SPECIAL PAPER

Mental health reforms in the Czech Republic

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This paper describes the history and current provision of mental healthcare in the Czech Republic. After the political changes in 1989, there was an expansion of out-patient care and several non-governmental organisations began to provide social rehabilitation services, but the main focus of care still rested on mental hospitals. In recent years, mental health reform has been in progress, which has involved expanding community-based services and psychiatric wards of general hospitals, simultaneously with educational and destigmatisation programmes.

Mental health services in European countries of the former communist block are characterised by the persistence of asylum-type care. They show only slow changes towards modernisation of their mental healthcare systems (Krupchanka & Winkler, 2016). The aim of this article is to provide insight into the past and present development of mental healthcare in the Czech Republic, as an example of those countries where steps towards mental health reform have recently been initiated.

Basic data about the Czech Republic

The Czech Republic is a landlocked country situated in Central Europe. It covers an area of 78 866 km^2 and in 2016 had a population of 10.55 million. Measured by gross domestic product (GDP) per capita, it ranks among the group of high-income countries.

Historical context

Since the late 19th and early 20th centuries, mental hospitals have traditionally been basic providers of psychiatric care. After the Second World War and at the beginning of the communist regime, only minimal changes were made to bring mental healthcare closer to the social context of patients, e.g. the launch of a network of out-patient psychiatrists, establishment of a day clinic for anxiety disorders in Prague and psychotherapeutic programmes for patients with schizophrenia in some departments of mental hospitals.

The 1989 ‘Velvet Revolution’ to some extent broke down state hegemony for the provision of care, and opened the doors to civic initiatives and the greater application of human rights. The system of health insurance enabled independent contracts with out-patient psychiatrists and psychologists, the foundation of new psychotherapeutic day clinics and, to a limited extent, mobile teams of psychiatric nurses and a few crisis centres. By the 1990s, new non-governmental organisations (NGOs) had already started to emerge and function within the social sphere. They were directed towards providing psychosocial rehabilitation in a community setting and were mainly staffed by social workers. Community multidisciplinary case management teams have only recently been formed in some places. Together with the development of non-profit services, the self-awareness of patients has grown and several patient organisations have been established (Hoschl *et al*, 2012).

Current state of mental healthcare

Mental health services in the Czech Republic are not as well financed as those in Western European countries, with their funding being comparable with that in Eastern European countries, although GDP in the Czech Republic is substantially higher (Winkler *et al*, 2013). In 2006, the share of mental health expenditure out of total health expenditure was estimated at only 4.14%. Moreover, 52.4% of these resources were allocated to mental hospitals (Dlouhy, 2011). In EU15 countries, this share is estimated at 7%, and in Eastern European countries at 3.3% (Krupchanka & Winkler, 2016).

As indicated above, mental hospitals are traditional and the best-funded component of mental healthcare. In 2015, there were 18 mental hospitals for adults with 8583 beds, and three psychiatric hospitals for children with 250 beds. Soon after the Velvet Revolution, the number of beds decreased. However, in subsequent years, this decrease was slighter (IHIS, 2016; Winkler *et al*, 2016). In spite of this reduction, the number of beds per hospital still remains very high. In 2014, there were on average 491.7 beds per hospital, which was a much higher number than in EU15 countries (184.6), and even higher than the average of 466.6 Eastern European countries (Krupchanka & Winkler, 2016).

The care provided in psychiatric asylums is highly disproportionate to the other components of care. Only one-fifth of in-patient care is provided in psychiatric wards of general or university hospitals. In 2015, there were 30 of these departments with 1308 beds. Even the out-patient sphere of care cannot compensate for the imbalance. In 2015, there were 875 full-time posts for out-patient psychiatrists (8.3 per 100 000 inhabitants), having 650 000 patients in their care. From 2013, the

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Table 1
Core activities of the psychiatric reform

Activity area	Activities
Quality of care	Identifying patient needs and their perceptions of quality of care
	Standards of care; guidelines for professionals
	Introduction of the quality system into practice; control system and certification
Regional networks of care	Creation of regional networks
Deinstitutionalisation	Educational programmes for hospital management
	Strategy of deinstitutionalisation; transformation plans for mental hospitals
Cooperation with related professions	Rules and procedures for relevant professions; seminars and educational programmes
Reimbursement mechanisms	Analysis and a new system of reimbursements
Introducing a multidisciplinary approach	Methodological support; courses and education
Support for multidisciplinary teams	Supervision, coaching, seminars
Sharing of good practice	Study internships in places of good practice for professionals
Operational support for new services	Out-patient departments with extended care, day clinics
	Educational courses for professionals; local and foreign internships
Draft amendments to the educational programmes	Proposals of educational programmes for relevant professions
Commissioning and pilot testing of Mental Health Centres	Launching of 30 pilot Mental Health Centres
Information instruments for monitoring the structure and quality of care	Informational portals, instruments for data collection
Destigmatisation	Regional destigmatisation campaigns
	Regional programmes for primary prevention

number of patients increased by approximately 8% (IHIS, 2016). Qualitative studies showed that out-patient psychiatrists are overloaded; they are forced to refuse new patients, or have long waiting times of up to 6 weeks for new patients (Raiter *et al*, 2004). The overload of out-patient psychiatrists is linked to inadequately developed community services, which then cannot take on the burden of care for seriously mentally ill patients. Only 21 day clinics and three crisis centres are operating in larger cities. Similarly, there are only a few case management teams staffed by psychiatric nurses or social workers. According to a census of the Community Care Association (Raboch & Wenigova, 2012), in 2011 psychiatric rehabilitation services were carried out by 30 NGOs, caring for approximately 3870 clients with serious mental illnesses and employing 326 social workers. Only 20 of these organisations provided sheltered housing or supported housing with trained staff, so the number of beds within community living remained low and was much lower than in social institutions.

The current status of care, with inadequately developed community services and the prevailing care in mental hospitals, might explain some recent alarming findings. In 2012, the average length of in-patient treatment for schizophrenia spectrum disorders was more than 100 days, which was several times higher than in high-income countries. Moreover, nearly 15% of those patients who were in hospital for more than 1 year between 1998 and 2012 were readmitted to hospital within 2 weeks of discharge (Winkler *et al*, 2016). During the 4-year research period, 402 out of 137 290 in-patients died by suicide during their hospital stay or within the 2 months after discharge (Winkler *et al*, 2015b). These findings are mirrored by the attitudes of society. The prevalence of reported intentional stigmatising behaviour towards people with mental health problems in the Czech Republic is worrying and is much higher than in England (Winkler *et al*, 2015a).

Mental health reform

Efforts to change mental healthcare has for many years been solely advanced by NGOs and the Czech Psychiatric Association. Only recently has the interest of the Czech government been instigated in relation to the new programming period of EU Structural and Investment (ESI) funds. The Czech Ministry of Health has decided to use 2014–2020 ESF funds partly for psychiatric care. The Ministry of Health, assisted by teams of mental health professionals, experts and patients, created the Strategy for the Reform of Psychiatric Care, which was issued in October 2013 (MHCR, 2013). The global aim of the Strategy is to improve the quality of life of people with mental illness, and its strategic aims are to reduce stigmatisation, to increase the satisfaction of patients and the efficacy of psychiatric care, to increase inclusion of patients into the community, to improve the linkage between health and social services, and to humanise psychiatric care. As the main instruments for attainment of these goals, the Strategy proposes destigmatisation programmes and educational programmes for public and mental health professionals. In relation to services, besides the enlargement of out-patient psychiatric care and in-patient care in psychiatric departments, the Strategy introduces a new element, Mental Health Centres (MHCs). According to guidelines endorsed by the Ministry (MHCR, 2016), MHCs should be developed for catchment

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areas of 100 000 inhabitants and offer community services for severe mental illnesses (SMI). An MHC multidisciplinary team should be staffed by nine psychiatric nurses, nine social workers, two psychiatrists and one psychologist. It should provide mobile case management services, crisis interventions, day care services, and out-patient psychiatric and psychological care. The Centres must be continuously accessible by telephone and available 12 h per day for out-patient visits. Moreover, they should be equipped with 2–10 beds for short-term emergency stays. During 2017, a pilot operation will be launched in 30 Centres; this will be financed from EU funds during the first 18 months, then subsequently by the public health insurance system and local social funds. The guarantor of the Reform is the Czech Psychiatric Association, which is preparing for the individual activities of the Reform in close cooperation with the Ministry of Health (see Table 1).

Future tasks

Although the first plans for the transformation of hospitals are already included in the current Reform, more effort will be needed for deinstitutionalisation of large hospitals in future, in order to prevent parallel care and to recruit the necessary staff for new services. Regarding community services, more attention should also be paid to target groups other than SMI, e.g. children and adolescents with mental health problems, and elderly people with dementia.

Another point is that there seems to be insufficient legislation for mental healthcare, promotion and prevention. Amendments to legislation which would cover these issues seem to be necessary for the future.

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SPECIAL PAPER

Reform of mental health services in Eastern Europe and former Soviet republics: progress and challenges since 2005

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For over a decade, concerted efforts have been made in Europe to reform mental health services and move away from institutions to community-based models of care, supported by international policy statements, good practice examples and research evidence. Progress has been uneven. So what is the status of mental healthcare across the World

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