PSYCHOTERAPIA 1 (212) 2025
PAGES: 19–28
DOI: 10.12740/PT/202296

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OPEN DIALOGUE METHOD – A REVIEW OF INTERNATIONAL RESEARCH AND THE SITUATION IN POLAND

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Open Dialogue
psychosis
mental health

Summary

Open Dialogue (OD) is a method of treating people who have experienced psychosis. It was created in Finland and is gaining interest in many countries. It is an alternative approach to traditional psychiatric treatment, its aim is to deal with the healing process of the person, instead of focusing on the illness. Studies conducted so far indicate high effectiveness of OD in shortening the duration of hospitalization, reducing the dose of neuroleptic drugs and the risk of social exclusion. The article reviews studies on attempts to implement OD in various countries, focusing on the difficulties that arise in this process. The most common challenges were financial costs, adaptation to all patients, difficulties related to ensuring mobility, creating cooperation between specialists and a shortage of staff. Then, reference was made to the situation in Poland, where the Polish Open Dialogue Institute (PIOD) has been operating since 2011 and Mental Health Centers (CZP) have been developed since 2018. It seems that the experiences of various countries in implementing the OD method may be valuable in the process of developing the CZP, especially since the experiences of PIOD indicate that the OD methods are effective not only in working with people with experience of psychosis.

Open Dialogue – model and its history

Open Dialogue is a model for treating individuals who have experienced a psychotic crisis. This method is gaining popularity in many countries. It includes both a therapeutic intervention adapted to the individual needs of the patient and a specific way of organizing the work of the staff. The aim of this model is to support the person who has experienced a psychotic crisis and their recovery process by involving their social network, rather than focusing solely on the illness, offering an alternative to traditional psychiatric treatment [1, 2]. From this perspective, psychosis is not understood as an illness, but as an experience or a reaction to crisis. Therapeutic intervention involves working not only with the patient, but also with their social network, including family, friends, and healthcare professionals

involved in the treatment process. This method is based on collaboration, dialogue, and jointly seeking a way out of the crisis the patient is experiencing. The focus is not on making a diagnosis, but on understanding the meaning of the symptoms. Decisions are made through network dialogue rather than through professional directives. Thus, flexibility and mobility of the therapeutic team are extremely important. Immediate intervention is also crucial, as it can prevent the development of pathological intrapsychic mechanisms [3].

The creators of the model are Jaakko Seikkula and Brigitta Alakare, and its origins can be traced back to the need-adapted approach (NAA) [1], developed in the context of the Finnish Turku project and the national schizophrenia project [3]. In these projects, the treatment of psychosis was seen as a continuous process, in which various treatment methods were combined to meet the therapeutic needs of each patient and their social networks [4]. The emergence and development of the Open Dialogue model were linked to systemic changes in psychiatry in Tornio, Finland, in the 1980s, which included the introduction of family therapy training for various psychiatric professions [3]. The core idea of this treatment system was to focus on the patient's family and social network [1].

The Open Dialogue method emphasizes the importance of the time elapsed between the onset of a psychotic crisis and the initiation of treatment—the longer this period, the worse the prognosis [3]. The procedure begins with a meeting during which a team is assembled to match the specific needs of the patient. This team typically includes two or three professionals from an outpatient clinic or hospital (e.g., a psychiatrist, psychologist, psychotherapist, nurse, or social worker). This team is responsible for the entire course of the patient's treatment, regardless of its duration or whether the patient is at home or in the hospital. Open Dialogue is based on collaboration among various professionals, allowing the patient to avoid simultaneous interactions with multiple, separate institutions. This prevents chaos and enables more effective action. This is a shift from the traditional model of team meetings aimed at treatment planning and separate individual or family therapy sessions to open meetings that combine treatment and planning, both within the patient's personal network and among professionals [3]. The method is based on the premise that neither clients nor professionals operate in isolation. It focuses on cooperation within the patient's social network, rather than on treatment in the conventional sense. Working with the Open Dialogue method requires adopting an open attitude and striving to understand the meaning of symptoms for the individual. This calls for a change in how professionals view the patient and function within a team. One major challenge for therapists is abandoning the hierarchical division of responsibility, especially when working with someone in an acute crisis [3].

The Open Dialogue method is built on several principles: immediate response (therapeutic intervention takes place within 24 hours of the crisis), inclusion of the social network (e.g., family), flexibility and mobility (e.g., meetings at the patient's home, or, if not possible, in a clinic or hospital; treatment plans are continuously adapted to the patient's evolving needs), shared responsibility (treatment decisions are made together with the patient), continuity of psychological support provided by the same therapeutic team, tolerance of uncertainty, and the adoption of a dialogical attitude. Meetings focus on discussing the patient's individual situation rather than on the illness itself [3, 5]. The goal of immediate intervention is to avoid hospitalization, so several initial meetings take place during the

peak of the psychosis. Including the social network is key to understanding the problem, as it is often the patient's close relatives who first notice the issue. Flexibility and mobility involve adapting therapeutic methods to the changing needs of the patient. Shared responsibility refers to making treatment decisions together with the patient. The team remains responsible for the therapy as long as needed, regardless of the patient's location, and does not refer them elsewhere, though it may include, for instance, an addiction counselor. Ensuring continuity means that different specialists cooperate within a single therapeutic process, rather than competing with one another. Tolerating uncertainty is related to providing a sense of safety for the patient and their network, ensuring everyone feels heard and empowered to influence their own lives.

This stands in contrast to illness-oriented practices, where the primary goal in the early stages of treatment is usually symptom reduction, most often through the use of neuroleptics. Adopting a dialogical approach primarily means focusing on supporting dialogue and only secondarily on promoting change in the patient. Dialogue becomes a space where the patient and their network, by discussing existing difficulties, can gain greater agency in their lives. The therapeutic meeting is a shared exploration. The team does not set a predefined topic for the meeting but guides the dialogue based on what the participants say. Everyone has the right to comment on others' statements. Professionals may ask follow-up questions or share reflective thoughts. The dialogical approach should therefore be understood not merely as a conversation between participants, but fundamentally as a dialogical relationship based on shared thinking, not just on exchanging questions and answers. All participants—not just individuals—become thinking subjects. The meeting takes on a team-based form and is built on mutual listening and sharing of thoughts and emotions. The group of professionals is responsible for ensuring that all participants feel important, and for providing safety and predictability throughout the meetings. These principles were developed based on research into therapeutic effectiveness and quality, rather than being imposed in advance as formal guidelines [3].

The team consists of at least two professionals, the patient, and their social network, and the core of its work is shared reflection. It is important that the team includes people from diverse professions—psychiatrists, psychotherapists, occupational therapists, nurses, social workers, and peer support workers. The varied experiences and perspectives of team members foster reflectiveness and openness, making the quality of the co-therapist relationship crucial to the therapeutic process [1, 6, 7].

Open Dialogue worldwide

This article presents research on the effectiveness of the Open Dialogue model and experiences related to its implementation in various countries, also highlighting clinicians' perspectives. Both meta-analyses [4, 5, 9, 20, 21] and individual research projects [6, 7, 8, 11, 12, 13, 14, 15, 16, 17, 18, 19, 22, 23] have been referenced. Most studies concerning the Open Dialogue method have focused on treating psychotic disorders, but the conclusions drawn are not specific to this particular diagnosis [3]. In Western Lapland, attempts have been made to apply the principles of Open Dialogue in all types of psychiatric treatment

conducted in the region, regardless of the diagnosis [4]. This method was also introduced in 2017 in an Australian women's shelter [8]. In Poland, Open Dialogue has been utilized at the Day Center for Psychiatry and Speech Disorders for Children and Adolescents in Wrocław (https://otwartydialog.pl/otwarty-dialog-w-kryzysie-psychotycznym).

The goal of the Open Dialogue method was to create a comprehensive, psychotherapeutically oriented treatment model within the public mental health sector to meet the real and changing needs of patients with schizophrenia and their families [3]. It aimed to be a family-oriented model promoting reciprocal dialogues between patients, their social networks, and mental health professionals, leading to a shared understanding of the situation [4]. The expected outcome was the patient's return to active social and professional life and a reduction in the intensity of psychotic symptoms.

One of the first studies on the effectiveness of the Open Dialogue method was the ODAP (Open Dialogue Approach in Acute Psychosis) program, which ran from January 1994 to March 1997. It also examined the role of neuroleptics in treating psychotic episodes. In comparison groups, neuroleptics were administered traditionally, while in the study groups, efforts were made to avoid them in the early stages of treatment (benzodiazepines were used if necessary in the first three weeks, and neuroleptics were introduced only if there was no improvement). According to the method's principles, the integration of pharmacological treatment with psychosocial interventions was attempted. Effectiveness assessments were conducted at the beginning, after two years, and after five years. The two-year study indicated that patients in the comparison group were hospitalized more frequently than those treated according to the Open Dialogue method. In the study group, one-third of patients were treated with neuroleptics, whereas all patients in the comparison group received them. The five-year follow-up study demonstrated that patients treated with the Open Dialogue method were hospitalized significantly less often than those in the comparison group. Treatment outcomes showed that patients participating in Open Dialogue programs recovered better from psychotic crises, had fewer relapses, experienced fewer residual psychotic symptoms, and had better occupational outcomes (returning to work or education; while most patients in the comparison group were on disability benefits, only 19% in the study group were) [3]. Studies conducted in Tornio observed a significant decrease in the incidence of schizophrenia and a reduction in the number of individuals with chronic schizophrenia who were continuously hospitalized [3]. These studies also highlighted the importance of patients' situations before experiencing a crisis: those who lived passively, did not work, or did not seek employment were more likely to have poor outcomes two years after the crisis. However, many exceptions to this rule were noted [1].

Many studies from various countries align with those from Finland. Analyses of the relationship between the duration of untreated psychotic episodes and outcomes 12 years after the first episode indicate that a longer duration of untreated psychosis leads to more severe symptoms, poorer functioning in remission, and lower quality of life [9]. Early intervention and involving the social network in the treatment process are crucial for the course of the crisis and are associated with higher motivation to continue treatment. Many studies indicate that using the Open Dialogue method resulted in shorter hospitalizations and the use of lower doses of antipsychotic medications [10, 11], and also significantly reduced the risk of social exclusion, although it did not prevent the occurrence of the cri-

sis itself. A long-term treatment effect is also evident [11, 12]. However, analyses of the implementation and effectiveness of Open Dialogue are often of low quality, with small study groups, and lack consistent implementation strategies or methods for verifying this approach [2, 5]. It is not a single intervention but rather a set of principles and practices that integrate various treatment approaches depending on needs, which may complicate the identification of key components for success and research on its effectiveness [9].

Studies on attempts to introduce Open Dialogue in the USA and the UK have shown that although the method was considered clinically helpful, the costs of training and implementing it in the local context posed significant challenges [12, 13, 14, 22]. In a 12-month study in the USA involving 16 patients and 8 team members, it was demonstrated that the Open Dialogue method could play an important role in American mental healthcare. The greatest difficulty in implementing the project was financial costs. Insufficient funds were found for the participation of many clinicians in meetings, travel to patients, or varying meeting durations. The study also indicated that this method might be unsuitable for families with conflicts or a history of violence [12].

In Portugal, a small crisis team was created consisting of two clinical psychologists (also trained as psychotherapists), one clinical psychologist with a doctorate in psychotherapy, and one psychiatrist. All team members underwent Open Dialogue training. The team worked five days a week with the aim of improving the quality of psychiatric, psychological, and social services for people experiencing mental health crises. The conducted study indicated positive outcomes of this method, including improved functioning within patients' social networks, better interpersonal relationships, and symptom reduction. However, the study also pointed to difficulties in implementation, particularly due to a shortage of professionals in the fields of psychotherapy and psychiatry [15].

Australian clinicians showed openness and a supportive attitude toward implementing Open Dialogue; however, the method was challenged by the dominant medical model and the emphasis on cost-efficiency in treatment [16]. Research conducted in Australia also showed that professionals experienced the dialogical attitude as disorienting and risky in terms of self-disclosure [17].

During a study in Greece, clinicians participated in short online seminars led by Scandinavian specialists, rather than a full Open Dialogue training. Additionally, a weekly discussion group was established for professionals to promote familiarization, self-education, and reflection on Open Dialogue practices and other topics emerging from implementation efforts. The method was appreciated by clinicians, who saw it as a source of personal professional development, increasing openness and teamwork. Its implementation involved acknowledging the limitations of professionals, challenging their perceived omnipotence, and moving away from the position of authority. At the same time, clinicians highlighted the challenges and uncertainty in connecting theoretical assumptions with practice, as well as cultural differences that complicated the implementation of the method [18].

In Spain, Open Dialogue was first used as a therapeutic tool in 2016 at the Mental Health Center in Badalona [19]. Its implementation in the country was marked by regional variation—in some cases, professionals incorporated Open Dialogue principles into their individual practices or integrated them with other existing methods. Peer support workers with lived experience were often involved. Some associations and groups developed their

own approaches based on Open Dialogue frameworks. In 2020, the first university course on the method was offered in Barcelona, and in 2022, an online course co-led by Jaakko Seikkula was launched at the University of Almería. Another example of the growing interest in this approach was the 26th International Open Dialogue Network Meeting for the Treatment of Psychosis, held in Spain in 2022 [19].

A review of studies on the implementation of Open Dialogue in Scandinavian countries pointed to challenges faced by staff, despite greater cultural coherence. Common difficulties included interdisciplinary collaboration, high levels of uncertainty and anxiety regarding self-disclosure, and the challenge of relinquishing the expert role [20].

The success or failure of implementing Open Dialogue can be attributed to various organizational, social, and cultural factors. The most commonly reported obstacles involved organizational and financial issues, as well as a lack of sufficient mental health professionals. Crucial factors influencing implementation outcomes also included the engagement and collaboration of specialists [12, 13, 14, 15, 16].

The role of professionals is central to the introduction and development of the Open Dialogue method and dialogical thinking in working with people experiencing mental health crises. Research indicates that most professionals consider this method valuable in building relationships and dialogue, both within the team and in contact with the patient, as well as in personal development [12, 17, 18]. At the same time, adopting an open, reflective attitude proved to be challenging, likely because it represents a way of being with others rather than just a professional technique [14, 20]. Clinicians experienced uncertainty as they tried to maintain appropriate boundaries between an authentic, reflective "not-knowing" attitude and self-disclosure. Reverting to earlier psychiatric practices and relying on professional knowledge helped reduce their professional anxiety, restoring a sense of control over the therapeutic process [17, 18, 21]. Another challenge for professionals was letting go of the traditional expert role, rethinking both the treatment process and their own professional identity, and tolerating the uncertainty associated with applying a relational approach in clinical practice [14, 18, 20]. Professionals also often felt a greater sense of responsibility associated with limiting hospitalization [11]. They valued interdisciplinary collaboration, although it posed challenges that required questioning existing hierarchies and building a dialogical culture of cooperation. Therefore, relationships among team members are also a key factor [13, 18, 21, 23].

Community psychiatry, community Mental Health Centers, and Open Dialogue in Poland

Since the 1970s, the community-based model of psychiatric care has been developed in Poland. Since that time, the number of mental health clinics, community treatment teams, 24-hour psychiatric wards, and day hospitals has increased. Additionally, within the framework of social assistance, community-based social support facilities for people with mental illnesses have been established [24]. The community care model refers to the treatment and organization of psychiatric care, as well as the philosophy behind its functioning. Its development is linked to the abandonment of isolation-based treatment

for individuals with mental health disorders [10]. The essence of the community model is treating people experiencing mental health crises, focusing on the healing process by addressing various aspects of mental health, with an emphasis on the crucial role of the environment. Social and occupational activation of those affected by the crisis is understood as a form of rehabilitation. It also includes other aspects of mental health, such as prevention, education, and promotion; however, in practice, it most often focuses on treating individuals affected by crises [10, 24].

An important role in the development of community-based care and the concept of Open Dialogue in Poland is played by the Polish Institute of Open Dialogue (PIOD), a foundation that has been operating since 2011 in Wrocław. Its aim is to support individuals experiencing difficulties with mental health in their healing process and to organize Open Dialogue courses in cooperation with other countries. The foundation has trained 54 individuals in Poland. PIOD emphasizes that the implementation of Open Dialogue in Poland requires changes to regulations regarding the financing of psychiatric care and the preparation of conditions for this method (particularly in terms of early intervention and mobility). Despite these limitations, there are centers in Poland attempting to implement and apply the principles of Open Dialogue (https://otwartydialog.pl/otwarty-dialog-w-kryzysie-psuchotycznym).

Since 2018, as part of a pilot program, Mental Health Centers (*Centra Zdrowia Psychicznego*, CZP) have been developed in Poland. According to the Ministry of Health's regulation of September 13, 2023, the functioning of CZPs aims to provide comprehensive psychiatric care and coordinated actions by specialists, community treatment teams, home care, as well as care in day and 24-hour institutions. Their tasks also include reducing the frequency and duration of hospitalizations, integrating individuals experiencing mental health crises into the local community, preventing exclusion and stigmatization, engaging caregivers, recognizing the autonomy of patients, and adjusting treatment to their needs, mental health prevention, and implementing staff training. CZPs are being created in accordance with the number of residents in a given area, so that territorial responsibility covers no more than 200,000 people. CZPs are also expected to provide immediate assistance in emergency cases and, in urgent cases, within 72 hours. Therefore, the development of CZPs can be seen as consistent with the concept of both community psychiatry and Open Dialogue in terms of replacing a healthcare system based on hospitalization and isolation, focused on the illness process, with an approach aimed at the healing process. However, in Poland, there is a lack of financial mechanisms that would allow for services for a single patient to be provided simultaneously by multiple professionals [3].

Open Dialogue and Community Mental Health Centers (CZP)

In Poland, most attempts to implement the Open Dialogue approach have been based on project activities, which are inherently time-limited, even if they brought good results. The cited studies indicate that the implementation of Open Dialogue as a method faces many challenges, including financial costs, incompatibility with all patients, ensuring mobility,

cooperation among various specialists, and a shortage of staff [12, 13, 14, 15, 16, 17, 18]. At the same time, the results regarding the effectiveness of the method are promising, and specialists appreciate the dialogical approach to working with patients [11, 12, 13, 14, 15, 18]. Experiences from different countries highlight the importance of cultural differences and adapting existing structures to innovative methods. It seems that a good direction could be an attempt to philosophically align the Open Dialogue model with the adopted policy of public mental health organizations [9], especially in the context of actions by, among others, the PIOD foundation, which points out that Open Dialogue methods are effective not only in working with people with experiences of psychosis.

The principles of CZPs are partially consistent with the working methods of Open Dialogue. This includes a focus on the patient (rather than the illness), immediate or urgent help, mobility and flexibility, and reducing the length and frequency of hospitalizations. In both cases, it is important to maintain the activity of the person experiencing a mental health crisis (CZP emphasizes integrating them into the local network and preventing exclusion) and the involvement of the social network in the healing process (in CZP, this concerns caregivers). Collaboration among various specialists is also highlighted as essential, although CZP does not propose simultaneous meetings of the team and the patient. Building cooperation and openness within a team of various specialists has proven difficult to implement, as shown by experiences from different countries described in the cited studies. Therefore, this seems to be an area requiring particular attention in the process of developing CZP. A noteworthy example of such actions is the introduction of weekly discussion group meetings for specialists in a Greek project, which could be a valuable element in fostering a cooperative and open atmosphere, as well as engaging and integrating different approaches and specializations [18]. It is important to observe the development of the changes being implemented, as experiences from research on the Open Dialogue method may prove helpful in the process of developing dialogue both with people experiencing a crisis and between different specialists. An interesting idea is also the introduction of Open Dialogue courses at universities in Spain [19]. These could shape a dialogical, open way of thinking among students who are still in the early stages of their professional careers. This aligns with the previously mentioned review of research [20], which showed that less experienced specialists found it easier to integrate the principles of Open Dialogue into their professional practice [18].

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