RE THINKING SCHIZOPHRENIA

Phase III: Country Profiles

Rethinking Schizophrenia in Poland: Schizophrenia and Brain Health

EBC European Brain Council

EPA

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Executive Summary

Key Insights and Challenges

Schizophrenia is increasingly recognised as a brain disorder of neurodevelopmental origin, typically emerging between the ages of 16 and 28, though it can appear earlier. In Poland, while recent reforms such as the rollout of Mental Health Centres (MHCs) and tiered child psychiatry services mark important progress, significant gaps remain:

- Fragmented transitions between child/adolescent and adult services undermine continuity of care.
- Access to early diagnosis and evidence-based treatments is uneven, with persistent regional disparities and stigma.
- Peer support and family engagement are insufficiently embedded within the care pathways and underfunded, despite their demonstrated benefits.
- Structural limitations persist in integrating psychiatric, educational, and social services, especially among youth and those in early adulthood.

Emerging Opportunities

Poland's reform momentum presents a timely opportunity to reshape care around brain health principles. Community-based MHCs with an emphasis on early intervention and psychosocial models improve accessibility and responsiveness. Innovative tools, including artificial intelligence (AI)-based diagnostics and pilot peer support programmes, are making progress. The tiered model of youth mental health care, which provides stepped levels of support based on the severity of needs, from community-based psychological centres to specialised inpatient facilities, will be scaled across the country.

Policy Priorities Moving Forward

To strengthen mental health care and ensure continuity of support, especially for youth, a shift toward more integrated, community-oriented and person-centred systems is essential. The following priorities outline key strategic directions to build more resilient, equitable, and brain-health-informed mental health services across Poland:

- Develop a coherent, multidisciplinary brain health pathway — from early signs to long-term recovery, with a strong focus on transitions and prevention.
- Integrate the involvement of peers (e.g., recovery assistants) and families into mental healthcare systems, protocols, and practices — making it a normalized routine and recognized part of holistic service delivery.
- Expand and integrate community-based services across all regions.
- Promote public awareness campaigns to reduce stigma and increase mental health literacy.
- Ensure sustainable investment in digital health tools, such as telemedicine and reimbursement for innovative treatments.

Background

As a continuation of the recommendations set out in the European Brain Council (EBC)"Rethinking Schizophrenia Care Pathway in Europe" Study Paper, the next phase of the project provides an in-depth analysis of the current state, challenges, and future directions of mental health care, and more specifically, schizophrenia treatment at the country level. Poland, Denmark, and Germany were selected for the initial development of Country Profiles to conduct a reality check of national mental health systems based on strategic, geographic and policy considerations, including upcoming European Union (EU) Presidencies, health system strengths, and opportunities for policy dialogue. Ahead of the roundtable in Warsaw, Poland, on 5 June 2025—focused on improving quality care for child and adolescent mental health, with an emphasis on brain health and schizophrenia—a **validated template** was used to compile a 'Country Profile' for Poland drawing on the most relevant national data and expert input.

Poland is undergoing a **transformative shift** in the way mental health care is organised and delivered, particularly with regard to young people and individuals living with severe mental health conditions such as schizophrenia. Guided by strategic frameworks such as the National Mental Health Protection Programme 2023–2030 and Healthy Future 2021–2027, as a country, Poland has made important strides in expanding access to care, reducing stigma, and promoting integrated, community-based support. The introduction of a three-tier model for child and adolescent psychiatry, along with the development of Mental Health Centres (MHCs), marks a significant advancement toward early intervention, continuity of care, and patient-centred services.

These efforts reflect a **growing societal and political commitment** to addressing mental health as a public priority, recognising the need for systemic solutions that bridge healthcare, education, and social support. Schizophrenia, often emerging in early adulthood, highlights the importance of timely diagnosis, innovative treatment approaches, and sustained psychosocial support. By investing in innovation, professional training, family involvement, and cross-sector collaboration, Poland is laying a strong foundation for more resilient, inclusive, and effective mental health care. An EBC Insights Paper will be released during Spring of 2026 building on these achievements, identifying remaining challenges that persist, and presenting concrete policy directions to strengthen the national and the overall European response to youth mental health needs.

1. Mental Health System and Policy Framework

The population of Poland is 37.4 million. In 2024, the National Health Fund's expenditure amounted to Polish złoty (PLN) 193 billion (45 billion Euros). Poland's mental health system is in a period of undergoing reform, guided by the **National Mental Health Protection Programme for 2023–2030** and the **"Healthy Future" Strategy for 2021-2027**. Two distinct psychiatric systems operate in the Polish context: one for adults and another for children and adolescents. Comprehensive reforms have been initiated continuously since 2018.

Reforms for adult psychiatry have focused on **deinstitutionalisation** and piloting community-based **MHCs**. While financing has **increased**, psychiatry **still receives only 3–4% of Poland's annual public health budget**, below the 6% target[1]. The system relies on EU and Polish National Medical Fund investments for infrastructure upgrades.

For children and adolescents in Poland, a **three-tier model** is in place for delivering mental health care services, structured according to the severity and complexity of needs:

- Level I: Community psychological centres,
- Level II: Mental health centres with psychiatrists and day care units in place,
- Level III: 24-hour specialised inpatient facilities

This particular reform of the three-tier model has improved access to care, shortened hospital stays, and reduced regional disparities. However, significant challenges remain, including **infrastructure gaps** (such as a lack of dedicated spaces for community-based care), **workforce shortages**, and **ineffective information exchange** - both within the healthcare sector (e.g., between public and private healthcare providers) and across sectors such as health, education, social services, and justice.

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[1] The **6% target** refers to the **widely recommended international benchmark** for **mental health spending** — specifically, **6% of a country's total public health budget** should ideally go toward mental health services (including psychiatry). This benchmark is often cited by the **World Health Organization (WHO)** and in **EU mental health policy guidance**.

A major barrier in mental health care is the erosion of family support structures, with many parents unable or unwilling to recognise and respond to their children's psychological needs—particularly in situations involving abuse, neglect, or dysfunctional family dynamics. To address this barrier, a **draft amendment to Poland's Patient Rights and Patient Ombudsman Act**[2] proposes allowing minors (individuals under 18 years of age) experiencing a mental health crisis to access basic psychological support without requiring parental consent.

Additionally, the **outdated and fragmented addiction treatment system** in Poland requires urgent reform. The mental health of young people has been **a key priority**[3] **of the 2025 Polish Presidency of the European Union**, especially considering the growing influence of digital technologies and social media use as risk factors. Poland's mental health reform places particular emphasis on the joint role of schools, child protection services, and digital platforms in safeguarding the mental health of youth.

2. Epidemiology and Burden of Schizophrenia

Schizophrenia affects **200,000–400,000 people** in Poland, **with approximately 16,000 new cases annually.** Most onset occurs between the ages of 20–30; one-third of the first episodes occur before the age of 18. The incidence rates show regional disparities (e.g., 5.8/100.000 in Warminsko-Mazurskie vs. 53/100.000 in Kujawsko-Pomorskie. Early psychotic symptoms affect an estimated **79,000 young people annually**, yet diagnosis is often delayed due to symptom heterogeneity, misdiagnosis, or stigma.

Dual diagnoses (e.g., psychosis and substance use, or psychosis and Post Traumatic Stress Disorder (PTSD)) complicate care. There are **significant regional differences in incidence** (ranging from 5.8 to 53 per 100,000 inhabitants). **Awareness** among parents, educators and general practitioners remains limited.

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[2] **Patient Rights and Patient Ombudsman Act**: Enacted on **6 November 2008**, it came into force on **5 March 2009**. **The Draft amendment to the Patient Rights Act** (granting minors in mental health crisis access to psychological and psychotherapeutic care without parental consent): This is a recent proposal currently under parliamentary discussion in **2025**, but no exact date of submission or expected enactment has been published yet.

[3] The mental health of young people has been a key priority of the 2025 Polish Presidency of the Council of the European Union, as reflected in the Council Conclusions adopted on 20 June 2025 on promoting and protecting the mental health of children and adolescents in the digital age.

3. Access, Diagnosis and Treatment

The **prolonged duration of untreated psychosis (DUP)** is the most critical prognostic factor, as longer DUPs are associated with greater neurobiological damage and worse psychosocial outcomes. This underscores the i**mportance of identifying high-risk states and acting promptly to prevent progression to the first episode of psychosis (FEP)**. Hospitalisation should be a last resort in psychiatric crisis management. Effective intervention depends on **early detection, rapid treatment initiation, especially during the prodromal phase** (when subtle symptoms begin to appear e.g. social withdrawal, cognitive decline, or mood changes) **and community-based care.**

Despite reforms, access to timely diagnosis is **uneven**. In MHC-covered regions (which represents **50% of Poland**), access for mental health facilities and support has improved, with most urgent cases seen within 72 hours, but outside of these regions, **waiting times can exceed 5 months.**

Pharmacotherapy, including **long-acting injectable antipsychotics**, is currently reimbursed in Poland, although **off-label use in youths** remains common due to a lack of paediatric authorisations. Non-pharmacological interventions such as psychotherapy, psychoeducation, rehabilitation, and family support are critical, but inconsistently available.

Care continuity and **transition between child and adult mental health services** are underdeveloped, leading to service disruption during the adolescence phase. The need for **system-wide coordination** and transition pathways (e.g., protocols) could be facilitated by shared electronic health record systems. Finally, meaningful peer support and family involvement are key components of crisis prevention and management, reinforcing the need for a holistic, recovery-reoriented approach throughout the full continuum of care.

4. Socioeconomic Impact and Workforce Challenges

Schizophrenia significantly reduces life expectancy (by 15–20 years) and quality of life. The disease contributes to **67,000** Disability-Adjusted Life Years (**DALY**s) annually and carries **substantial public and private economic burdens**:

- 2022 National Health Fund (NFZ) spending: PLN 2.5 billion;
- Social Insurance Institution disability spending: PLN 5.5 billion;
- 70% of schizophrenia patients receive disability benefits; only 15% return to work post-diagnosis.

Caregivers, most often family members, are deeply impacted - **81% cohabit with their affected loved ones, 72% contribute financially to treatment and daily living expenses, and 13% reduce their work hours in order to provide care and supervision**. Many caregivers live with high rates of stress, depression risk and work disruption.

Despite a growing interest in psychiatry among medical graduates, the overall workforce shortage persists, particularly in public care. Poland has **1 psychiatrist per every 12,000 children**, aligning with World Health Organization (WHO) psychiatrist-per-child standards, but regional inequalities (in rural/underserved areas), and loss of specialists to the private sector limit service availability in the Polish context.

Stigma remains pervasive: 62% of teenagers see mental illness as shameful, and people with schizophrenia face **discrimination in work, education and daily life**.

5. Innovations, Best Practices, and Recommendations

Innovative practices, including digital health tools (e.g., telepsychiatry, e-prescriptions, AI diagnostics), are emerging. Promising projects include:

- **Mentalio AI** to assess youth mental health,
- **Retina-based AI diagnostics** for schizophrenia,
- **Avatar-based therapy** for hallucinations.

Additionally, NGOs and medical centres in Poland run psychoeducation groups like Alliance Against Depression and anti-stigma campaigns like "Open the Door" and "See the person. Stop the stigma!".

Conclusion and Key Recommendations

Poland is undergoing a critical reform of its mental health system, aiming to transition from hospital-based care to a modern, community-oriented model. This transformation aligns with EBC's call to rethink schizophrenia care through the lens of brain health – prioritising early detection, integrated care, cross-sector coordination, and youth-focused prevention.

1. Strengthen Early Detection & Youth Care

- Train general practitioners (GPs), educators, paediatricians, etc., and strengthen primary care integration (training initiatives like mhGAP);
- Introduce practical early diagnostic tools;
- Expand psychoeducation tools and resources for both families and caregivers.

2. Improve Access and Continuity

- Expand MHCs to national coverage;
- Introduce shared electronic records (EHRs) and care coordinators;
- Ensure seamless child-to-adult care transitions by establishing integrated care pathways.

3. Address Social Determinants

- Boost housing, employment, and social reintegration programmes;
- Expand support for caregivers

4. Reduce Stigma

- Scale up awareness campaigns targeting youth and schools;
- Embed mental health education in curricula.

5. Invest in Strengthening the Workforce and Research

- Support interdisciplinary training;
- Fund more schizophrenia research, especially for those under 18 years-of-age;
- Promote more clinical trials and pharmacovigilance initiatives for paediatric mental health treatments;
- Develop a national mental health information platform in Poland for the public.

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