Mental health reforms in the Czech Republic

Ondrej Pec

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 km² 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
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

### Table 1

| 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                           |
| Cooperation with related professions  | Rules and procedures for relevant professions                           |
| 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 | 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                                      |
| Reimbursement mechanisms              | Regional programmes for primary prevention                               |
Reform of mental health services in Eastern Europe and former Soviet republics: progress and challenges since 2005

Matt Muijen¹ and Andrew McCulloch²

¹International Mental Health Policy Adviser, former Regional Adviser, World Health Organization Regional Office for Europe, Copenhagen, Denmark. Email: matt.muijen@gmail.com.

²For 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?