psychiatric hospitals, and the utter chaos that ensued in the psychiatric care system there, show how delicate a topic this is and the amount of consideration it requires (Morzycka-Markowska et al. 2015). It must be stressed in the strongest possible terms that institutions such as psychiatric hospitals are needed and we cannot afford to terminate them. There is, and probably always will be, a group of people experiencing mental health crises who need treatment in closed conditions at some stage of their illness. Either because of the legitimacy of introducing intensive pharmacotherapy that cannot be administered on an outpatient basis and/or because of the need to ensure safety – for oneself and one's relatives. However, it is legitimate to ask about proportions and who should really go to 24-hour wards and who can be treated outside the hospital? It is also no less important for patients who require a stay in hospital wards to leave as soon as possible and then have the chance to continue their treatment in a community-based model (in a day ward, in sheltered housing, or taking advantage of regular visits to specialists). This type of approach counteracts social exclusion and makes it much easier for people experiencing mental health crises to return to their pre-sickness level of functioning. Each of the parties – the person affected by a mental crisis, his or her relatives, and ultimately society as a whole – wants to ensure that a mental crisis does not mean having to enter permanently into the social role of a sick person, but is merely a life challenge that, with the support of people and institutions, can be overcame without significant losses.

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