

Mental Health

in the workplace

situation analysis

Poland

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INTRODUCTION

Mental health problems are among the most important contributors to the global burden of disease and disability. Of the ten leading causes of disability worldwide, five are psychiatric conditions: unipolar depression, alcohol use, bipolar affective disorder (manic depression), schizophrenia and obsessive-compulsive disorder.¹

POLAND

Population:

38.6 million

GDP per capita:

\$6,800 (est. 1998)

Unemployment:

10% (est. 1998)

The burden of mental disorders on health and productivity throughout the world has long been profoundly underestimated.² The impact of mental health problems in the workplace has serious consequences not only for the individuals whose lives are influenced either directly or indirectly, but also for enterprise productivity. Mental health problems strongly influence employee performance, rates of illnesses, absenteeism, accidents, and staff turnover.

The workplace is an appropriate environment in which to educate and raise individuals' awareness about mental health problems. For example, encouragement to promote good mental health practices, provide tools for recognition and early identification of the symptoms of problems, and establish links with local mental health services for referral and treatment can be offered. The need to demystify the topic and lift the taboos about the presence of mental health problems in the workplace while educating the working population regarding early recognition and treatment will benefit employers in terms of higher productivity and reduction in direct and in-direct costs. However, it must be recognised that some mental health problems need specific clinical care and monitoring, as well as special considerations for the integration or re-integration of the individual into the workforce.

Mental health problems are among the most important contributors to the global burden of disease and disability.

Why Should the ILO be involved?

Mental illness constitutes one of the world's most critical and social health problems. It affects more human lives and wastes more human resources than any other disabling condition.³ The ILO's activities promote the inclusion of persons with physical, psychiatric and intellectual disabilities into mainstream training and employment structures.

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The ILO's primary goals regarding disability are to prepare and empower people with disabilities to pursue their employment goals and facilitate access to work and job opportunities in open labour markets, while sensitising policy makers, trade unions and employers to these issues. The ILO's mandate on disability issues is specified in the ILO Convention 159 (1983) on vocational rehabilitation and employment. No. 159 defines a disabled person as an individual whose prospects of securing, retaining, and advancing in suitable employment are substantially reduced as a result of a duly recognised physical or *mental impairment*. The Convention established the principle of equal treatment and employment for workers with disabilities.

Most recently, the ILO has recognised the need to promote increased investment in human resource development, which can help support employment productivity and growth. This focus pays particular attention to the human resource needs of vulnerable groups, which include individu-

als with mental health problems. As pointed out, employee mental health problems and their impact on an enterprise's productivity and disability costs are a critical human resource issue. Increasingly, employers, employers' organisations and international organisational bodies are recognising that the economic and social costs of mental health problems in the workplace cannot be ignored.

*In the ILO study, **Mental health in the workplace, situation analyses of Finland, Germany, Poland, the UK and the USA provide in-depth assessments of the impact of mental health concerns in the workplace to determine the scope of the problem in the open labour market.***

The Purpose of the research

With a grant from the **Eli Lilly and Company Foundation**, the ILO conducted in-depth situation analyses in five countries. The five countries selected were Finland, Germany, Poland, UK, and USA. The primary purpose of these situation analyses was to conduct an in-depth assessment of the impact of mental health problems in the workplace in order to determine the scope of the problem in competitive employment. Related to this purpose was also the assessment of the specific ramifications of the impact of mental health problem for employees and enterprises such as workplace productivity, loss of income, health-care and social security costs, access to mental health services and good practices by employers.

An essential objective of these situation analyses is that the information collected and assessed may be used to create further educational materials and assist in designing programmes which can be used by governmental agencies, unions, and employers' organisations for mental health promotion, prevention, and rehabilitation.

The situation analyses were based primarily on a thorough literature review, including documents from government agencies, NGOs, employer and employee organisations, as well as interviews with key informants.

The case of Poland

During the 1990's, significant political changes took place in Poland, and the country has been experiencing a major socio-economic transformation. The transformation of Poland's socio-economic system brought new qualities to all sectors of public and private life including the sphere of labour. The following situational analysis examines mental health issues in Poland, focusing on employment and the general work environment. Although this situational analysis is primarily concerned with mental health and work, mental health issues are often described within a broader societal and national context. This helps to present a more comprehensive analysis, since specific information and data on the relationship between mental health and working conditions are limited.

The situation analysis examines three major areas: Mental health at the national level, mental health issues and the labour market, and the role of government and social partners.

MENTAL HEALTH AT THE NATIONAL LEVEL examines the impact of Poland's social and economic transformation on mental well-being in the populace; attitudes regarding mental health problems; prevalence of mental health disorders; the status of the delivery of mental health services, and national mental health legislation and policies.

MENTAL HEALTH ISSUES AND THE LABOUR MARKET examines the relationship between mental health and working conditions; the impact of unemployment on mental health; disability and employment status; pre-

The socio-economic transformation of Poland in the 1990s has had dramatic implications for the way in which the country perceives and deals with mental health issues.

vention, promotion and rehabilitation programs; and access to employment for the mentally ill.

THE ROLE OF GOVERNMENT AND SOCIAL PARTNERS examines the role of workers, employers, non-governmental organizations, and noted academic institutions in the area of employment, work environment, and mental health.

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GLOSSARY

The definitions and terms related to mental health are evolving and still subject to much debate. Terms are often used interchangeably, which can be confusing as well as inaccurate. It is therefore useful to attempt to define the vocabulary of mental health and to make distinctions. Specific countries use different terminology to refer to the same issue. In the five situation analyses of mental health in the workplace, the reports have remained faithful to the terminology used by the mental health community in each country. This glossary therefore includes definitions of these nation-specific terms. The following definitions and terminology are based on current usage by such organizations as the WHO and ILO, participating countries in the situational analyses, and the European Union.

This glossary is conceptually oriented and will give the reader the familiarity with the vocabulary of mental health, which is necessary to fully understand the situation analyses.

MENTAL HEALTH: Though many elements of mental health may be identifiable, the term is not easy to define. The meaning of being mentally healthy is subject to many interpretations rooted in value judgements, which may vary across cultures. Mental health should not be seen as the absence of illness, but more to do with a form of subjective well-being, when individuals feel that they are coping, fairly in control of their lives, able to face challenges, and take on responsibility. Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity specific to the individual's culture.¹

MENTAL HEALTH PROBLEMS: The vast majority of mental health problems are relatively mild, though distressing to the person at the time, and if recognized can be alleviated by support and perhaps some professional help. Work and home life need not be too adversely affected if the appropriate help is obtained.² In the situation analyses, the terms mental health problems and mental health difficulties are used interchangeably.

MENTAL ILLNESS: Mental illness refers collectively to all diagnosable mental health problems which become "clinical," that is where a degree of professional intervention and treatment is required. Generally, the term refers to more serious problems, rather than, for example, a mild episode of depression or anxiety requiring temporary help.

The major psychotic illnesses, such as endogenous depression, schizophrenia, and manic depressive psychosis, would fall in this category and would be seen less often in the workplace.³ Mental illness is sometimes referred to as *psychiatric disability*.⁴ This term is used primarily in the United States.

MENTAL DISORDERS: Mental disorders are health conditions characterized by alterations in thinking, mood or behaviour (or some combination thereof) associated with distress and/or impaired functioning. Mental disorders are associated with increased mortality rates. The risk of death among individuals with a mental disorder is several times higher than in the population as a whole.⁵

DEPRESSION: Depression is an example of a mental disorder largely marked by alterations in mood as well as loss of interest in activities previously enjoyed. It affects more women than men, by a ratio of about 2 to 1. It is projected that up to 340 million people will suffer from depression in the near future. The risk of suicide is high amongst those suffering from depression. Yearly, over 800,000 deaths attributable to suicide are recorded worldwide: The majority of suicides are due to depression.⁶

There is a great deal of information about the different types, causes and treatments of depression. However, it is important to realize that depression is not simple. There are different types and different degrees of each type. There is a high degree of variation among people with depression in terms of symptoms, course of illness, and response to treatment, all indicating the complexity and interacting causes of this illness. The most common form of depression is chronic unipolar depression (clinical depression). This category of depression has been frequently discussed and written about in the popular media in recent years, primarily due to new modalities of treatment.

Other types of depression recognized at this time are:

- Acute Situational Depression
- Dysthymia
- Bipolar Depression (manic depressive disorder)
- Seasonal Affective Disorder (SAD)
- Post Partum Depression
- Depression secondary to other diseases or drugs.

MENTAL HEALTH PROMOTION: Mental health promotion is a multidimensional concept that implies the creation of individual, social, and environmental conditions, which enable optimal overall psychological development. It is especially focussed, among other concerns, on personal autonomy, adaptability, and ability to cope with stressors, self-confidence, social skills, social responsibility, and tolerance. Prevention of mental disorders could be one of its outcomes.⁷

MENTAL HEALTH PREVENTION: Prevention is based on specific knowledge about causal relationships between an illness and risk factors. Prevention results in measurable outcomes. Within the context of the workplace, prevention is concerned with taking action to reduce or eliminate stressors. *Prevention* and *promotion* are overlapping and related activities. Promotion can be simultaneously preventative and vice versa.⁸

POST TRAUMATIC STRESS DISORDER: PTSD or post-traumatic stress disorder can occur as an acute disorder soon after a trauma or have a delayed onset in which symptoms occur more than 6 months after the trauma. It can occur at any age and can follow a natural disaster such as flood or fire or a man-made disaster such as war, imprisonment, assault, or rape.

REHABILITATION: A process aimed at enabling persons with disabilities to regain and maintain their optimal physical, sensory, intellectual, psychiatric, and/ or social functional levels, by providing them with tools to change their lives towards a higher level of independence. Rehabilitation may include measures to provide and/ or restore functions or compensate for the loss or absence of a function or for a functional limitation. The rehabilitation process does not involve initial medical care. It includes a wide range of measures and activities from more basic and general rehabilitation to goal-oriented activities, for instance vocational rehabilitation.⁹

STRESS: Stress is defined as a nonspecific response of the body to any demand made upon it which results in symptoms such as rise in the blood pressure, release of hormones, quickness of breathe, tightening of muscles, perspiration, and increased cardiac activity. Stress is not necessarily negative. Some stress keeps us motivated and alert, while to little stress can create problems. However, too much stress can trigger problems with mental and physical health, particularly over a prolonged period of time.¹⁰

JOB STRESS: Job stress can be defined as the harmful physical and emotional response that occurs when the requirements of the job do not match the capabilities, resources, or needs of the worker. Job stress can lead to poor health and even injury. Long - term exposure to job stress has been linked to an increased risk of musculoskeletal disorders, *depression*, and *job burnout*, and may contribute to a range of debilitating diseases, ranging from cardiovascular disease to cancer. Stressful working conditions also may interfere with an employee's ability to work safely, contributing to work injuries and illnesses. In

the workplace of the 1990s, the most highly ranked and frequently reported organisational stressors are potential job loss, technological innovation, change, and ineffective top management. At the work unit level, work overload, poor supervision, and inadequate training are the top-ranking *stressors*.¹¹

The following are specific examples that may lead to *job stress*:¹²

The design of tasks. Heavy workload, infrequent rests breaks, long work hours and shiftwork; hectic and routine tasks that have little inherent meaning, do not utilize workers' skills and provide little sense of control.

Management style. Lack of participation by workers in decision-making, poor communication in the organization, lack of family-friendly policies.

Interpersonal relationships. Poor social environment and lack of support or help from coworkers and supervisors.

Work roles. Conflicting to uncertain job expectations, too much responsibility, too many "hats to wear."

Career concerns. Job insecurity and lack of opportunity for growth, advancement or promotion; rapid changes for which workers are unprepared.

Environmental conditions. Unpleasant or dangerous physical conditions such as crowding, noise, air pollution, or ergonomic problems.

BURNOUT: This term is used most frequently in Finland to refer to job stressors and the resulting mental health problems that may occur. It is defined as a three-dimensional syndrome, characterized by energy depletion (exhaustion), increased mental distance from one's job (cynicism) and reduced professional efficacy.¹³

MENTAL STRAIN: This term is used in the German situational analysis to refer to psychological stress that impacts everybody in all realms of life.

WORK ABILITY: Individuals' work ability is based on their, physical, psychological and social capacity and professional competence, the work itself, the work environment, and the work organization. This term is often used in Finland in the world of work.

JOB INSECURITY: Job insecurity can be defined as perceived powerlessness to maintain desired continuity in a threatened job situation or as a concern about the future of one's job.¹⁴

STIGMA: Stigma can be defined as a mark of shame, disgrace, or disapproval, which results in an individual being shunned or rejected by others. The stigma associated with all forms of mental illness is strong but generally increases the more an individual's behavior differs from that of the 'norm.'¹⁵

INTELLECTUAL DISABILITY: This disability is defined by a person's capacity to learn and by what they can or cannot do for themselves. People with this disability are identified by low scores on intelligence tests and sometimes by their poor social competence.¹⁶ The term mental retardation is also used to refer to a person with an intellectual disability and is the most common term used in the situation analyses.

DISABILITY MANAGEMENT: The process of effectively dealing with employees who become disabled is referred to as "disability management." Disability management means using services, people, and materials to (i) minimize the impact and cost of disability to the employer and the employee and (ii) encourage return to work of an employee with disabilities.¹⁷ It should be noted that the term "disability management" is not commonly used, despite the fact that practices understood to be within the scope of disability management processes are now taking place within enterprises of all sizes worldwide.¹⁸

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Part 1

Mental health in Poland

Mental health and social transformation

The transformation of Poland's socio-economic system, which has taken place over the past decade, has had an impact on the mental health of Poles.

Over the past decade, the transformation of Poland's socio-economic system brought new qualities to all sectors of public life, including the sphere of labour. It fostered positive values such as pluralism, democracy, and freedom, but also had negative consequences. Growing rates of poverty, unemployment, and crime, a decreasing sense of security in everyday life, are all new and distressing to a majority of Poles. Analyses based on public opinion polls indicate a decreasing sense of social and economic security and a growing sense of vulnerability to lower living standards, poverty, and unemployment. All of these factors have an impact on mental health in Poland.

Attitudes regarding mental illness

In Poland, public interest in mental health problems has been limited. This can be attributed, partly, to the political system and social attitudes toward people with mental health disorders.

In research completed in 1996,¹ over 70% of respondents indicated that, in their community, people with mental health disorders are described in derogatory terms, such as crazy, loony, idiot, abnormal, cuckoo. According to the majority of respondents, the mentally ill are more often harmed and jeered at (90%) and are more aggressive and dangerous (69%) than other people. When asked about their personal attitude toward the mentally ill, 74% of respondents described it as kind, but perceived such kindness in only 42% of people in their milieu. Respondents who know somebody with mental illness (81%) are definitely more sympathetic towards the mentally ill than those who have no personal connection with someone suffering from a mental health disorder (61%). When the same research was conducted in 1999, changes in findings were statistically negligible.²

Recent changes in medical practices are expected to improve popular attitudes towards people with mental health disorders.

The medical treatment of people with mental health disorders has contributed considerably to the negative attitudes towards them. Traditionally, the mentally ill have been treated in large psychiatric hospitals, usually situated in little villages or isolated areas away from town centres. Hospitalisation lasted many years and separated patients from their families. The number of chronically mentally ill patients living outside of psychiatric hospitals was very small. Doctors routinely testified to their permanent inability to work. Persons with mental health disorders have therefore been perceived as incurable, incapable of leading independent lives, unable to work, and requiring special care provided in special places.

In recent years, new medical practices have been developing which stress the need for people with mental illness to be treated in community based services. Hopefully these will gradually change current popular attitudes.

The mass media in Poland seldom focuses public attention on the risks connected with the incidence of mental health disorders. Mental health issues are reported on sporadically, and their coverage tends to highlight the dramatic consequences of job loss or poverty, usually when they result in

attempted suicide. Television and radio broadcasts on the risks of alcohol or other forms of substance abuse are far more frequent.

Prevalence of mental health disorders

Consistent data on mental health problems was not published before the 1970s. Currently, statistics on mental health disorders are collected and published in the Statistical Yearbook by the Institute of Psychiatry and Neurology.³ Psychiatric care facilities and alcohol and drug treatment units provide data on the number and type of first admissions and patients in treatment. The data in the table below pertains to people with a variety of mental health disorders treated in inpatient or outpatient facilities between 1980 and 1997 (rates denote the number of patients treated per 100 000 inhabitants).

Number of outpatients (rate per 100 000 inhabitants)				
Diagnosis	1980	1990	1995	1997*
Alcohol-related disorders	286	261	274	310
Psychoses	434	466	566	x
Schizophrenia	190	217	243	230
Affective disorders (depressive disorders)**	86	105	148	318
Non-psychotic disorders	803	838	972	x
Neuroses (anxiety disorders)	545	569	667	531

*Since 1997 the new ICD-10 classification has been in force, thus data from 1997 cannot be directly compared to data from previous years.

Source: Zakłady Psychiatrycznej oraz neurologicznej opieki zdrowotnej. Rocznik statystyczny (Psychiatric and neurological care institutions. Statistical Yearbook). Instytut Psychiatrii i Neurologii, Warszawa 1980-1998

**For the purpose of this document the term “affective disorders” refers to all depressive disorders.

The comparisons reveal a growing number of people receiving psychiatric care in outpatient facilities and a growing number of people treated for depressive disorders. In 1997, if new criteria for diagnosing depression are taken into account, the number of patients treated for depressive disorders is higher than the number of patients treated for schizophrenia. The table below provides a more detailed characterisation of individuals treated for depressive disorders in 1997.

Diagnosis	Rate per 100 000 inhabitants
F30 and F32 (depression)	77.3
F31 and F33 (depression)	169.6
Other mood disorders F34-F39	70.7

Source: Zakłady Psychiatrycznej oraz neurologicznej opieki zdrowotnej. Rocznik statystyczny 1997 (Psychiatric and neurological care institutions. Statistical Yearbook). Instytut Psychiatrii i Neurologii, Warszawa 1998

This data indicates that over half the patients treated for depressive disorders are diagnosed as suffering from recurrent depression or bipolar affective disorder, while a third manifest various depressive reactions. A similar trend is noted among patients treated in mental hospitals.

Number of inpatients with depressive disorders (rate per 100 000 inhabitants)				
	1980	1990	1995	1997
Among all inpatients	25.9	29.8	32.0	41.0
Among first admissions	5.8	7.7	11.0	18.0

Source: Zakłady Psychiatrycznej oraz neurologicznej opieki zdrowotnej. Rocznik statystyczny (Psychiatric and neurological care institutions. Statistical Yearbook). Instytut Psychiatrii i Neurologii, Warszawa 1980-1998

In 1997 the number of inpatients treated for depressive disorders was about 50% smaller than the number of schizophrenic inpatients (41 and 83 per 100,000 inhabitants, respectively). Among first admissions, however, depressive patients outnumbered schizophrenic patients (18% and 12%, respectively). This seems to indicate that the incidence of depressive disorders (including severe depressive states requiring hospitalisation) is increasing in Poland.

Statistics reveal that a growing number of people are being treated for depression.

The data above pertains to patients registered in public psychiatric facilities. Some patients with mental health disorders, including depressive disorders, are not treated at all or receive treatment outside the public health care system. Private clinics are not included in the system of statistical data collection. Research findings also indicate that primary care practitioners see 70% of patients with mental health problems, most of whom are non-psychotic.

Research, involving over 2000 people, was conducted on changes in the mental health of adults in Poland between 1991 and 1997.⁴ It reveals that mental health problems improved gradually between 1993 and 1995, specifically the incidence and prevalence of depression. In one study, subjects were asked, "How often in the past month were you sufficiently depressed to think of suicide." From the responses, researchers deduced that the number of persons responding "never" increased in 1993 and 1996 and decreased significantly in 1997. According to parallel research conducted between 1994 and 1997, self-reporting symptoms of depression decreased and then stabilised during the same period.*

The decrease in the severity of depressive symptoms can be related to the consolidation of changes in the Polish economy, following the reforms introduced in 1990. Almost 2 million small businesses were created, unemployment dropped, and people learned to cope with a new way of life and became more self-reliant.

* Results in the first study were arrived at using the statistical methodology tool, the t-test. The second study relied on the Beck Depression Inventory, a four-grade scale to self-estimate symptoms of depression.

Status of the mental health care system

According to 1998 statistics, Poland's mental health care system included the following:⁵

- 49 mental hospitals (26,000 beds),

- 57 psychiatric wards in general hospitals (3,700 beds),
- 112 day centres
- 20 mobile community teams,
- 603 mental health outpatient clinics,
- 228 community self-help homes
- 50 to 60 centres providing community specialist services.
- 312 occupational therapy workshops,
- 2480 psychiatrists, 1500 psychologists, 400 other mental health professionals with a college or university education, and 450 social workers.

New standards of psychiatric treatment suggest that the basic venue for caring for the mentally ill should be the community and the major goal of psychiatric care should be improving the quality of life of patients with chronic mental health disorders. There has been a significant reduction of beds in the large psychiatric hospitals. Small psychiatric wards are being opened in general hospitals, which are more accessible to patients' homes; and mobile community teams, day treatment hospitals, and sheltered workshops have been established. Within the framework of community psychiatric care, associations of patients, their families, and friends have been organised and are having an impact on decisions taken by local and central governments. The associations have promoted the treatment of patients in their own communities, raised funds, helped find jobs, apartments etc. Rapid crisis intervention centres have been opened to deal with the sudden onset of psychological problems.

The only available figure on the cost of psychiatric inpatient care is the figure for national expenditures quoted in the state budget. In 1998, this was PLN 535,8 million (about USD 134 million), which corresponds to 0.4 % of the national budget and 2.8% of expenditures on the entire health care system.

No figures are available on private insurance or social security expenditures for the treatment of depression.

Definitions and diagnostic procedures

DEFINITIONS OF MENTAL HEALTH DISORDERS

Poland has always used international classifications to define mental health disorders and has always applied international standards to their treatment. Currently, the 10th revision of the International Classification of Diseases (ICD-10), introduced in Poland in 1997, is in force.

Definitions of mental health disorders, including depression, are applied in accordance with the ICD-10, which has been translated into Polish and is officially used in all institutions dealing with the treatment of mental health disorders. Basic manuals, such as *Clinical Description and Diagnostic Guidelines*, *Diagnostic Criteria for Research*, or *Handbook for Primary Care Practitioners*, have also been translated into Polish.

There are no specifically Polish terms to define stressful situations and depressive states. The definition of "psychological stress" contained in the *Leksykon Psychiatrii* is similar to Selye's, i.e. "a non-specific response of the organism to demands," and to Lazarus's concept of a "a set of transactions between the subject and community."⁶ These terms have the same meaning in Poland that they do in other countries. The *Lexicon of Psychiatric and Mental Health Terms*, published by WHO in 1989, is being translated into Polish.

New standards of psychiatric treatment suggest that reliance on large psychiatric hospitals should be replaced with community-based care and a commitment improving the quality of life of individuals with chronic mental health disorders.

DIAGNOSTIC PROCEDURES

As noted earlier, mental health disorders have been perceived as a “shameful” disease. In the case of severe mental illness the usual treatment was long-term hospitalisation in a psychiatric institution. Other mental health disorders, such as depression, were usually diagnosed many years after their onset. Psychiatric treatment has been, and often still is, perceived as a sad necessity, experienced with shame, and kept secret even from the patient’s family.

In the past, treatment of individuals with mental health disorders by primary care practitioners or by various non-psychiatric medical specialists was usually ineffective and frequently inappropriate. It sometimes exacerbated mental health problems and had negative effects, such as unnecessary prescribed drug dependency. Only in recent years have primary care physicians ((family doctors) acquired more extensive knowledge in the field of mental health disorders. In undergraduate and postgraduate training, psychiatry now ranks as one of the five basic medical disciplines. Postgraduate training courses for family doctors acquaint them with methods of diagnosing and treating mental health disorders, especially depression. A regulation, passed in 1999, now requires that primary care physicians make decisions concerning diagnostic procedures and treatment for any self-referred patient with mental health problems. However, despite the new training initiatives, the majority of physicians are still not adequately prepared for early diagnosis and appropriate treatment of mental health disorders.

People with mental health problems can consult a psychiatrist through self-referral, without referral from a family doctor. In recent years, as the public has become more knowledgeable about the nature of mental health problems, many individuals have taken advantage of self-referral.

In Poland neither social workers (welfare officers) nor occupational medicine physicians have been trained in evaluating and diagnosing mental health disorders. Steps have been taken to correct this. The Institute of Occupational Medicine obtained the rights to a Polish adaptation of the General Health Questionnaire (GHQ) developed by David Goldberg.⁷ This is a widely used tool for assessing mental health status. It provides a screening scale to identify people in need of more detailed psychiatric diagnosis and care. Physicians trained in occupational medicine will be equipped with the Polish adaptation of the GHQ so that they can identify workers requiring psychiatric or psychological help during routine workplace medical examinations. Until now this type of diagnosis has been based on an interview and the doctor’s intuition.

Legislation and policy

Before passage of Poland’s Mental Health Act, “mental health” was defined as an “absence of mental health disorders.” Therefore, activities on behalf of mental health protection consisted in treatment and rehabilitation rather than in the prevention of mental health disorders. The Mental Health Act provided the first explicit definition of “mental health” and set out goals and methods for addressing mental health promotion and the prevention of mental health disorders.

For at least two decades, efforts to pass legislation to guarantee the mentally ill their basic human rights and the rights to employment and decent living conditions were unsuccessful. Though the first draft of the Mental Health Act was completed in 1970, the Polish Parliament did not consider

Family doctors are acquiring more extensive knowledge in the field of mental health disorders, but despite new training initiatives, most of them are still not adequately prepared to make early diagnoses and deliver appropriate treatment.

such legislation until 1990. During this period, even the organisation of Alcoholics Anonymous groups was hampered, since they were seen as a potential threat to the political regime.

MENTAL HEALTH ACT

The Mental Health Act was finally passed by the Polish Parliament in 1994 and has been in force since 1995. It was amended in 1997, 1998, and (twice) in 1999. The act filled a glaring gap in the Polish legal system. Until its passage, there was no definitive legal protection for the rights of people with mental health disorders, and no clearly articulated legal principles governing the psychiatrist-patient relationship.

The Act was patterned on similar legislation in other countries. It conforms to international pacts and conventions on human rights signed by Poland.

According to the Mental Health Act: “Acknowledging that mental health is a fundamental human value and that the protection of rights of people with mental health disorders is an obligation of the State, this act proclaims the following:

- **Article 1.1.** Mental health protection shall be provided by the State administration, local government agencies, and appointed institutions.

- **1.2.** Voluntary associations and other civic organisations, foundations, vocational councils, churches, and other denominational unions, and self-help groups consisting of patients and their families may participate in the provision of mental health protection.

- **Article 2.** In particular, mental health protection shall consist in:

- **1.** Promoting mental health and preventing mental health disorders;

- **2.** Providing the mentally ill with comprehensive and accessible health care, as well as other forms of care and assistance essential for them to live in the family and the community;

- **3.** Developing appropriate social attitudes towards persons with mental health disorders, in particular, understanding, tolerance, and kindness, and counteracting discrimination.” This seems to be one of the few legal acts to so clearly state the need for an anti-discrimination policy concerning the disabled

In addition to these general principles, the Act details more specific provisions, and defines a person with mental health disorders:

- **Article 3.1.** Whenever the provisions of this Act refer to a person with mental health disorders, they shall apply to a person who: is mentally ill (i.e. demonstrates psychotic disorders), is mentally retarded,* demonstrates other disturbances in mental functioning which, according to the current medical knowledge are classified as mental health disorders, and who needs health care or other forms of aid and care in order to live in the family or social community.

* It is important to note that mental retardation refers to limited intellectual functioning and is not in any way associated with mental illness. However, a person who has mental retardation can also have mental health problems as a person with mental illness can also be mentally retarded.

- **Article 4.1.** Preventive measures with respect to mental health shall be targeted first and foremost at children, youth, the elderly, and people in situations involving risk to their mental health.

- **Article 4.2.5.** Measures referred to in Par. 1 shall include, in particular, the introduction of mental health care issues in the professional training curricula of persons working in management and administration.

The Mental health act fills a significant gap in the Polish legal system. It acknowledges “that mental health is a fundamental human value and that the protection of rights of people with mental health disorders is an obligation of the State.”

- **Article 7** states the obligation to provide mentally retarded children and adolescents with education and rehabilitation.
- **Article 8** outlines the particular obligation of social welfare agencies to “provide in their catchment areas social support to people who due to their mental illness or mental retardation face severe difficulties in daily life, especially with respect to interpersonal relations, employment, and the ability to support themselves.”

MENTAL HEALTH PROGRAMME

In 1992, a Mental Health Programme was developed by a team of experts from Poland’s Institute of Psychiatry and Neurology in collaboration with the World Health Organisation Regional Office for Europe.⁸ The programme’s primary aim was to de-institutionalise psychiatric care and increase the accessibility of outpatient services. Instead of large mental hospitals, small psychiatric wards were to be established in regular hospitals. Various forms of intermediate psychiatric care were recommended such as day treatment hospitals, occupational therapy workshops, nursing homes, and sheltered housing. In implementing the programme it has become obvious that the care of people with severe mental illness should not be delivered solely by the health service.

In 1999 an amended and revised version of the programme emphasised the co-operation of many parties in mental health protection, including local authorities, labour and social welfare agencies, educational institutions, and the mass media. The goal of the amended programme is to improve the quality of care for the mentally ill. In addition, it seeks to implement prevention programmes which target people at risk, and educational programmes, which prepare people to cope with the new socio-economic conditions, and shape more positive attitudes toward people with mental health disorders.

The Mental Health Programme, even as amended in 1999, devotes too little attention to mental health protection in the workplace. The only reference is to sheltered work, which is mainly for patients with severe mental illnesses such as schizophrenia and chronic schizophrenia and the mentally retarded. It advocates “enlargement of the network of sheltered workshops and cottage industry teams under the management of social co-operatives* and increasing the number of opportunities for supportive employment.” Responsibility for the program’s administration is currently being debated within the government. Attempts will be made to broaden it beyond the Ministry of Health, where it currently resides.

*Social co-operatives are also known as social firms. The Confederation of European Social Firms and Social Co-operatives (CEFEC) defines a social firm as a regular business in the market that employs a significant number of people with disabilities. In a social firm, people with disabilities are paid regular wages and work on the basis of regular work contracts. All employees have the same rights and obligations whether they are disabled or not. People with disabilities and other people work together on an equal basis. There are approximately 2,000 social firms in Europe. A large percentage of people with disabilities who work in social firms have a psychiatric disability.

(Schwarz, G. & Higgins, G: Marienthal the social firms network Supporting the Development of Social Firms in Europe, UK, 1999)

Poland’s Mental health programme seeks to deinstitutionalise psychiatric care, increase accessibility of outpatient services and improve the quality of care for the mentally ill.

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Part 2

Mental health issues and the labour market

Mental health and working conditions

During the years of “real socialism,” the relationship between mental health and working conditions was never researched or analysed. The incidence and prevalence of mental health disorders, particularly of depression, stress reactions, attempted suicide, even alcoholism and drug abuse, were not publicised, and were not linked to working conditions. Analyses focused on issues such as how productivity and discipline at work are affected by alcoholism, and not how working conditions contribute to alcohol abuse. No programmes were designed to prevent or monitor the relationship between working conditions and the development of mental health problems among workers.

Since 1989 the Central Statistical office in Warsaw has been conducting surveys concerning health status and the situation of people with disabilities.

Since 1989, there have been some changes. The Central Statistical Office in Warsaw conducts comprehensive surveys concerning health status and the situation of people with disabilities in Poland. Assessments of health status and disability are based on specific physical and mental health indicators and their impact on an individual’s working capacity. Mental illness and mental health disorders are included in the broad category of chronic somatic diseases. They are related to the occupational activity of the disabled and to their needs. Relevant data are presented in two reports: *Occupational activity and health in 1996* and *Health status and needs of the disabled in Poland in 1996*, prepared by the Central Statistical Office in Warsaw.⁹

Next year, a research programme will be launched to analyse the effects of reforms implemented in Poland, including psychological response to the ongoing changes. The survey will include a national representative sample. It will cover psychological responses such as depressive symptoms, anxiety, and life satisfaction. Variables under study will relate to factors such as respondents’ living conditions, their experiences with job change, job loss, and the need to acquire new skills through vocational training. Tools for the survey have been developed. A report based on the survey is also expected to cover factors detrimental to mental health. Although funding is limited, it is proposed to conduct this survey on a yearly basis.

Though studies on the relationship between stressful working conditions and workers’ health status have been sporadic, Poland does have a history of research into mental health in the workplace. The first studies on job satisfaction and identification of workplace stressors were undertaken at the initiative of trade unions 35 years ago, first in the engineering industry and then in the iron and steel industries. In the early 1980s, the University of Warsaw conducted research on job and life satisfaction, and a team from the Polish Academy of Sciences has done a study on mental and physical work efficiency.¹⁰ More recently, research on these issues has been conducted at the Institute of Occupational Medicine in Łódź.

The first of two studies undertaken by the Institute¹¹ covered 2570 workers employed in 47 jobs in 168 workplaces, none of which had violated occupational health standards. The main health risks were psychosocial, involving job factors which cause employees to become irritated, nervous, and stressed. These include work overload, physical danger, role conflict,

responsibility for others, and lack of job security. The study showed that work stress contributed to heart disease, chronic ulcers, and mental health problems.

A strong link was found between work stress and health status in a subgroup whose jobs were perceived as highly stressful, both by the workers themselves and by experts (i.e. in jobs evaluated as stressful both subjectively and objectively). In a group of employees who perceived their work stress as low, though it was rated high by experts, the incidence of psychosomatic complaints and mental health disorders was less frequent than in a comparative group, where work stress was rated low by both the employees and experts. The design of this study made it difficult to establish a causal relationship between stress and the incidence of mental health complaints. It is hoped that a follow-up study will make it possible to draw inferences about causal relationships.

Recent studies have examined the impact of job factors and traumatic events in the workplace on mental health.

In 1995, the Institute began research into the psychological consequences of traumatic events in the workplace.¹² These may manifest themselves as post-traumatic stress disorder (PTSD). PTSD can occur as an acute disorder soon after a trauma or have a delayed onset in which symptoms occur more than 6 months after the trauma. It can occur at any age and can follow a natural or man made disaster. The subjects of the study are firemen, policemen, and ambulance service workers. The incidence of traumatic events in these occupational groups is high. Between 70% and 80% of the subjects reported experiencing such events in their work. In about 4% of cases PTSD developed. One of the major risk factors for PTSD turned out to be a lack of opportunity to talk with colleagues about the traumatic event. This finding indicates a need for preventive interventions, in the form of debriefing teams for emergency and rescue service workers.

The Institute of Occupational Medicine has launched an experimental programme of stress management in the police force. A pilot study using two approaches to stress management, is under way at four police stations. In the first approach, psychologists focus on the individual, training the person to become more competent at coping with stress. The second focuses on identifying stressors within the organisation and on finding ways to either eliminate them or diminish their severity. The individual and organisational approaches will each be applied exclusively to one of the four police stations. A combination of the two will be applied to the third station. The fourth station will serve as a control group. Effectiveness will be evaluated during a 24-month follow-up.

Until 1996 Poland maintained a nation-wide database on absenteeism. It recorded number of days lost from work due to disease or accidents, estimated from a random sample of workers employed in state institutions and factories. A preliminary analysis of the data for the years 1990-1994 (i.e. the period of dramatic socio-economic change) indicates that absenteeism resulting from mental health problems increased more than twofold in men, and by over 10% in women. Unfortunately, the analysis treated mental health disorders as a uniform group without identifying specific problems, i.e. depression, anxiety etc. However, the database makes it possible to analyse absenteeism due to mental health problems by gender, age, and economic sector.¹³

No statistical data is available on costs resulting from the absenteeism of people with depression or on the benefits they receive from insurance companies. There have been no studies on accidents caused by employees with depression/mental illness.

Unemployment

Joblessness seems to be the phenomenon most threatening and upsetting to Poles. In January of 1990, when official registration of unemployment began, the number of unemployed persons was close to 50 000. Six months later it reached 568 000 or 3.1%. By December of 1991 it was 11.8%. In 1993, it reached a peak of 16.4%. After several years, unemployment slowly decreased and was 9.6% in 1998.¹⁴

It appears that, in a situation where unemployment is a constant threat, some employers feel free to exploit workers mercilessly. Regulations about working hours and paid holidays are notoriously neglected, and pressure to work is exerted on employees whose inability to work has been diagnosed by a physician. All these factors contribute to considerable psychological stress for employees, which is often neglected by the occupational medical services, whose training in this field has been unsatisfactory for a long time. The problems of psychological stress have not been included in the recent edition of *Hygienic-Physiological Norms in Industrial Medicine* (in Polish, Warsaw 1983), though they are discussed in manuals published in 1972 and 1973, which have been unavailable for years.

THE HEALTH CONSEQUENCES OF UNEMPLOYMENT

Systemic, uniform, and exhaustive studies that provide information on the mental health risks and consequences of unemployment are lacking. No data is available on the prevalence of depression among unemployed workers, on unemployment caused by depression, or on depression caused by unemployment.

Subjective indicators of the impact of unemployment on mental health can be found in sociological surveys carried out on representative samples of the adult population. Surveys on the subject are conducted periodically by public opinion poll centres. They use a number of scales that measure factors such as the perceived threat of unemployment, social pessimism, and social optimism. In recent years, surveys have indicated that Poles feel increasingly threatened with unemployment and that pessimism is growing.

A recent survey conducted by the Central Statistical Office and the Main School of Commerce in Warsaw dealt with the impact of unemployment on health. The findings indicated that stress related to unemployment impacts physical well being. They revealed an increase in the prevalence of many mental health problems and in consumption rates of psychoactive substances.¹⁵

Based on sociological surveys, the Department of Analyses and Prognoses of the Prime Minister's Office has noted¹⁶ that, in 1999, anxiety related to the threat of unemployment grew by almost 50% compared to the 1997 level. Respondents to a 1997 survey on the quality of life had already ranked unemployment as the second greatest cause of frustration, after "political chaos and fights" and before "rising prices." There is reason to believe that unemployment contributed to the increase in suicide in Poland during the years of economic transformation. Suicides went from 13.9 per 100 000 in 1991 to 14.9 per 100 000 in 1992, and then back down to 13.1 per 100 000 in 1998.¹⁷

No nation-wide programme has been organised to train welfare officers in dealing with the unemployed. However, with the emergence of unemployment as a social problem in Poland, centres all over the country have conducted such training courses on their own initiative. The courses address the impact of joblessness on the emotional state and the possible onset of

The threat of joblessness results in considerable psychological stress for employees.

depressive responses. In 1993 a training courses on “Social work with the unemployed,” supported by funds from PHARE*, were offered in 13 out of Poland’s 49 administrative districts. A total of 180 participants completed the training

*PHARE was established by the European Commission to assist countries of Central and Eastern Europe in reconstructing their economies in the 1990s. Initially targeted at Poland and Hungary, it now includes 13 countries in the region. In addition to economic issues it covers health and social issues.

Disability

In Poland there is a process for legally certifying disability due to mental health disorders and awarding disability benefits. These benefits include: disability pension and social welfare assistance such as home care provided by community nurses or residence in a nursing home or a community mental health facility. People with mental health disorders are also in the category of the disabled who are entitled to legal and financial support when they enter paid employment.

According to the Central Statistical Office, in 1996¹⁸ there were 5.15 million disabled people in Poland. Of that number over 4.1 million received disability pensions. Of these, 1.45 million people (over 28%) were disabled due to mental health disorders. Over 311,000 (about 6% of the total disabled) suffered from severe mental illness. Of those, 271,000 received disability pensions.

Slightly over one sixth of all disabled people are employed. Over 84% of the mentally ill are inactive. There are no data indicating how many of those reporting an occupational activity (16% of people with mental health disorders) are in paid employment. The experience of professionals involved in their treatment and rehabilitation indicates that the vast majority of people with mental health disorders are unemployed and only a few secure employment. For those who do obtain work, there was no information indicating how long they were able to maintain a job.

According to Social Security Agency statistics, 250,500 people received their first disability pension in 1996. In 34,900 cases (14%), the disability was due to mental illness.¹⁹

Prevention and promotion

According to Article 4 of the Mental Health Act, “preventive measures with respect to mental health shall be targeted first and foremost at children, adolescents, the elderly, and people in situations involving risk to their mental health.” An executive regulation added by the Minister of Health and Social states that “activities in the field of mental health promotion and prevention of mental health disorders shall be implemented above all...in the form of psycho-educational initiatives, and development of skills necessary to the individual for the formation of appropriate interpersonal relations in the workplace.” The Minister of Health and Social Welfare appointed a Council for Mental Health Promotion affiliated with the Institute of Psychiatry and Neurology. The aims of the Council include the development of a programme of activities for mental health promotion and prevention of mental health disorders. The programme will cover mental health promotion in the workplace. The input of experts from other countries in this work would be greatly appreciated.

In 1996, over 28% of people receiving disability pensions in Poland were disabled due to mental health disorders.

Prevention is the professional responsibility of physicians trained in occupational medicine. However, since there are no detailed statutes governing the prevention of mental health disorders, preventive interventions are not taking place. In 1992, at a conference on unemployment²⁰ and its consequences, the following recommendations were made: that multidisciplinary centres for counselling and assistance to the unemployed be established; that preventive interventions by medical services take place in workplaces threatened with restructuring; and that there be more and better training of health care and social welfare staff in workplace issues. However, no information on implementation of these recommendations is available. So far, there is no nation-wide data bank of information on preventive and therapeutic interventions in the case of people who develop mental health disorders in response to job loss.

In preparing this report, no information was found on workplace policies or programmes relating to prevention of mental health disorders or on the evaluation of workplace health promotion programmes. If such initiatives are occurring in Poland it is due to local mental health professionals, and they have not been publicised.

There have been some sporadic efforts by employers to develop anti-stress programs in the workplace. The Institute of Occupational Medicine conducted a survey of 812 successful Polish enterprises, which were members of the Business Centre Club. These firms were expected to be leaders in promoting health in the workplace. The response rate was 11% (93 firms). Only 14 of the respondents reported having a stress management programme, while 32 had alcohol prevention programmes.²¹

Steps which have been taken in the area of promoting good mental health practices in the workplace include:

- preparing guidelines on stress management in the workplace;
- providing occupational medical practitioners with training courses and seminars on stress management in the workplace;
- developing a set of instruments for assessing the impact of workplace stress;
- designing methods for evaluating and identifying persons at risk for physical and mental health problems due to work-related stress.²²

In 1997 a National Centre of Workplace Health Promotion was established at the Institute of Occupational Medicine, at Łódź.²³ The Centre's main purpose is to "support implementation of comprehensive health promotion programmes in Polish companies." Its work is based on the concept that a company's health promotion program exists within the context of its human resources policy to enhance profitability through activities which ensure the good health of employees. Because health promotion in the workplace is a new concept in Poland, part of the Centre's challenge lies in educating management to the importance of this approach and creating a business culture which is friendly to its implementation. The Centre has undertaken the following activities:

- Promulgating the concept of health promotion in the workplace among occupational health professionals (physicians and nurses), people responsible for work safety, employers' associations, and managers. A package of information on health promotion was prepared and disseminated to 3000 major Polish companies.
- Encouraging organisational structures for health promotion in the workplace, such as a network of regional health promotion leaders. The leaders (employees of the Regional Occupational Medicine Centre and of the

In 1997, a National Centre of Workplace Health Promotion was established at the Institute of Occupational Medicine, at Łódź. Its main purpose is to "support implementation of comprehensive health promotion programmes in Polish companies."

Epidemiological Stations) are expected to help local companies implement promotion programmes.

- Training people to organise health promotion in the workplace. These are mainly regional leaders, physicians, and nurses specialising in occupational medicine, students, and representatives of commercial companies. 300 people have been trained so far.
- Preparing educational and advertising materials for employers, managers, and employees. Seven handbooks, many leaflets, and posters were published. The Centre also provides consulting for pilot programmes in health promotion.
- Conducting research and preparing analyses which result in scientific principles of health promotion in the workplace.

Implementation of health promotion programmes in the workplace will only progress when employers and trade unions begin to recognize the long-term economic and social benefits associated with a “healthy workforce”, i.e. reduced absenteeism and job turnover and improved productivity.

In 1998 the Centre carried out research on the level of interest in health promotion programmes in commercial companies. Only 10% of the companies selected for the survey responded. Of those who responded the results show that 25% of Polish companies employing over 300 workers are unaware of the concept of health promotion in the workplace. 27% of firms have implemented at least some elements of promotion programmes, primarily as extra medical services or activities intended to improve the functional and aesthetic aspects of social facilities. The relatively low interest of Polish companies in promoting health among their employees is due to their precarious finances. Health promotion is not perceived as a way to enhance the company's future, and there are no direct benefits, such as reduced insurance rates, to serve as incentives for companies to undertake health promotion activities. Implementation of health promotion programmes in the workplace will only progress when employers and trade unions begin to recognize the long-term economic and social benefits associated with a “healthy workforce”, i.e. reduced absenteeism and job turnover and improved productivity.

There are also weaknesses at the government level. The reform of Poland's administrative system, launched in 1999, reduced the number of regions from 49 to 16 and disrupted the network of regional health promotion leaders. Though health promotion is among the responsibilities of local authorities, funding for health promotion activities is still not in place.

Though the following programs do not relate directly to mental health in the workplace, they are examples of preventive and educational programs underway in Poland that promote good health habits. Two of these programs specifically target young people. This is a first step towards mental health in adults, and should impact the workplace as today's youth comes of age.

Prevention and Management of Drug Abuse in Poland

The project was initiated by the Institute of Psychiatry and Neurology and funded by the European Commission. It was implemented in 1994-1995 in Starachowice and Malczyce, two communities thrown into crisis by the economic transformation. The largest industrial plants in the towns had shut down, leading to a significant rise in unemployment, and the bulk of the population became impoverished. The activity of cultural centres diminished, and new social problems, including drug abuse, emerged. The project's major objectives were to establish comparable data on drug abuse and drug related issues, increase public concern about drug abuse and the necessity for community-based prevention initiatives, and facilitate changes in treatment policy and organisation. Its main outcome was the Prevention and Community Action Package, which summarised the communities' expe-

riences and formulated guidelines for other communities dealing with drug abuse prevention in Poland and other countries in the region.²⁴

Have a Second Look

This programme was designed by a team from the Polish Psychological Association in Starachowice to prevent drug use among schoolchildren. It is based on two American prevention programmes “Substance Education” and “Drug Education Curriculum.” Its objectives are to promote self-esteem, develop problem coping skills, and promote a healthy lifestyle. It has been implemented in all primary school grades (1-8). A package of educational materials was prepared and used in schools.

Programme for Home Detectives

This is an innovative primary prevention programme for 11 year-olds, based on the American “Slick Tracy Team” programme. It was adapted by the staff of the Institute of Psychiatry and Neurology in 1998 and is used in schools throughout Poland. It consists of teacher- and peer-led sessions combined with parent-child activities aimed at preventing juvenile drinking.

Rehabilitation

There are more rehabilitation services and programs for people with severe mental health disorders than for workplace mental health promotion and prevention. Over the past decade there have been reforms in the rehabilitation of people with long-term mental illness. Formerly, psychiatric care took place primarily in large mental hospitals. Statistical data indicates that 20% of patients were residents of these hospitals because they lacked the skills necessary for independent living. An intensive programme developed by the Institute of Psychiatry and Neurology was initiated to prepare these patients to live independently. Interventions were proposed in following areas:

- Education of society at large and of local communities to which the psychiatric patients were expected to be discharged. A series of educational programmes was broadcast on radio and television, educational booklets were published, etc.
- Various forms of intermediate care were initiated across the country to provide patients with graduated levels of care commensurate with their needs.
- A package of behavioural training modules called “Return to the Society,” and educational programmes for patients and their families were developed. Within two years, the programmes and a training course for staff were disseminated to all major psychiatric centres in Poland. These programmes have already been used in rehabilitation at 50% of the centres. Six community psychiatric teams have been established over the past two years thanks to a Polish-Dutch collaboration. Three of them provide care to patients from rural areas.

Access to the labour market for the mentally ill

Many provisions of the Mental Health Act have not yet been implemented. This is particularly true of regulations governing the availability of capability-matched employment for people with mental health disorders, and the development of standards for appropriate rehabilitation goals. Effective action to develop employment opportunities for people with mental health

Longterm treatment of the mentally ill in large institutions is currently being replaced by an emphasis on rehabilitation and independent living.

Effective action to develop employment opportunities for people with mental health disorders is hampered by general difficulties in the labour market, leaving the issue of paid employment for people with mental health disorders unresolved.

disorders is also hampered by general difficulties in the labour market. Overcoming these conditions, which result from the transformation of Poland's economic system, has included a huge job creation effort and has required the jobless to acquire new skills. With job opportunities so limited, neither funds nor energy are available to assist people who require special legislation and educational programmes to compete and succeed in the job market.

These factors are partly responsible for the absence of national or local government programmes that support and train people with mental health disorders so that they can gain access to the open labour market. There is some NGO activity in this area, but no systematic data is available. One recent initiative was an All-Polish Forum for Employment of the Disabled, organised by Channel III of the Polish Radio, *Gazeta Wyborcza* (a popular Polish newspaper), and the Polish Association of Employers of the Disabled.²⁵ The Forum's main purpose was to identify companies prepared to employ the disabled. An announcement that some firms were offering jobs to the disabled, resulted in over 100 applications from disabled people (including people with mental health disorders). The number of disabled people employed in the open labour market is estimated at about 50 000, while that in sheltered workshops is about 250 000.

The issue of paid employment for people with mental health disorders remains unresolved. Prior to the 1989 political changes, it was relatively easy for them to get jobs in sheltered workshops, especially in large cities. Within the framework of social co-operatives they performed simple activities under controlled, highly disciplined circumstances and were paid low salaries. Sheltered workshops did not survive open market competition and most of them have collapsed. The state subsidy is inadequate and does not provide sufficient incentive for firms to employ people with mental health disorders. Employment agencies list very few paying jobs for people with mental health disorders, and very few of them have managed to join the mainstream workforce. Even if they find employment, they usually lose their jobs after the first two or three weeks.

Poland does have occupational therapy workshops and centres for work activities for people with moderate and severe mental health disorders. The Act on Employment and Occupational Rehabilitation of Disabled People of 1991* (with several later amendments) sets out principles for their organisation and activities. The primary aim of therapy workshops is to promote social skills necessary for independent living including work. There are about 300 occupational therapy workshops in Poland. They provide temporary occupation and a small stipend for people with mental illness who have lost their jobs. There is one experimental Centre for Work Activities, in which the staff consists of people with severe mental illness. This centre is supported financially by the State Fund for Rehabilitation of the Disabled.

* Act of Employment and Occupational Rehabilitation of Disabled People, *Dziennik Ustaw RP*, no 46, 1991

Part 3

The role of government and the social partners

Poland's Labour Code specifies the following:²⁶ "Under Article 15, employers are required to provide workers with "safe and hygienic working conditions." Article 227 mandates that they "take appropriate measures for the prevention of occupational diseases and other conditions connected with performed work." Article 229 requires them "to submit employees to entrance and periodic medical examinations." Moreover, "employers with more than 50 workers are obliged to appoint a committee on the safety and hygiene of working conditions ... as an advisory and opinion-formulating body".

These regulations have a direct bearing on the role of the occupational medicine services. According to Article 2 of the Occupational Medicine Services Act of 1997,²⁷ the services consist of "medical doctors, nurses, psychologists, and other professionals having qualifications necessary for fulfillment of this service's multidisciplinary tasks." The Act mandates that the service supervise the material and psychosocial environment of the workplace, in terms of its organisation, methods, and conditions, to identify health risk factors. According to the Act, representatives of the occupational medicine services serve on the committees for the safety and hygiene of working conditions established by the Labour Code.

Article.18 of the Labour Code establishes the State Labour Inspectorate to "supervise and control adherence to labour law provisions, including the regulations and rules on safety and hygiene of working conditions." Physicians in the occupational medicine service are responsible for monitoring the health status of disabled employees, implementing health prevention in high-risk groups of employees, and creating conditions for the provision of occupational rehabilitation. According to Article 6 of the Occupational Medicine Services Act, the occupational medicine service staff must "advise employers and workers on work organisation, ergonomics, physiology and psychology of work." This implies their collaboration in adapting the workplace to the needs of employees whose working ability is limited due to mental or psychosomatic disorders. No data on the implementation of these regulations was available from the National Inspectorate of Labour when this report was in preparation.

There is no overall data permitting evaluation of the effectiveness of government policy on people with mental retardation or mental health disorders.* In the year 2000, funds to supplement the income of the disabled with mental health disorders, mental retardation, or epilepsy should cover over 20.000 employees. The funds are expected to meet 100% of their needs, as estimated by regional sections of the PFRON (State Fund for Rehabilitation of the Disabled). In 2000, supported employment for the mentally ill, mentally retarded, and epileptics is planned to increase by more than 2,000 jobs over the 1999 level. According to the Plenipotentiary for the Problems of the Disabled, at the end of 1999, 438 social co-opera-

Poland's labour code provides the legal infrastructure for building a workplace environment which promotes mental well-being

PFRON (State Fund for Rehabilitation of the Disabled)

PFRON's responsibilities are two-fold: It provides aid for restructuring sheltered workshop cooperatives, especially those in regions of high unemployment and makes loans to the disabled for launching small businesses or agricultural enterprises.

tives for the disabled and the blind should be functioning, with a total of 98,826 employees. Of that number, 67,624 are disabled, and 20,953 are on category I or II disability pensions.

*Often policies related to mental health disorders include people with mental retardation or neurological disorders.

Workers' and employers' organisations

There is no available data on the activities of workers' and employers' organisations in this field. It is our impression, however, that neither employers' organisations, nor trade unions are interested in the employment and retention of people with mental health disorders. Employers seem to be afraid of employing people with mental health disorders, possibly reflecting Polish society's more general attitude of anxiety towards the mentally ill. In times of high unemployment (over 13%) the mentally ill cannot get regular paid jobs. There is no information on any initiatives on the part of employers or trade unions to improve this situation.

Non-governmental organisations (NGOs)

The growing role of NGOs in Poland has generated some positive expectations. In 1997, a catalogue of "non-governmental organisations and institutions acting on behalf of the disabled" listed 5577 NGOs. About 6% of these organisations included assistance to people disabled due to mental health disorders or retardation among their statutory goals. These NGOs are usually small foundations established by families with disabled children and have at most a few dozen members.

The major NGOs in Poland, i.e. the Polish Red Cross, the Polish Committee for Social Aid, and Caritas Polska, have not created any specialised organisational structures to deal with the problems of people with mental health disorders. In contrast, organisations that benefit the mentally retarded* are relatively well developed and can serve as models for organisations devoted to people with mental illness.

*Depending on the country, the terms mental retardation and intellectual disabilities are often used interchangeably.

- **The Polish Association on behalf of the Mentally Retarded**, which seceded from the Society of the Friends of Children in 1963, now has 125 regional sections comprising 28 000 members. The goals of the Association are: to strive for a level playing field for the mentally retarded; to create conditions for upholding their human rights; and to promote their active participation in community life. This is accomplished through activities such as the promotion of legal regulations concerning the provision of care, medical treatment, education, and employment of the mentally retarded, and training and education of parents, professionals, and volunteers.

- The international movement for the mentally retarded, their families and friends, **Faith and Light**, is another NGO active in the area of mental retardation. It is dedicated to young people and provides support to persons with mental retardation and their families. It helps the mentally retarded become self-sufficient and attain spiritual and emotional maturity.

- **The Coalition for Mental Health**, which is the only organisation to co-operate with the World Federation for Mental Health, could become a key partner in the project on mental health in the workplace. It was established in 1993, and, in 1997, was granted legal status as a nation-wide association, with headquarters in Warsaw and five regional sections.

In Poland, organisations that benefit the mentally retarded are relatively well developed and can serve as models for organisations devoted to people with mental illness.

From the bylaws of the Coalition for Mental Health

Chapter 2, Article 6.

The aims of the Coalition are:

- Mental health promotion.
- Providing better opportunities for getting competent assistance in a mental health crisis.
- Taking steps to improve the living conditions of people who have or used to have mental health problems.
- Organising co-operation between self-help groups, professionals, professional associations, and local authorities.
 - Submitting opinions to the authorities on legal regulations, expertise and projects relating to changes in the field of mental health.
- Creating conditions enabling people diagnosed as mentally ill to enjoy their rights as human beings and as citizens.
- Promoting attitudes favourable to the social integration of people who have or used to have mental health problems.
- Co-operating with national and international organisations with similar objectives.
- Lobbying for the amendment of the Act on Associations so that the association of federations and other legal (non-profit) entities, as well as its individual members, are able to pursue a common purpose.

Chapter 2, Article 7

The Coalition achieves its goals through:

- Encouraging the exchange of information and experience among its members.
- Education and information programmes.
- Publications.
- Consulting to Coalition members.
- Consulting to other organisations, institutions, and individuals active in the area of mental health.
- Providing expertise and conducting research to further the objectives of the Coalition.
- Establishing self-help centres, therapeutic and rehabilitation services, and other facilities which provide social support and promote the social integration of people who have or used to have mental health problems.
- Supporting self-help activities for people with mental health problems.
- Supporting self-help activities for families of people diagnosed as mentally ill.
- Assisting persons after psychiatric treatment in their attempts to find employment and live independently.
- Supporting professionals who co-operate with self-help organisations in developing their qualifications.

The Coalition's first priority is to co-operate with other associations, societies, and institutions dealing with the problems of health and disability and dedicated to improving the quality of life and the cultural level in Poland. It strives to bring together scientific and educational institutions; professional organisations of lawyers, physicians, nurses, psychologists, sociologists, social workers, therapists, rehabilitation specialists, teachers, and educators; Parliament and Senate committees; trade unions and employers' organisations; local authorities; local and state administration; mass media, artists, and scientists and their organisations.

The Coalition's activities have been supported by the World Federation for Mental Health, the Committee for Ethics, Law and Psychiatry affiliated with the Council of Europe, the European Association of Users and Former Users of Mental Health Facilities, and the European Association of Families of the Mentally Ill. The Coalition participates in the collaborative network organised by the European Forum of NGOs dedicated to the problems of disability.

An extract from the Coalition's by-laws is reproduced above. Only Article 7.10 pertains to activities that enable people with mental health problems to gain access to the labour market. It states that one of the ways in which the Coalition will fulfill its mission is by: "Assisting persons after psychiatric treatment in their attempts to find employment and live independently."

Though there are NGOs which do some work toward preparing the disabled for paid employment, there is still no effective support system to help peo-

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ple suffering from mental health impairments to compete in the open labour market.

Academic Institutions

In Poland, the Institute of Psychiatry and Neurology is the only academic institution that conducts research and training in the field of mental health and also provides mental health services. Beyond education, the role of the Psychiatric Clinics of the Academies of Health is confined to supervising the quality of psychiatric services. The Central Institute of Labour Protection and The Institute of Occupational Medicine are engaged in research on work and the working environment.

The Institute of Psychiatry and Neurology combines research and training in the field of mental health with the delivery of mental health services.

- **Institute of Psychiatry and Neurology, Warsaw**, was established by the Cabinet in 1951. It was conceived as a national centre for promotion of basic and clinical research on mental and neurological disorders. After several reorganisations, the Institute has created new clinical and theoretical departments, opened new laboratories, and has expanded its research into new areas. These include organisation of psychiatric and neurological health care, genetics, pathogenesis and treatment of depressive disorders, alcohol and drug abuse, psychopharmacology, psychotherapy, and neurochemistry. Modern diagnostic and research techniques, including magnetic resonance imaging (MRI), were introduced during the last decade.

The Institute consists of 25 departments, including, four departments of psychiatry, two departments of neurology, the Department of Neurotic Disorders and Psychotherapy, the Department of Child and Adolescent Psychiatry and the Department of Forensic Psychiatry. Several departments conduct basic research, frequently in co-operation with other clinical units. They include the Departments of Biochemistry, Pharmacology, and Physiology of the Nervous System, Genetics, Neuropathology, and Clinical Neurophysiology.

The epidemiological and statistical studies carried out by the Department of Studies on Alcoholism and Drug Dependence and the Department of Health Care Organisation provide a conceptual basis for health policy including the organisation of the treatment system.

Considerable work is devoted to pathogenesis and new methods of diagnosis, prevention, and treatment of depressive disorders, schizophrenia, and alcohol and opiate dependence. The Institute co-ordinates cerebral stroke studies carried out in Poland with centres abroad. It also acts as the co-ordinator of the Research Program on Mental health disorders and Diseases of Nervous System, sponsored by the Ministry of Health and Social Welfare.

The Institute collaborates with 50 scientific centres around the world. The World Health Organisation designated it a Collaborating Centre for Research and Training in Mental Health for 1992-1995, a designation that has been extended until 2000. It publishes the following journals:

- Farmakoterapia w Psychiatrii i Neurologii (Pharmacotherapy in Psychiatry and Neurology), quarterly;
- Postepy Psychiatrii i Neurologii (Advances in Psychiatry and Neurology), quarterly;
- Alkoholizm i Narkomania (Alcohol and Drug Abuse), quarterly;
- Rocznik Statystyczny (Statistical Yearbook).

In addition to being a research institution, the Institute is also a psychiatric and neurological hospital. It provides treatment to patients with mental and

neurological disorders and serves as a nation-wide consulting centre. It takes part in nation-wide supervision in psychiatry, neurology, and clinical psychology, and has acted as a supervisory board and adviser to the Ministry of Health. Its staff members serve on other supervisory and advisory bodies, including the Commissions for Postgraduate Education in Psychiatry, Neurology and Psychology, and the Drug Commission.

The Institute organises postgraduate training for psychiatrists, neurologists, clinical psychologists and psychotherapists and courses that address the professional needs of physicians, psychologists, nurses, social workers and teachers. It collaborates with the Medical Academy in Warsaw in teaching pharmacology, biochemistry, and psychiatry to medical students, and with Warsaw University in teaching psychology.

- **The Central Institute of Labour Protection, Warsaw**, carries out research on the impact of working conditions on security, health and behaviour and provides training for people preparing for the job market. It publishes *The International Journal of Occupational Safety and Ergonomics* and *Podstawy i metody oceny Srodowiska pracy* (Methods for evaluating the work community)
- **The Institute of Occupational Medicine, Łódź** is a leading academic institution in research on occupational safety and health issues in the workplace. It also focuses on public health, including health promotion.

The Institute's Department of Work Psychology offers training and educational programmes for psychologists, medical students, physicians, and nurses carries out research on the following topics:

- Psychological aspects of exposure to workplace stressors and the development of research methods to determine this assessment.
- Psychological determinants and consequences of violence at work
- The development of norms and criteria for assessing occupational exposure to workplace stressors and neurotoxic chemicals.
- Psychological aspects of health promotion in the work place
- Occupational determinants of workers' mental health
- The development of new methods in the area of health and occupational psychology
- Methodological supervision of occupational psychologists.

The Institute's Occupational Stress Unit performs research on:

- Health effects of occupational stress (chronic stress and trauma at work)
- Determinants of resistance to stress
- Burnout and its effects on workers' health
- Stress prevention
- Implementation of stress prevention programmes in the work place
- Development of educational programmes for occupational and health psychologists.

The Institute publishes the following journals:

- *International journal of occupational medicine and community health* (quarterly)
- *Medycyna Pracy* (Occupational Medicine).

Two Polish institutes study work and the working environment.

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CONCLUSION

To promote mental health care reforms in Poland, it is necessary to develop integrated prevention, treatment, and rehabilitation programmes at the level of small administrative units and to delegate responsibility for their implementation to local authorities.

In Poland the issues and concerns relevant to mental health in the workplace have not been adequately addressed to meet the needs of the population. Current methodology and tools are inadequate and information is insufficient. The available data is fragmentary, and there has been no follow-up or in-depth analysis.

The core of the problem lies in the government and in social attitudes towards people with mental health disorders. Though change is coming gradually, most facilities and services for the mentally ill are still located in large psychiatric hospitals with little connection to the local community. To promote mental health care reforms in Poland, it is necessary to develop integrated prevention, treatment, and rehabilitation programmes at the level of small administrative units and to delegate responsibility for their implementation to local authorities. This should lead to an increase in financial support and to more effective collaboration between the various stakeholders in mental health protection, including employers.

Mental health protection is one of the main objectives of reforms. It should include:

- Providing people with mental health disorders with the resources to live in the community. This means more housing (ranging from independent to sheltered housing) and capability-matched working conditions; steps should also be taken to improve the quality of life of the chronically mentally ill;
- Mental health promotion should involve the State, local communities, educational institutions, and employers in providing for the psychological and social needs of the individual;
- Services should, first and foremost, target people at risk of mental health disorders or health-compromising stress reactions; they should include early diagnosis and intervention. Services should be provided mainly by the primary care system, but there should also be specialised facilities for psychological counselling and crisis intervention, which would offer help in coping with difficult life situations and in developing problem-solving skills.

Because of the specific situation of the mentally ill in Poland and the current status of programmes promoting change in the field of mental health protection, the Mental health in the workplace project should address the following:

- Legislative initiatives obliging employers to provide working conditions which promote mental health development and maintenance; A statutory guarantee of the right to employment for persons disabled by mental health disorders, including opportunities in sheltered workshops;
- Development of community psychiatric care and prevention programmes involving appropriate local institutions (including employers' organisations) in measures on behalf of mental health protection and delivery of care to the mentally ill;
- Research on the consequences of the socio-economic transformation in Poland. These have included: privatisation of enterprises and the rise of unemployment; changes in the agricultural sector which will require about a million people to seek new types of employment; the post communist syn-

drome of learned helplessness, which persists in many people, and is characterised by an inability to make independent decisions, reliance on outside help to solve problems, and poor skills of self-promotion which impact job seeking.

Another issue that impacts mental health protection, especially in the workplace, is the inadequate legislation covering the employer's obligations toward the worker. Current regulations do not sufficiently protect workers' mental health and oblige employers to ensure mental health protection. Information from the Ministry of Labour seems to indicate that, in Poland, there is only limited familiarity with relevant legislation in other countries. Since there are no legal standards defining working conditions necessary to protect mental health in workplace, the State Labour Inspectorate cannot exercise a control function in this area. The enactment of these standards should be major goals for research, policy development. and implementation.

Poland is just beginning the process of involving employers, trade union representatives and professionals in occupational medicine in these problems. Change is highly dependent on the stabilisation of the Polish economy. The significant strides made since the transformation of the Polish economy began a decade ago bode well for the prospects of initiatives promoting mental health in the workplace.

The significant strides made since the transformation of the Polish economy began bode well for the prospects of initiatives promoting mental health in the workplace.

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