Annex No. 2

National Mental Health Action Plan 2020-2030

Analytical Section:

The analytical section of the action plan contains the current situation with an identification of problems that the action plan should address in the next ten years. In order to adequately cover all areas necessary for a quality and effective mental health care system, in addition to the general analytical introduction, the explanatory section has been divided into modules as defined by the WHO in The European Mental Health Action Plan (WHO, 2015):

Legislature

Management and coordination

Funding

Services network

Human resources and training

Destigmatization and prevention

Defending the rights of clients and family members

Quality improvement

Information systems

Research and evaluation of policies and services

Mental health is a condition that enables people to experience meaningful lives, happiness and fulfilling relationships, to acknowledge and realize their own potential, to cope with normal life stress, to work productively and to contribute to the well-being of society. Mental health is not just the absence of mental illness, but a basic component of health, i.e. a state of physical, mental and social well-being (WHO, 2014).

Mental health problems are the cause of approximately one-third of all years marked by disability due to illness, and depression is the most common reason for life in disability globally

(Vigo, Thornicroft, Atun, 2016). If we use the DALY[I] (Disability Adjusted Life Years) indicator, mental illnesses collectively cause a burden of approximately 15%, which is comparable to oncological illnesses.

The incidence of mental illness in the Czech population is more than 10% for alcohol-related disorders, more than 7% for anxiety disorders, approximately 5.5% for mood disorders (4% severe depression), almost 3% for non-alcoholic and non-tobacco drug disorders and 1.5% for psychotic disorders (Winkler et al., 2018). Other people suffer from ADHD, eating disorders, personality disorders, dementia and other mental illnesses. Approximately 4 people commit suicide in the Czech Republic every day. A significant incidence of mental disorders is found in children and adolescents. Globally, the overall prevalence of mental disorders is 13.4%, with anxiety disorders being the most common with 6.5%, ADHD and behavioural disorders 5.7% and depressive disorders 2.6%, (Polanczyk et al., 2015). There are risk subpopulations where the incidence of mental disorders is several times higher. For example, in children of parents with a serious mental disorder, the incidence of a psychiatric disorder is up to 70% (Rasic et al. 2013). Suicide is the third most common cause of death in adolescents (WHO, 2016). Up to 50% of mental disorders in adults begin before the age of 14 (WHO 2012). The delay between the onset of difficulties and treatment may be 6-8 years because symptoms are not recognized in time (Wang et al. 2007).

People with severe mental illness often live in poverty, are stigmatized and discriminated against and die at a significantly younger age than the general population (Kondrátová et al., 2018; Krupchanka et al., 2018). People with mental illness are also more likely to abuse alcohol and other addictive substances. They are more often traumatized or victimized, which contributes to a higher risk of aggression (Elbogen, Johnson, 2009). There is a growing need for pedopsychiatric care. There are increasingly more children with autism spectrum disorders and other neurodevelopmental disorders, behavioural and anxiety disorders in children are more common, and we are observing a new and alarming trend of an increase in the frequency of

[I]By combining all the Years Lived with Disability (YLD) with all the years lost due to premature deaths in connection with illnesses (YLL - Years Life Lost), we obtain a global indicator of years affected by illnesses (DALY - Disability Adjusted Life Years).

self-harm and suicide attempts among adolescents (information from mapping provided by the Division of Child and Adolescent Psychiatry, the Committee of the Psychiatric Society of the CMA JEP). Low population literacy in mental health and high stigmatization lead to concealment of the disease and reluctance to seek professional assistance, which in turn leads to a poorer prognosis and reduced chances of recovery, which is a deeply personal, unique process of changing attitudes, feelings, values, goals, skills and roles with the aim of living a happy, hopeful and rewarding life despite all the mental constraints imposed by mental illness (Anthony, 1993).

The economic costs of poor mental health are enormous. They affect people with mental illness (through high unemployment), as well as their employers and the state. Employers face a loss of employee productivity and a high rate of absenteeism, and the state bears an economic burden in the form of high social and health costs. In 2010, these costs were estimated at 6.12 billion euros in the Czech Republic and were related not only to the provided health and social care, but also to lost productivity, informal care and other costs (Ehler et al., 2013). Mental illnesses are the fastest growing cause of disability pensions and care allowances (Janoušková et al., 2001; Janoušková et al., 2014).

The system of psychiatric care in the Czech Republic is still based on large-capacity inpatient healthcare facilities in the field of psychiatry where people with serious mental illness are hospitalized for more than 20 years, which is clearly cost-inefficient compared to community care, i.e. care provided in the natural environment of people with mental illness (Hoschl et al., 2012; Winkler et al., 2017; Winkler et al., 2018; Winkler et al., 2018b; Winkler et al., 2016). In the context of mental health care reform, the term community care is used in accordance with the international definition, where it refers to care in one's own social environment, not individual services. Services usually include multidisciplinary field teams, psychiatric clinics, clinics of clinical psychologists, acute inpatient care provided in general hospitals, day hospitals, supported housing, etc. Long-term hospitalizations are associated with non-compliance with the principles of the Convention on the Rights of Persons with Disabilities (WHO, 2018), but also with an increased risk of suicide after discharge from care (Winkler, Mladá, Csémy, Nechanská et al., 2015). The network of inpatient facilities for both acute care and aftercare is

very unevenly distributed, the number of acute care beds is inadequately low and is not integrated into general hospitals and linked to the complement of somatic medicine. In the field of mental health care for children, there is an insufficient network of outpatient services, which leads to unbearably long waiting times. There is also a lack of coverage for acute inpatient care. Pedopsychiatric inpatient departments with inpatient care providers specializing in child and adolescent psychiatry are often staffed for aftercare, and do not accept acute patients. Only a small part of inpatient facilities thus meets the requirements for accreditation for education in pre-certification training, which limits the increase in staff capacity in the field. Furthermore, children and adolescents tend to be hospitalized relatively far from their place of residence and parents are often unable to visit them and participate in family therapies. This mainly affects families with a lower socio-economic status, in which there is also a higher risk of mental illness. In the vast majority of hospitals, counseling care is not available for pediatric beds, and patients with obvious mental health problems are discharged without the necessary proposal for further care. Services for children and adolescents are departmentally separate and the cooperation of ministries on their integrated work is not effective. Families must thus rely on an independent search for professional care, within which, however, mutual communication is lacking (information is processed by the Division of Child and Adolescent Psychiatry, WG CMA JEP). Community care is underdeveloped, failing especially in the area of prevention and the rehabilitation and integration of people with mental illness into everyday life (including housing and employment). Healthcare services for people with mental illness in the community are connected neither within the healthcare system (e.g. with primary care) nor with social and complementary services in the given region and are based on the work of independent specialists offering only a narrow range of services. The multidisciplinary method of work as the most effective model for working with people with complex needs is a minor component of care; community multidisciplinary teams for people with mental illness are in the phase of piloting their first operations. The mental health care system does not have sufficient competent human resources, which is due to the structure and financing of the care provided, the system of education of professionals, but also the lack of flexibility with regard to new opportunities of working with human resources. Users of care are merely in the role of consumers, without the possibility of interfering in its management,

inspection or provision.

Stigmatization is high not only in the general Czech population, but also among physicians (Winkler, Csémy et al., 2015; Winkler, Mladá et al., 2016). Little attention is paid to the issue of mental health in children and adolescents, both in the field of prevention and medical care. The situation is similar for the elderly. Likewise, comprehensive care and support is not available for families who are exposed to a high emotional burden for a disproportionate period of time with excessive stress, which can result in chronic mental illness.

The management of the mental health care system is divided according to the responsibilities of individual ministries, where the largest share is borne by the Ministry of Health and the Ministry of Labour and Social Affairs, followed by the Ministry of Education, Youth and Sports, and the Ministry of Justice. In this environment, effective management is very difficult to implement and, together with fragmented legislation and unconnected funding, is based on an uncoordinated, fragmented system of care with insufficient effectiveness and benefits for its beneficiaries. Even decision-making within individual care segments is often non-transparent; funding does not support the desired behaviour of providers, which is due not only to the low level of available records, but also to socio-cultural factors (Winkler, Krupchanka et al., 2017; WHO, 2018b). A detailed situation analysis is elaborated in Annex No. 2.

Systemic changes in response to the situation described above were triggered by the mental health care reform, the basic framework of which was described in the Psychiatric Care Reform Strategy issued by the Ministry of Health in 2013 (MoH, 2013) and the National Health Protection and Promotion Strategy “Health 2020” (in Action Plan No. 3: Mental Health, MoH, 2015). The main idea of these documents is to support quality services available to people close to their homes, which respect human rights and ensure functionality through multidisciplinary teams in well-defined regions.

Significant support was agreed for the implementation of the first stage of the reform in the form of European Structural and Investment Funds (ESIF), namely the OPE program (Operational Program Employment) and the IROP (Integrated Regional Operational Program). The implementation of reform projects financed from the OPE program was approved and the implementation of the OPE program was launched (call No. 39 with an allocation of

approximately 1 billion CZK for the period 2017-2021). The recipients of the subsidy are the Ministry of Health (MoH), the National Institute of Mental Health (NIMH) and the Institute of Health Information and Statistics (IHIS).

As part of these projects, 30 mental health centres will gradually be established by 2022, evenly distributed throughout the Czech Republic, as the backbone of the future network of approximately 100 MHCs. MHCs or health and social multidisciplinary teams for the seriously mentally ill are a new element in the care system for people with mental illness. Similarly, a specific form of community care will be piloted in the form of multidisciplinary teams for pedopsychiatric patients/clients, gerontopsychiatric patients/clients, patients/clients with substance abuse issues and for patients/clients with prescribed protective treatment, always with 2-3 teams for each target group. The standards of the outpatient clinic with extended care, i.e. outpatient care with an extended range of services (services of a psychiatrist, psychiatric nurse, psychotherapy, etc.) and close cooperation with primary care will be verified at 6 operating locations. Two of these outpatient clinics in pilot operation will be specialized addictology outpatient clinics according to the Design of the Basic Network of Addictology Regional Outpatient Clinics for Adult Patients, prepared by the Society for Addictive Diseases of the CMA JEP (material in the comment process). The objective of the support activity of the reform is to standardize a multidisciplinary approach in caring for the mentally ill and introducing it into practice among healthcare and social service providers by supporting methods and sharing best practice.

A large part of the activities in the reform projects focuses on the reduction of aftercare beds of providers of health services for inpatient aftercare in the field of psychiatry by integrating the seriously mentally ill into the mainstream community. For this purpose, a transformation plan has been created for providers of health services for aftercare in the field of psychiatry and cooperation has been established with the regions and the MoLSA. For the purpose of developing acute inpatient care, a change in its financing is being piloted in connection with the fulfillment of defined quality criteria. The projects include a section focused on the implementation of the Convention on the Rights of Persons with Disabilities in institutional care and, in general, increasing the quality of care provided, including initial mapping of the current situation, implementation of changes and the design of a quality assessment system.

Destigmatization activities are initiated in all regions of the Czech Republic and work is also underway to set up the data collection necessary to evaluate the entire reform process. Investment resources (IROP calls - approx. 2 billion CZK) were also allocated to support the implementation of the Psychiatric Care Reform Strategy, which are being used to reconstruct the acute care department and provide facilities for community services.

LEGISLATURE

The legislation provides a legal framework to protect individuals from human rights violations while providing mental health services that promote access to care. Legislation concerning mental health is widely dispersed outside the health field and includes issues relating to education, housing, employment, justice, etc. (see Annex No. 9).

V The Czech Republic does not have separate legislation on mental health care; it is incorporated into general legislation. The last update of this legislation took place in 2011 (Act No. 372/2011 Coll., On health services and on conditions of their provision, Act 373/2011 Coll., On specific health services). The Czech Republic has implemented into its legal system all fundamental obligations in relation to the protection of mental health by which it is bound as a signatory to international conventions or as a member state of the European Union. The legislation of the Czech Republic formally includes most of the domains related to mental health legislation set out in WHO-AIMS 2.2. (WHO, 2005). However, there is a consensus among the professional public that the legislation is not comprehensive and in some domains it is necessary to revise the existing legislation according to examples of good practice (e.g. abroad, more experts must comment on involuntary hospitalization). The performed legal analysis (see Annex No. 9) shows that the adoption of a special act on mental health does not solve the key problems that currently exist in the field of mental health care. The often mentioned legislation in other developed EU Member States does not represent a comprehensive regulation of mental health care, but is very strongly focused on the regulation of the rights of hospitalized patients, which is sufficiently regulated in our legal system in accordance with international obligations.

V In the Czech context, the current situation should be analyzed in terms of legislation on mental health protection from the point of view of acute priorities of legislative amendments to partial legislation, especially the Act on Health Services and implementing regulations, the Public Health Insurance Act and the Social Services Act in such a way as to address in particular the following issues:

- creating a basis for the joint provision of health and social services and their financing;
- the "legalization" of the Mental Health Centre as a multidisciplinary health and social service with specific material, technical and personnel standards;
- the legal regulation of the creation of MHC networks, the anchoring of competencies within state and regional responsibility for the availability of MHCs;
- embedding specific commitments in the field of care for the preservation and strengthening of mental health, especially at the community (municipal and regional) level;
- possible strengthening of the protection of the procedural rights of users of care.

The issue of the rights of people with disabilities

In relation to human rights issues, the Czech Republic ratified the Convention on the Rights of Persons with Disabilities (UN, 2006) in 2009. Unfortunately, despite a number of related legislative changes, it is still clear that some articles of this Convention are not being implemented in practice, which affects the lives of people with mental illness.

An example is Article 5 of the Convention: Equality and non-discrimination, which guarantees the equality of all persons before the law, their egality, their right to equality before the law and equal rights under the law without any discrimination. Although equality before the law is contained in the Charter of Fundamental Rights and Freedoms, in practical life society discriminates against people with mental illness, for example: when applying for a job or in the field of somatic medicine, where it turns out that people with mental illness often do not receive the same quality of care as the general population. The consequence of this phenomenon is a lower life expectancy of people with mental illness by about 20 years

(Krupchanka et al., 2018b). Another example is the situation where low disability pensions, a lack of sheltered, supported and social housing, high rents in rented flats, and a lack of job opportunities for people with mental illness in the open labour market very often do not allow people with mental illness to live independently, which is contrary to Article 19 of the Convention: Living independently and being included in the community Also, long-term stay in inpatient care facilities in the field of psychiatry or in MHCs has an impact on people with mental illness in terms of their abilities to live independently in the community, i.e. behind the walls of a psychiatric hospital/clinic or other institutional facilities. In addition, psychiatric hospitals/clinics and MHCs do not allow for a stay that respects the privacy of a person with a mental illness.

Restraints, protective treatment

The use of restraints is implemented within the framework of the Methodological Instruction of the Ministry of Health, which specifies the interpretation of the given provisions of Act No. 372/2011 Coll., On health services and on conditions of their provision. Based on a survey of 14 providers of inpatient care in the field of psychiatry (including 3 children's psychiatric hospitals) and 7 psychiatric wards of teaching hospitals (including the NIMH), data were obtained from records of restrictive measures for the period from 1 January 2018 to 30 June 2018. In this six-month period 2,422 patients experienced some form of restriction, which proves that this is not a marginal topic, but rather an issue that deserves attention.

The Czech Republic has not yet obtained representative data on the use of restraints in healthcare facilities in general, or specifically in inpatient psychiatric care facilities. NGOs carried out occasional monitoring in various projects, and the ombudsman has been systematic since 2006, but these activities did not encompass the entire system of inpatient psychiatric care. In such a situation, it is necessary to interpret the available information judiciously, generalize, or look for a trend. However, the very fact that sophisticated data are not available at a national and regional level or, in many cases, even at the level of the provider, is a negative reality that prevents the systematic work on increasing safety in the provision of care and reducing the risks associated with the use of restraints. It is therefore not surprising that there is no government or ministerial strategy to reduce the need to limit restrictions on free

movement and increase the safety of care. At the same time, it seems that there is no need to further cultivate the rules under which a restraint can be used, as compliance with international human rights standards, the law and recommended psychiatric care practices has already been achieved. As steps for improvement, the ombudsman suggests placing an emphasis on measures to reduce the need to use restraints at the level of providers. The rule that it is possible to resort to restraint only as a last resort loses its force if preventive procedures to minimize danger situations are not developed in care operations and no alternative procedures are available that would respond to these situations in a way other than restrictively (see Annex No. 6).

Forensic care is regulated by the provisions of Act No. 373 Coll., on Specific Health Services, especially in the performance of institutional protective treatment; outpatient care is relatively very briefly regulated, community care is not included.

The issue of preventing and reducing harm associated with addictive behaviour

The prevention and reduction of harm associated with addictive behaviour (drug policy) is also part of the broader concept of mental health. Legislatively, this area is anchored mainly in Act No. 65/2017 Coll., on the Protection of Health from the Harmful Effects of Addictive Substances, as amended. Act No. 65/2017 Coll. for example, imposes the obligation to carry out short interventions, which also applies to professional care for people with addictological disorders, anti-drug policies, etc.

At the international level, an important legally binding document in this field that partly affects the area of mental health is, for example, the WHO Framework Convention on Tobacco Control (No. 71/2012 Coll. of Int. Conventions). Its objective is to "protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke by providing a framework for tobacco control measures to be implemented by the Parties at the national, regional and international levels in order to reduce continually and substantially the prevalence of tobacco use and exposure to tobacco smoke."

MANAGEMENT AND COORDINATION

The direction of the development of the mental health care system is anchored at the level of

relevant transnational documents (UN, 2006, WHO, 2013a, WHO, 2013b), government documents and related documents of individual ministries, regions and municipalities. The Ministry of Health, Ministry of Labour and Social Affairs, Ministry of Justice, Ministry of Education, Youth and Sports, Ministry of Regional Development, Ministry of the Interior, individual regions of the Czech Republic, municipalities and health insurance companies participate in various forms in the management of mental health care. The basic responsibilities of the individual ministries in relation to mental health issues are the following:

Ministry of Health:

- education of healthcare professionals
- health legislation and by-laws
- participation in the management of healthcare funding
- establishment and management of inpatient psychiatric care facilities

Ministry of Labour and Social Affairs

- assessment of disability, care allowances, severe health disability cards
- records at labour offices
- social entrepreneurship
- job support
- social services
- social and legal protection of children

Ministry of Justice

- issues of detention proceedings, legal capacity (including the legal capacity of minors), guardianship
- protective treatment
- education of judges, attorneys, etc. in the field of mentally ill persons

Ministry of Education, Youth, and Sports

- school act on disadvantaged children (equal inclusion of children with mental

disorders)

- destigmatization/preventive activities in schools, early intervention in the field of mental illness in children
- curricula of the pedagogical faculties of universities
- performance of institutional education in school facilities (Act No. 109/2002 Coll., on the Performance of Institutional Education or Protective Education in School Facilities and on Preventive Educational Care in School Facilities) in terms of compliance with standards arising from the right to health

Ministry of Regional Development

- the issue of affordable housing for people with mental illness
- the concept of "permeable housing" or social housing

Ministry of the Interior

- training of the police and other units of the Integrated Rescue System

Regions, villages, cities

- management of healthcare facilities and social services and school facilities
- having a budget for social services and responsibility for a network of social services linked to healthcare for people with mental illness and, where appropriate, for the MHC network
- the issue of affordable housing for the mentally ill
- regional branch of the Labour Office of the Czech Republic - implementation of an employment policy

Health insurers

- healthcare funding
- responsibility for the service network, i.e. the availability of care

The current system does not have coordinated management based on the sharing of clearly-defined competencies and responsibilities of individual actors on the basis of the knowledge of

needs, quality and cost-effectiveness evaluation and joint planning of necessary changes. Conversely, mental health system management suffers from fragmentation. The presence of fragmentation and the absence of effective coordination will logically manifest itself at a time when changes to the system are already inevitable, and is one of the most significant risks of their implementation, especially if these necessary changes are related to the establishment of health and social services and the introduction of multidisciplinary cooperation between services and actors from different ministries at the regional level.

As the Analysis of General Organizational Economic and Legal Parameters of the Current Management of Regional Networks of Care for People with Mental Illness document (see Appendix No. 3) states, the double-tracking of provided services is reflected in the incompatibility of the organizational structure of institutions legally responsible for their provision, the incompatibility of the flow of funds, the unevenness of coverage of the territory of the republic, and insufficient communication between persons actually providing different types of services. All these circumstances limit the quality of their provision and stand in the way of fulfilling the basic goals of the psychiatric care reform. Health services are provided by a network of state, centrally established and managed hospitals, regional (managed or established by self-governing units) hospitals and private outpatient workplaces, connected to the region indirectly through approbation procedures preceding the conclusion of a contract with an insurance company. Social services are provided through various public and private entities. Their coordination is partly enabled by the obligation of community planning (structured according to the territorial administrative division of the state) imposed by the Act on Social Services, which has no adequate equivalent in healthcare, and the budget flows ensuing from these plans. The double-tracking of services provided to the mentally ill is reflected primarily in the system of their funding. Funds for health services paid for from the public insurance system cannot be aggregated in any way with funds that are intended for the financing of social services by budgetary instruments of the state and local governments. Therefore, there is no cumulative factor that can be redistributed according to the complex needs of the target group of beneficiaries, whose health status depends on the simultaneous provision of both types of services. It is clear from the above that, in principle, there are currently no networks for the provision of care to psychiatric patients that can be effectively

managed in any way, nor the tools for such management. Management is impossible due to the organizationally inconsistent nature of the services currently provided, the different degrees of binding hierarchy of their providers, and the different method of their financing. Even after the (difficult) removal of these barriers and the establishment of networks of providers as an internally coordinated entity with clear vertical links, their management could at most lead to the economic efficiency of their activities. However, it would still not guarantee direction toward the necessary result, i.e. the effective (from the users' point of view) provision of services, including preventive services. The existence of a common plan is an essential basis for the coordinated management of any multi-entity network, whether horizontal or vertical. This does not mean an economic-type plan, focused on the parameters of the financial framework, but a plan of activities, to which the financial plan is merely tied. At present, in the absence of well-established networks, planning in a multidisciplinary space is difficult to imagine. Even if such a plan were to be created in the completely informal cooperation of the providers concerned, they lack the knowledge of "demand", i.e. mapping the needs of the target group. At the same time, this demand is wider than the sum of patients registered for psychiatric health services and narrower than the sum of disadvantaged people who are provided with social services. The problem with an informally created plan is its non-binding nature, i.e. unusability for the effective management of the entire structure. Methodologically, a manageable state is approached by social service providers within the legal institute of community planning. However, even this is not a concept that has proved to be fully effective in practice. It fails to balance the interests of providers, who are mainly involved in the planning, and users, represented only sporadically.

Managing the reform process

In the Czech Republic, there is a government strategic document called the "Strategic Framework Czech Republic 2030", which emphasizes, among other things, the possibility for all inhabitants to obtain decent work, health and social care, access to culture, education and social inclusion. In the field of healthcare, it specifically emphasizes the availability of healthcare, lifelong prevention and a healthy lifestyle, while drawing attention to the multi-sectoral nature of modern healthcare, which "requires the involvement of institutions at all levels of the government, non-profit and private sector, scientific and educational institutions,

communities and citizens themselves."

Furthermore, in the Czech Republic there is a National Strategy for Health Protection and Promotion plan called "Health 2020", which in Action Plan No. 3: Mental Health emphasizes the connection to the Psychiatric Care Reform Strategy issued by the Ministry of Health in 2013 (MoH, 2013). Significant support was agreed upon for the implementation of the first stage of the strategy in the form of European Structural and Investment Funds (ESIF), namely the OPE program (Operational Program Employment) and IROP (Integrated Regional Operational Program). This implementation commenced in 2017 through projects financed from the OPE (call No. 39 with an allocation of approximately 1 billion CZK for the period 2017-2021). The OPE program is intended for so-called soft projects to support the transformation and deinstitutionalization of health services in the field of psychiatric care. The recipients of the subsidy are the Ministry of Health (MoH), the National Institute of Mental Health (NIMH) and the Institute of Health Information and Statistics (IHIS). The funds are distributed through the payment of wage and operating costs or public contracts. One of the parts of the projects of the Ministry of Health is also support for ensuring the management and professional guarantee of the entire reform. From June 2017, the *Executive Committee for the Implementation of the Psychiatric Care Reform Strategy* began to meet regularly. It is a working group of representatives of the Ministry of Health, the regions, the Ministry of Labour and Social Affairs, Ministry of Finance, insurance companies, users and managers of individual projects, who meet once a month or more often for the operational management and coordination of all reform activities implemented in individual projects. Once every 2 to 3 months, the *Expert Council for the Implementation of the Psychiatric Care Reform Strategy*, appointed by the Minister of Health meets, in which the main groups of the professional public are represented by recognized experts. The Expert Council approves documents, makes recommendations, or prepares expert opinions on identified issues within the reform process. In June 2017, the Expert Council selected 4 globally-recognized mental health professionals as members of the international advisory board for the reform.

Given the time-limited period of the projects, which does not even cover half of the real time requirements of the reform process, the question is the follow-up form of managing the systemic changes that have been commenced. Even if the current management model is

maintained with the support of the Ministry of Health, it will not be able to guarantee the active participation of other ministries and stakeholders, and cannot ensure the currently necessary supra-ministerial coordination of the entire process.

FUNDING

Health insurance companies, the Ministry of Labour and Social Affairs, Ministry of Education, Youth and Sports, regions and municipalities participate in the financing of the mental health care system in the Czech Republic. People with mental illness also contribute to the financing themselves, in the form of surcharges for some medicines and payments for certain social services. In addition, some foundations, employers and other private entities participate in the financing, but these only marginally affect the NMHAP 2030.

The effective coordination of funding is a basic precondition for a well-functioning mental health care system. However, as already mentioned, health and social care, which are key to this area and must work together closely, are funded by different mechanisms from several unconnected sources and, conversely, financial inputs from other important ministries (MoJ, MEYS) are missing. This situation reduces the efficiency and complexity of care provided and the division of the core of care between two departments and sources of funding also limits the ability to monitor the cost of care for people with mental illness at a central level.

Health services (Source: Analysis of the VZP (General Health Insurance Company) 2018, Annex No. 10)

The right to free healthcare in the Czech Republic is guaranteed by the Charter of Fundamental Rights and Freedoms. The mechanism ensuring this right is a system of public health insurance with the role of health insurance companies as legal entities that are the holders of public health insurance for their insured persons and payers of health services. The total costs of psychiatric care from public health insurance in 2015 amounted to CZK 13.7 billion, which represents approximately 4.08% of the healthcare budget (as calculated by the OECD SHA 1.0 methodology, 3.38% as calculated by the OECD SHA 11 methodology; Broulíková, 2019).

The costs of psychiatric care in outpatient healthcare facilities have increased by about a third in the last five years, from CZK 1.6 billion in 2012 to CZK 2.16 billion in 2017 (extrapolation from

VZP data, VZP 64%). However, significant differences were found in the cost of care provided from a regional perspective. The current setting of reimbursements for psychiatric care in outpatient healthcare facilities is based on payments for services provided without additional regulatory limits, so outpatient specialists may prefer modern pharmacological and psychotherapeutic treatment and a sufficient intensity of care without the fear of reduced reimbursements for exceeding them. On the other hand, in the absence of regional responsibility, this measure will not ensure the provision of the full range of interventions and care for all target groups of people with mental illness; on the contrary, in terms of profit maximization, there is a certain risk of preferring less demanding patients and omitting more demanding types of interventions (care for patients in protective treatment, dispensary care, etc.). In addition, the work of independent specialists does not make full use of the expertise of a certified doctor, because in patients with complex needs, the doctor needs to cover less professional medical and, in some cases, social tasks. For this reason, as part of the reform of psychiatric care, a model of an outpatient clinic with extended care is being piloted, which functions on the basis of a multidisciplinary medical team, the necessary part of which is a psychiatrist, psychiatric nurse and clinical psychologist (with the possibility of using other specialists for specific target groups, e.g. a pedopsychiatrist, gerontopsychiatrist, addictologist). This outpatient clinic is responsible for the care of people with mental illness within the entire diagnostic spectrum in a certain catchment area, has room for the treatment of new and acutely impaired patients, guides patients in protective treatment, provides dispensary care and, according to the established methodology, hands over stabilized patients with neurotic and depressive disorders to the care of a general practitioner. In 2020, six outpatient clinics with extended care (including two outpatient clinics specializing in addictology) will be supported within the project for 18 months; the standard for this type of outpatient care will be adjusted and the funding of the service will be set according to the results of the pilot operation. Reimbursements for acute inpatient psychiatric care are significantly affected by historical reimbursement mechanisms that maintain different amounts of reimbursements for individual providers. In addition, the analysis of the system revealed a low average occupancy of the ward with contracted acute care, and the mapping of providers of inpatient care in the field of psychiatry revealed a high percentage of the provision of acute

care in aftercare beds. To remedy this situation, a pilot project of acute care funding was set up in cooperation with VZP and SZP (the Union of Health Insurance Companies) (both in acute care departments and in psychiatric hospitals actually providing acute care) for 2019, which set the incentive payment for acute care on the basis of DRG while maintaining clearly-defined quality and efficiency criteria for the service.

In addition, the evaluation of this pilot operation may provide missing data on the number of patients requiring acute psychiatric care and the costs involved.

The largest share of costs for psychiatric care is borne by inpatient aftercare, according to VZP data it is 51.6% (CZK 7.6 billion), which is covered by a flat rate per treatment day. The payment system therefore motivates the provider to occupy as many beds as possible for as long as possible.

Tab. 1. Distribution of costs according to the form of psychiatric care (for VZP in 2017).

Inpatient aftercare	Acute inpatient care	Outpatient care	Medicines
51.6%	9.0%	19.2%	20.2%

Source: VZP

From the above data and analyses, it is clear that improving the quality of life of people with mental illness, which is the goal of the psychiatric care reform in the Czech Republic, will also require a revision of the funding model under the public health insurance system. This revised model should set equal conditions for all healthcare providers and health insurers, reflect the growing demand for psychiatric care and facilitate changes in the structure of health services provided in the context of limited resources in the public health insurance system. Appropriate methods for measuring the quality and results of psychiatric care need to be put in place to facilitate change, which is lacking in the current, relatively rigid model, and the absence of which can cause system inefficiency. Increasing costs should also be associated with greater benefits for patients. One of the necessary elements of reimbursement mechanisms must therefore be the motivation for providers' performance and the possibility of a flexible

response to changes in their performance (see Annex No. 10).

A specific area that is not treated in the process of the deinstitutionalization of people with mental illness is the financing of the "transformation" period. The transformation period is usually a period of about five years (according to the capacity of the system for developing community care), when it is necessary to maintain the operation and financing of existing services in parallel during the gradual establishment of new services for people with mental illness. In both areas, it is both a question of operating costs and maintaining the infrastructure. Another necessary component is the use of financial incentive mechanisms to gradually shift the maximum current human resources to the necessary forms of care. According to foreign experience, the acceleration or underestimation of this period has an impact on the temporary decline in the quality of care provided and the increased incidence of negative social consequences and phenomena in society.

Social services

Social services in the Czech Republic are financed from multiple sources. One of the important sources of financing is funds from the state budget. These funds are distributed through subsidies to support the provision of social services. The subsidies are implemented by the Ministry of Labour and Social Affairs. Subsidies can only be provided to registered social services. Other sources of funding are mainly care allowance (CA), payments from users and budgets of regions and municipalities; reimbursements from health insurance companies and EU funds (projects) contribute to the financing to a lesser extent. Due to the system of financing social services by the budget and not in relation to the client/patient as the recipient of care, it is simply not possible to assess the direct costs of care for a specific target group. In 2017, MoLSA subsidies for social services with a predominant target group of "persons with chronic mental illness" amounted to CZK 1.37 billion. In line with the increase in the total subsidy of the Ministry of Labour and Social Affairs for social services, this amount has a growing tendency, reaching CZK 573 million in 2013 and CZK 913 million in 2015, but is not comparable with expenditures from public health insurance and is completely insufficient in the context of the ongoing deinstitutionalization of people with mental illness (see Annex No. 8). The cost-effectiveness of services in this segment of care is not evaluated.

Social security

The social security system should ensure that people with mental illness do not fall into poverty and can afford to finance basic living needs and pay surcharges for the social services they need.

According to the NIMH analysis, the main income of 93.3% of people with mental illness is a disability pension (Kondrátová et al., 2018). Mental illness is one of the four most common reasons for granting a disability pension in the Czech Republic. MoLSA statistics show that the group of diagnoses (mental disorders and behavioural disorders) differs compared to other groups of applicants for disability pensions by age composition. That is, it has the highest proportion of disabilities granted at a younger age. Disability pensions awarded in early adulthood are often very low due to insufficient insurance periods, and in practice it is possible to identify a serious socio-economic situation of persons who have been granted a certain degree of disability, but due to an insufficient share of employed years in a given period are not entitled to its payment.

The second type of social benefit used by persons with mental illness is the care allowance, which is provided in accordance with Act No. 108/2006 Coll., as amended, to persons dependent on the assistance of another natural person. They then pay for the assistance provided by a close person, a social care assistant or a registered provider of social services from the provided allowance. However, the mechanism of the evaluation of a care allowance is focused on somatic and mental disabilities in its criteria and does not take into account both the manifestations of mental illnesses and the different needs of the scope of care based on these manifestations. In practice, therefore, there is an underestimation of the severity of addiction or its complete negation in the case of people with a mental illness applying for a care allowance.

The described situation with disability pensions and care allowances is the cause of the low socioeconomic status of people suffering from chronic mental illness, but can also result in high rates of long-term hospitalizations in healthcare facilities for social reasons, and, in extreme cases, homelessness and criminal behaviour.

Another area where mental disability is socio-economically disadvantaged compared to

physical disability is the use of benefits connected to a disabled person's disability card (severe health disability), where again there are no assessment criteria or an equivalent form of relief for people with mental illness.

Mental health expenditure from the budget of the Ministry of Justice

The Ministry of Justice uses the institute of protective treatment, which allows courts to entrust medical facilities with the performance of compulsory treatment. By using the institute of protective treatment, the court or Ministry of Justice becomes a de facto customer of psychiatric care, which, in addition, places an increased burden on care providers because of specific requirements for treatment standards. At present, however, the Ministry of Justice does not participate in the financing of the care it orders; all reimbursements are paid from health insurance, which is an exceptional situation in the European context. This subgroup of patients has specific demands in both inpatient and outpatient care. Given the lack of compensation, only about 1/3 of outpatient facilities provide care for people with prescribed protective treatment (IHIS, 2017). It is therefore necessary to strengthen the funding of this type of care from funds outside of the payment of health insurance for a regular insured person (see Appendix No. 11).

Mental health expenditure from the budget of the Ministry of Education, Youth and Sports

The Ministry of Education, Youth and Sports (MEYS) is one of the key components of state administration in the field of mental health care. Most mental illnesses start in children/adolescents (50% under the age of 14) and in MEYS facilities, systematic efforts can not only prevent mental health problems at a general level, but also identify and provide support for the group of children and adolescents in whom there is a higher risk of developing mental illness. The Ministry of Education, Youth and Sports is unable to quantify expenditures on these activities because it does not record them separately for the area of mental health.

However, the Ministry of Education, Youth and Sports does not currently participate in the financing of primary mental health care, nor does it make systematic and systemic efforts to address mental health in the workplace. Mental health care for children and adolescents is also covered by health insurance also within children's facilities managed by the Ministry of Education. There is a lack of definition of the competencies of school counseling facilities in the

field of mental health care, and a simple system of transferring patients to/from healthcare. There is no concept of care and facilities for potentially dangerous children and adolescents and children and adolescents with prescribed protective treatment. The issue of addictive diseases in this target group is not sufficiently addressed also, for example, due to the lack of support for the establishment of new services in reaction to changes in the prevalence of substance abuse.

It is clear from the above that the Ministry of Education, Youth and Sports is responsible for a large part of the field of mental illness prevention which, however, as in the case of the Ministry of Health or the Ministry of Labour and Social Affairs, does not have a specifically allocated amount of funds. Yet investments in the prevention of mental illness significantly save direct and indirect healthcare costs for this target group of patients and have a major impact on non-medical expenditures in this area and, in particular, on the quality of the life of people at risk of or suffering from mental illness.

Ensuring the funding of user and parent organizations, peer consultants.

Funding for user and parent mental health organizations is similar to funding for any non-governmental non-profit organization. For the most part, it is paid from public funds, in the form of grants to finance projects of the applicant organization. Individual grants can be applied for at the level of ministries, regional authorities and municipal authorities.

The aforementioned problems in financing user organizations do not allow the building of strong user organizations and these cannot co-create a strong user movement that would be consistently democratic, able to define the problems of people with mental illness, and find solutions to these problems on an equal basis with other stakeholders.

Another funding issue is the funding of peer consultants. Their role is not clearly specified, often the peer consultant is not included among the regular employees of the medical facility, and does not receive a salary like other regular employees, but is paid in another form, e.g. from projects, etc. Although the work of peer consultants is very beneficial, it is not clearly anchored in the law, and psychiatric hospitals and psychiatric wards seek a variety of ways to legally employ a peer consultant. This problem eventually results in a situation where the psychiatric facility prefers not to use the services of peer consultants.

Despite the demonstrable advantages and benefits of community care, quality community care in the field of mental health care in the Czech Republic is still very underdeveloped. People with mental illness do not obtain the necessary services available near their homes and inpatient care is still predominantly centralized in large-capacity facilities. The system does not define the responsibility for the management and interconnection of services, which contributes to the fragmentation of care and the lower efficiency of interventions. The system does not create sufficient space for multidisciplinary cooperation, case management or the sharing of care between the social, health and education system. Consequently, the whole system is burdened with bureaucracy, which often diverts employees from professional work, and thus results in the inefficient use of already limited human resources. The result is the absence of an individualized approach that would address human needs comprehensively, which can lead to inefficient prioritization and low cost-efficiency, i.e. the inefficient use of limited resources.

Health services

The publication *Psychiatrická péče* (Psychiatric Care) under the edition *Zdravotnická statistika* (Health Statistics), published by the Institute of Health Information and Statistics of the Czech Republic (IHIS, 2017), presents the following data:

In 2016, inpatient care was provided by a total of 18 psychiatric hospitals for adults with a total of 8,741 beds and 3 psychiatric hospitals for children with 230 beds. In 2016, inpatient care was provided by a total of 31 psychiatric wards in general hospitals with a total of 1,289 beds. In 2016, there were a total of 1,203 outpatient psychiatrist and child psychiatrist clinics. According to information from the IHIS, after confirmation with health insurance companies, the number indicating the amount of outpatient clinics is overestimated. Due to the registration of outpatient clinics in various areas of care provided, the outpatient clinic will receive several reports to be filled in, and the number of outpatient clinics contacted by the IHIS then seemingly increases. In addition, day hospitals (75) and crisis centres (3) also operate in the field of mental health in the healthcare system.

The Czech Republic is facing a critical shortage of the availability of outpatient care for the

mental health of children and adolescents. At present,there are only 6.8 child psychiatrists per 100,000 people under the age of 18, but if we take into account full-time employment only, this ratio drops to 2.8.

At present, there are about 590 pedopsychiatric beds available, with 74% of these capacities in psychiatric hospitals. At present, pedopsychiatric inpatient capacity in the Czech Republic (22.7 beds per 100,000 inhabitants under the age of 18) is close to the average in Western countries, but it does not meet requirements in terms of structure (predominance of aftercare), regional distribution and, due to lack of services in the community, it is also lacking in capacity.

According to the VZP analysis (see Appendix No. 10), the number of outpatient workplaces has increased in the last ten years, yet the capacity of outpatient psychiatric care is not sufficient to provide quality and individualized services for an ever-growing number of patients, especially in the field of care for children and adolescents. In a European comparison, the Czech Republic ranks among the lowest in the number of pedopsychiatric outpatient clinics (Signorini et al. 2017). The hospitalization burden with F00 - F99 diagnoses is very high in the Czech Republic, with more than 78,000 hospitalizations taking place annually for which psychiatric diagnosis is mentioned as the main cause. These hospitalizations are often repeated several times a year for a given patient; the total index of the annual number of hospitalizations per patient is 1.33. Psychiatric diagnoses account for approximately 3.4% of all hospital stays, but in the age group 11-20 it is 7.2%, and in the age group 21-50 this accounts for 5-6% of all hospital stays. Aftercare predominates in the inpatient segment, where aftercare beds represent more than 70% of all psychiatric beds. The analysis shows an imbalance between relatively centralized inpatient care and a denser network of outpatient and acute inpatient care, which may signal inequality in access to psychiatric care. In addition, the analysis of a representative set of all cases of hospitalization due to psychiatric diagnosis showed that in the Czech Republic, a large proportion of these hospitalization stays take place in acute beds, even for diagnoses such as neurotic and anxiety disorders, where acute inpatient care is usually not necessary if there are adequate outpatient services. On the contrary, the availability of acute care for serious diagnoses such as schizophrenia is extremely low (27% admitted to acute care beds, 73% of patients admitted directly to aftercare beds, source NRHOSP 2007-2015). The deinstitutionalization of psychiatric care should lead to the settlement of this situation, in

connection with the development of community care, the expansion of performance-based outpatient care and the restructuring of beds in terms of reducing aftercare beds in favour of acute beds.

Health and social services

In the Czech Republic, field-type community care for patients with chronic mental illness has developed over the last 25 years, especially in the social service sector. During this period, approximately 85 field community teams have emerged in the Czech Republic, which in many places provide a continuous coverage of care, used annually by approximately 8,000 clients with serious mental illness (according to mapping within the Deinstitutionalization project). Using the capacities of some of these services, 5 Mental Health Centres (MHC) for the seriously mentally ill commenced operation in 2018 and another 12 started operating in mid-2019. By 2022, a total of 30 MHCs from EU projects are planned. For the further development of MHCs, the plan is to strengthen and create the already mentioned field teams, which will gradually develop into MHCs in all districts of the Czech Republic in connection with the capacity of medical staff, up to a final number of approximately 100 MHCs.

Another psychiatric reform activity is to create a concrete form of community care in the form of multidisciplinary teams for pedopsychiatric patients, gerontopsychiatric patients, patients with addiction problems and patients with prescribed protective treatment. For this purpose, a total of 11 multidisciplinary teams will be selected for pilot operation in 2019, 2-3 teams for each target group.

Social Services

Social services are regulated by law and an implementing regulation. According to the current wording of Act No. 108/2006 Coll., on Social Services, as amended (hereinafter the “Act”), it is possible to provide 33 types of social services in the form of residential, outpatient and field services. Each type of social service is defined and contains a list of activities that the provider is always obliged to perform. The individual activities are specified by the so-called actions, which are specifically listed in the implementing regulation.

Social services are provided to persons on the basis of a contract for the provision of social

services with the amount of payment agreed and determined in accordance with Section 73 and 77. The provider may refuse to enter into a contract with a person for reasons stipulated by the law.

A total of 5,350 social services were registered in the Czech Republic as of 24 June 2015. The most frequently registered are care services (737), professional social counseling (549) and homes for the elderly (499). The fewest are intervention centres (18), therapeutic communities (18) and emergency care centres (18). The largest increase in the number of registered services was in 2007, i.e. after Act No. 108/2006 Coll., on Social Services entered into force. In the years 2007-2014, the number of newly registered social services increased by 200-300.

V In 2015, the number of recipients of social services was 350,494. Of these, the amount of users of residential services was 76,758 and the number of users of other services 49,451. The number of users of registered social services was 126,209.

The prevalence of psychotic illnesses in the Czech Republic is 1.5% in the adult non-institutionalized population (Formánek et al., 2019); less than 50,000 people are treated on an outpatient basis and more than 8,000 people consume inpatient care annually. Unemployment in persons released from inpatient care exceeds 75% (Kondrátová et al., 2018). 63% of people receiving community psychiatric services do not spend even one hour in any type of employment, including training and protected workplaces.

V In both groups, more than 90% of people draw a disability pension, which is also the source of their highest income. Approximately 30% of the people who use community services fail to reach a net monthly income higher than CZK 8,500, and less than a quarter of these people do not have an income higher than CZK 12,750. In addition to their mental health, these people have frequent and serious problems with physical health, daily activities, friendships and lack funds for basic living. The family provides care to about half of the people who receive community services, on average more than 42 hours a month. Psychotic illnesses are a major cause of newly granted disability pensions and care allowances.

People with mental illness are currently placed in institutional care, both in homes with a special regime, where there are currently 14,354 beds, but where we do not know the detailed needs and composition of the user group, i.e. we do not know how many of these beds are used by people with severe mental illness. (According to individual inquiries during network

mapping, we estimate that about 50 to 60 percent of clients at Special Regime Homes have a mental illness. That would represent about 7,500 people with mental illness living in institutionalized care.) In addition, approximately 2,700 people with long-term mental illness have been living in psychiatric hospitals and clinics for more than half a year. We have 6,000 beds in institutional care for children in the school segment.

Services of the Ministry of Justice

The Institute of Security Detention (SD) was established on 1 January 2009 (Act No. 129/2008 Coll., on Security Detention and on the amendment to certain related acts). Its purpose is to ensure the protection of society from dangerous offenders, who were granted partial or complete insanity at the time the crime was committed. The institutes are administered by the Prison Service of the Czech Republic and are subsidiary to the performance of protective treatment (this treatment can be converted into the performance of SD and vice versa). Currently, the capacity of these facilities is 85 inmates.

Healthcare for persons serving a custodial sentence is provided by the Prison Service, including the performance of specific programs aimed at the use of addictive substances or specialized programs for the treatment of paraphilias.

Care for inmates whose mental condition deteriorates is provided at the Brno Prison Hospital.

Protective treatment

The system of protective treatment (PT) consists of functional components: outpatient care, inpatient care and placement in Security Detention. The most significant deficit of the protective treatment system in the Czech Republic is the absent application of the Risk-need responsivity model (Andrews and Dowden, 2007), where the intensity of treatment should correspond to risk, the most dangerous offenders should be treated most intensively and the treatment program should correspond to these risks. Due to the fact that in our system the risks for individual patients are not determined, the system in this respect must be perceived as uncontrolled, subject to tradition, local decision-making habits at the level of forensic expertise, indication to individual levels of PT, transfers between different types of PT (institutional-outpatient-SD). This leads to inequalities in the relative numbers of patients in

different regions and could be an indicator of unequal access to care. Given that the care in PT is unsubsidized both at the level of inpatient care (in the form of subsidies or the state program) and in outpatient form (increased administrative costs, communication complexity, keeping medical records), the network of providers in some regions is sparse and the entity exclusively responsible for its structure (health insurance companies) is not motivated to expand it. The entry of the state is therefore necessary, where one of its components (courts) shall order these treatments, and the performance shall be left exclusively to the network of healthcare facilities paid for by health insurance funds, in order to define and financially secure this network, as this is in the public interest.

In 2018, approximately 950 persons underwent protective treatment in institutional form, and approximately 3,300 persons received outpatient treatment (see Appendix No. 11).

Network of social and educational services relevant to children's mental health

The Ministry of Education, Youth and Sports establishes facilities for the performance of institutional and protective education, the activities of which are governed by Act No. 109/2002 Coll., on the Performance of Institutional Education or Protective Education in School Facilities and on Preventive Educational Care in School Facilities and on amendments to certain acts. In residential facilities, which are a children's home, a children's home with a school, an educational institution and a diagnostic institute, alternative educational care is provided to minors from 3 to 18 years of age, or to adults up to the age of 19. According to this Act, preventive care facilities are educational care centres. The centres provide outpatient, full-time, residential and field services. In the 2018/2019 school year, there were 204 school facilities in the Czech Republic for institutional or protective education with a capacity of 7,496 beds, which were used by 6,394 children and adolescents, of which 74 were under the age of three and 441 were preschoolers. The highest number were in children's homes (4,248), the lowest in children's diagnostic institutes (394). With the entry into force of Act No. 89/2012 Coll., the new Civil Code, in 2014, the power to decide on the placement of children and adolescents in these facilities was transferred from diagnostic institutes to the courts in 2014. In the same school year, there were 31 educational care centres in the Czech Republic, which provided their services to 13,838 clients, mostly on an outpatient basis (12,367). A total of

1,264 patients/clients were placed in the residential boarding service.[1] The Concept of the Ministry of Education, Youth and Sports in the area of the transformation of the system of substitute educational care was approved in 2016. File no. MŠMT-9559/2013-22. According to this concept, a network of specialized facilities is to be established, to be used in cases where children cannot be placed in some form of alternative family care for serious reasons, or in cases where they need comprehensive (special pedagogical, psychological, health, social) professional care. Placing a child in institutional care should last only the necessary time and simultaneously guarantee the exercise of his or her fundamental rights. The basic vision of the concept is to limit the scope of institutional education with an emphasis on the development of outpatient care and the transformation of institutions into highly specialized workplaces providing various forms of prevention of risk behaviour in children. The concept assumes a reduction in bed capacity in favour of outpatient and all-day services. The concept also assumes the creation of consulting interdisciplinary teams.

Supporting family members in the area of children's mental health

An analysis of innovative procedures and services for families and children in the Czech Republic prepared within the project of the Ministry of Labour and Social Affairs entitled "Systemic development and support of tools for the social and legal protection of children", project number CZ.03.2.63/0.0/0.0/15_017/ 0001687[1] states deficits in the area of parental competencies as one of the main risk factors for endangering children. This term includes not only skills in childcare, housekeeping, ensuring healthcare, education, etc., but also the development and maintenance of safe and high-quality parent-child relationships. Insufficient parental competencies are the main reason for the placement of children in alternative types of care. For this reason, innovative services that respond to this problem are gradually beginning to appear on a limited scale. Until 2006, there was a care service for families with children in the Czech Republic, which provided families the support in caring for children and running a household[1]. With the adoption of Act No. 108/2006 Coll., on Social Services, this service ceased to exist. According to current legislation, this service may be included in social activation services for families with children, or also in the counseling activities of authorized persons. These services are based on the principle of voluntary use by the client and require a certain degree of motivation from the family. Thus, there is a basic legal framework for the

innovation of social services aimed at the development of parental competencies, although it is necessary to find a mechanism that will provide the service to the family in need.

As part of the aforementioned project, a document entitled Basic Principles of Selected Innovative Approaches and Services for Vulnerable Children and their Families[1] was also prepared by a wide platform of experts in 2018, which is to become a guide in implementing changes in existing services and preparing new support programs for vulnerable children. Among other things, there are recommendations for setting up services aimed at the development of parental competencies, as well as recommendations for the support of children with specific needs in the field of mental health. In relation to these children, an emphasis is placed on a multidisciplinary approach to support and the need to introduce the early detection of children with mental health needs due to the psychosocial burden.

HUMAN RESOURCES AND TRAINING

CURRENT STATE AND IDENTIFICATION OF PROBLEMS

Numbers of employees

The publication *Psychiatrická péče* (Psychiatric Care) under the edition *Zdravotnická statistika* (Health Statistics), published by the Institute of Health Information and Statistics of the Czech Republic (IHIS CZ), presents the following data regarding personnel capacities in the field of mental health:

- 13.6 psychiatrists per 100,000 inhabitants; 37% of these are in inpatient care in the field of psychiatry;
- 29.6 nurses per 100,000 inhabitants; 88% of these are in inpatient care in the field of psychiatry (the percentage of psychiatric nurses is not known, a qualified estimate based on available data is 40%);
- 3 psychologists per 100,000 inhabitants; 61% in inpatient aftercare in the field of psychiatry;
- 23.8 non-medical professionals per 100,000 inhabitants; of which 90% are in inpatient

aftercare in the field of psychiatry.

According to the VZP analysis (2018), 874 physicians (of which 259 are in acute care) and 4,781 university students/non-physicians (of which only 59 are in acute care) were employed in inpatient care in 2017. According to the current valid version of staffing standards, care in psychiatric inpatient workplaces is provided by a sufficient number of employees, or full-time positions. However, if stricter standards were already applied to acute care facilities (created as part of the psychiatric care reform), the current distribution of staff capacities for physicians and non-physicians would meet the standards, albeit at thresholds, but for nurses almost a hundred positions would be missing.

V As part of the ongoing deinstitutionalization of psychiatric care, a significant reduction in aftercare beds is expected, which will partially free staff not only for established MHCs, but also for acute inpatient care facilities, which are expected to increase slightly. However, even this managed change will not completely ensure the needs for personnel coverage for the development of the aforementioned services. In addition, it will be a complex process with the need for intensive training to ensure competencies in the new style of work and motivation of existing employees to change the conditions and methods of providing care.

V According to the VZP analysis, the development of the number of physicians in the field of psychiatry in the two most important outpatient specialties (psychiatry and child psychiatry) in the outpatient sector is characterized by a slight growth rate throughout the observed period of 2012-2017 (in 2017 it was 807 physicians with a specialization in psychiatry and 113 physicians with a specialization in child psychiatry). Other specializations (addictive diseases, gerontopsychiatry and sexology) have a more or less similar number of physicians and their capacities throughout the period (in 2017 it was 4 for addictive diseases, 21 for gerontopsychiatry and 32 for sexology). The current number and capacity of employees in psychiatric outpatient workplaces varies significantly according to the regions of the Czech Republic. It is clear that the focus of outpatient care is in the capital city of Prague. Regional differences can also be observed in workers with specializations 901 and 914, where the dominance of the capital city of Prague is once again noticeable, covering approximately one-third of the total capacity of clinical psychologists and psychiatric nurses.

There is a slightly different trend for nurses in the outpatient sector than for physicians - the number of nurses in outpatient service providers decreased slightly (in 2017 there were 269 nurses in the field of psychiatry and 24 nurses in the field of child psychiatry). Psychiatric nurses (specialization 914) continue to be at the margins of interest. However, in recent years a growing trend can be observed (17 nurses in 2017 for outpatient service operators). Nurses play a key role in the development of community services. It will be necessary for part of the existing capacity of nurses currently operating in the field of inpatient care to be gradually transferred to other types of services. However, this requires the creation of a level playing field in community services, competitive conditions in the inpatient sector, and stimulating the desired transfer of capacity.

Clinical psychologists (specialization 901) are mainly associated with employee category "K" in the outpatient segment - between 2012 and 2017 their number increased by more than 20% (to 649 in 2017). Their number grew also in the segment of institutional care (to 353 in 2017) (see Appendix No. 10).

Workers in psychiatric outpatient services, as in other segments of healthcare, face a generational shift which, however, is not as alarming as, for example, in primary healthcare workers. From the point of view of basic age structures, it can be judged that the focus of the age structure of physicians in the two main psychiatric specialties (psychiatry and child psychiatry) is in the age category of 45-49 years, which includes about 20% of all workers. Clinical psychologists show that the most numerous age categories include 40-44 years (approximately 20% of employees), but also 65-69 years (11% of employees, or 15% of capacity). The average age of physicians in acute care settings decreased between 2012 and 2017, mainly due to an increase in the number of young physicians under the age of 40, who make up more than two-thirds of the capacities in this healthcare segment. However, there is no similar generational shift in nurses, where both their average age and the share of staff capacity aged 60 and over increased, from one fifth in 2012 to a third in 2017. A similar trend can also be observed in aftercare workplaces (the share of nurses aged 60 and over has more than doubled); The demographic structure of physicians in aftercare workplaces remains more or less stable.

Training

The reform of psychiatric care aims to systematically provide coordinated, interconnected care aimed at patient/client recovery broadly defined in a bio-psycho-social context. To this end, a network of services will be set up to ensure continuity of care, thanks to coherence and a high degree of coordination, with a multidisciplinary approach being the basic tool. However, the reform of psychiatric care means not only a structural change, such as expanding the range of interventions for the mentally ill and their loved ones with new “non-inpatient forms of care”, but, above all, a change in healthcare providers' view of the needs and goals of people with mental illness.

In the new system, emphasis is placed on the autonomy of the patient/client, who is respected as a treatment partner, is expected to be able to participate in the choice of therapeutic and rehabilitation procedures and is willing to cooperate in treatment. The patient's/client's family is considered an indispensable element in comprehensive care. The motive of the organizers of psychiatric care for the involvement of relatives and close ones are demonstrable health benefits, such as a reduction of relapses, but also the fact that in an era accentuating shorter hospitalizations, some care and responsibilities may shift from the institution to a patient’s/client's immediate surroundings.

In order to achieve the main reform goal, i.e. to provide care that leads to recovery, it is necessary to identify the new professional competencies of the staff involved in direct patient/client care and, in this context, to review the existing training system.

Doctors

The current system of specialized education in psychiatry and child and adolescent psychiatry provides quality training for psychiatric practice, allows for the acquisition of the necessary comprehensive knowledge and skills and the resulting competencies for the profession of psychiatrist and pedopsychiatrist that meet national and international standards. However, this system of quality content encounters a number of barriers in the areas of 1) ***capacity***, mainly due to low interest in the field, an insufficient number of training places, limited capacity of training workplaces and trainers, and limited space for real interaction between the trainee

and the trainer; 2) ***procedural***, which includes the instability of specialized education due to frequent legislative changes, currently the absence of decrees and implementing regulations, and the administrative burden of care providers associated with providing new accreditations, the current critical situation in obtaining specialized competence in psychotherapy for psychiatrists, and the link to reimbursement mechanisms ; 3) ***educational***, especially the unavailability of educational programs expanding competencies (community psychiatry, social rehabilitation, multidisciplinarity), both for psychiatrists and cooperating professions; 4) ***financial***, especially insufficient funding for specialization education, lifelong learning, psychotherapeutic training and the reimbursement of interdisciplinary cooperation, and 5) ***political,*** especially, in some aspects, the missing support for comprehensive care, both in terms of interdisciplinary cooperation in the field of healthcare, as well as inter-ministerial (social services, state administration, legislation). If the comprehensive, systematic and sustainable education of psychiatrists is to be established in such a way that fulfills all the demands on physicians of the new system of care for the mentally ill, both a quantitative and qualitative aspect need to be applied.

From a quantitative point of view, it should be borne in mind that new facilities will be set up as part of the reform of psychiatric care, in particular outpatient clinics with extended care and mental health centres. Qualified psychiatrists will need to be sought for these facilities, which may prove very difficult in the current system of undergraduate and postgraduate education. For example, if 100 mental health centres are to be set up, with 1.5 full-time positions of a psychiatrist for each of them, then approximately 150 psychiatrists will be needed. It would be unrealistic to assume that this volume could be drawn from inpatient workplaces, where beds will be reduced. As for the timescale, a psychiatrist acquires the aforementioned competencies gradually, during training in a six-year undergraduate study of general medicine at medical faculties, during specialization (pre-certification), which currently lasts 5 years, after which the physician acquires a certificate of specialization in the field of psychiatry. The number certified is far from satisfying the aforementioned requirements: in 2016, a total of 46 physicians successfully completed certification, in 2017 it was 31, and in 2018, 34 physicians were certified in the field of psychiatry. In the current situation, the interest in certification in psychiatry is therefore stagnant or declining.

If we focus on the number of medical graduates, then on a national scale, schools produce about 1,060 new doctors a year. It is known from long-term statistics and registers that 70 to 100 of them will not commence work and four to six percent will leave their jobs very quickly, within about six months. Those who commence work also don't work full-time, but about 90 percent of full-time employment, which results in 850 full-time Czech doctors in Czech healthcare per year. The model shows that the current production of new graduates who will enter practice will not be able to cover the loss of capacity from 2018 due to the aging population of doctors, even if doctors over 65 will work in more than three thousand jobs. Predictive models show that the required state can be achieved by increasing the production of medical graduates by 20 to 25 percent in the long-term, i.e. until 2035 to 2040.

However, the question remains to what extent, even with higher numbers of graduates, it is possible to ensure greater interest in the field of psychiatry. Interest in the field of psychiatry among medical students in the Czech Republic is annually mapped by the survey Barometer among medics (http://www.hc-institute.org/cz/novinky/barometr- mezi-mediky-2018.html). In a nationwide survey among 4th, 5th and 6th year medics of eight medical faculties in the Czech Republic, respondents had the opportunity to choose their preferred field from a list, while they could select a maximum of 3 fields and also actively state the relevant field. Three percent of medics (1207 respondents) chose psychiatry in 2016, the same as in 2017 (917 respondents), and in 2018 it was four percent of medics (1,314 respondents).

The current system of the professional training of psychiatrists only partially meets the competencies that the psychiatrist will hold in the reformed system. There is a general lack of emphasis on recovery, a bio-psycho-social approach, knowledge of the specific methods of work needed in multidisciplinary teams, including specific rehabilitation procedures for patients with severe mental illness. Likewise, the education system does not prepare psychiatrists for their leadership role in the system. The following text describes the current situation in the field of undergraduate, specialization, postgraduate and lifelong learning. A special chapter is devoted to education in psychotherapy. "Gaps" in education are identified and possibilities are proposed to modify the education system so that it better corresponds to the competencies of the psychiatrist in the reformed system (output from the working group on the education of psychiatrists in the Deinstitutionalization project, MoH).

Nurses

70% of mental health professionals are nurses, of whom 3,904 work in psychiatric inpatient aftercare, 739 in acute inpatient care, 267 in outpatient care and 30 in community care. Thirty-one per cent of nurses in the field are under the age of forty, 60% are in the age range of 40-59 (see Appendix No. 10). The independent specialization of psychiatric nurse (914) was introduced into the Tariff of Procedures in 2004.

Education of psychiatric nurses

The need for changes in the training of psychiatric nurses stems from the ongoing reform of psychiatric care, as a result of which the structure of psychiatric services is gradually changing and the focus of care is shifting from institutions to the patients' natural environments. The vast majority of psychiatric nurses currently work in inpatient care and their current training corresponds to this. In the future, nurses should also find employment in other types of care, such as mental health centres, psychiatric outpatient clinics with extended care, mobile teams and day care centres. The training of nurses must respond to these changes so that nurses are prepared for the new tasks and equipped with the necessary knowledge and skills.

Identified deficiencies

1) The current educational program of the specialization Nursing in Psychiatry does not reflect ongoing and planned changes in the mental health care system:

- an insufficient emphasis is placed on the principle of recovery and long-term support of clients and also on the acquisition of basic skills in psychosocial approaches; the curriculum does not include rehabilitation processes or recovery approaches
- nurses do not acquire the knowledge and skills needed to perform certain specialization procedures of 914 - psychiatric nurse (e.g. individual psychiatric rehabilitation, supportive therapeutic activities, crisis intervention, etc.)
- studies lack a comprehensive explanation of the main principles and models of community care

- insufficient space is devoted to practicing skills, it is mostly a frontal teaching method
- nurses are not well acquainted with various evaluation tools - questionnaires of client needs and abilities (e.g. GAF, HONOS, etc.).

- practical training does not include practice in specialized mental health centres or in other multidisciplinary teams. A large part of the internship takes place at the student's workplace and its contribution is therefore problematic.

2) There is no appropriate specialized training for nurses in child and adolescent psychiatry.

At present, there is no specialized education for nurses in child and adolescent psychiatry; this program was cancelled in 2006. The field of pedopsychiatry was partially included in the specialized education of child and psychiatric nurses, but it was eventually discovered that this system is not suitable for theoretical, practical, professional and legislative requirements, and it is necessary to create a suitable form of training for nurses working in the field of child and adolescent psychiatry. In 2018, the field of specialized education Nursing care in child and adolescent psychiatry with the designation of a child nurse for child and adolescent psychiatry was successfully anchored in Government Regulation No. 31/2010 Coll., on the Fields of Specialization Education, for the occupation of a child nurse. In the following period, an educational program must be developed and approved, and education in this field must be commenced.

3) There is no systematic training in the area of psychotherapy.

Psychiatric nurses use a set of specific activities and resources (conversation, non-verbal behaviour, stimulating emotions, group interactions, etc.) to achieve wider contact with the patient and his/her loved ones, including helping to understand, eliminate or alleviate their problems. The activities provided by psychiatric nurses include, in particular:

- crisis intervention activities
- mental activation,

- supportive psychotherapy,
- educational and supportive work with the patient and his/her family,
- relaxation techniques,
- activation of cognitive functions
- activities of a co-therapist,
- other activities following specific training (e.g. the CBT strategy, etc.).

The current education system does not provide adequate preparation for the performance of the above activities. The current system of professional training does not offer comprehensive and conceptual training for the further education of nurses in the field of psychotherapy. Nurses take many therapeutic courses of varying quality, some of them participate in self-experiential training for psychiatrists and psychologists, but their skills are not sufficiently recognized in practice. Their work often overlaps with the work of psychologists and psychiatrists. Communication and the helper's personality are one of the key tools he/she uses in work with the mentally ill. Therefore, the nurse should be prepared for situations that may arise when interacting with the patient. Deviation from working directly with the client can, in many cases, be caused by the uncertainty that the helper experiences in various non-standard situations. Furthermore, the nurse should learn to use her potential, to work with herself, her experiences and also strengthen the healthy components of the patient's personality. This is important from the point of view of mental hygiene, safety and diagnostics. But he/she should also learn to define boundaries in some situations where it is appropriate.

The aim is to create a unified system of training in the field of psychotherapy. To define requirements for creating self-experience training specific to nurses and create a certified course. Comprehensive education will include a combination of theory, self-experience and supervision. After completion, the nurse will be ready to perform various psychotherapeutic activities under the supervision of an erudite psychotherapist and will play an important role in providing therapeutic care.

Psychologists

In the process of the mental health care reform, in addition to the need to adjust education to change the paradigm of care provided, there is a lack of clinical psychologists to provide quality existing services and develop new community services, as well as the unavailability of psychotherapy for people with mental illness.

Regarding the education process, the first condition for the exercise of the health profession is the acquisition of professional competence. The graduate of the single-subject bachelor's study of psychology and the follow-up single-subject master's study of psychology will achieve this by completing the accredited qualification course Psychologist in Healthcare. This is followed by specialization training in clinical psychology, which lasts 5 years, of which 3 years are the basic strain. During this time, the psychologist works in healthcare under the professional supervision of a clinical psychologist. The condition for acquiring the specialization of a clinical psychologist, i.e. specialized competence, is the successful passing of the certification exam. Education in psychotherapy is specialized, ord extended. It is currently being constituted in connection with the amendments to Act No. 96/2004 Coll. and Government Regulation 31/2010 Coll., on Fields of Specialization Education; a new two-year educational program is being prepared. According to this regulation, the condition for commencing it is completing basic education in the field of clinical psychology and 200 hours of comprehensive psychotherapeutic training approved for healthcare. The condition for acquiring the specialization of a psychotherapist is the successful completion of comprehensive psychotherapeutic training approved for healthcare (with a theoretical, practical and supervisory part), fulfillment of the conditions of the educational program and successful passing of a certification exam in psychotherapy. Education in child clinical psychology is specialized, or extended. At present, it is not possible to pass certification in psychotherapy for clinical psychologists or physicians. The current situation divides the meaningful concept of joint extended education in PT for clinical psychologists and physicians.

Social workers/health and social workers

The current transformation of psychiatric care focuses on community psychiatry, which uses interdisciplinary collaboration and an integrated approach to providing comprehensive care for

patients/clients in their natural environment. The overall changing concept of care gives rise to a completely new role for social workers in meeting the needs of mentally ill patients/clients, especially in the area of individualized support and ensuring a multidisciplinary approach in community services.

According to Act No. 108/2006 Coll., a social worker performs social investigations, provides social agendas, including solving social and legal problems in facilities providing social care services, social legal counseling, analytical, methodological and conceptual activities in the social field, professional activities in facilities providing social prevention services, screening, crisis assistance, social counseling and social rehabilitation, identifies the needs of the inhabitants of the municipality and the region, and coordinates the provision of social services.

Professional competence to perform the profession of a social worker providing social services in inpatient healthcare facilities pursuant to Section 52 is also acquired by a social worker or health and social worker who has acquired competence to perform the medical profession pursuant to a special legal regulation (Act No. 96/2004 Coll., on Non-Medical Health Professions).

In the current situation, it is possible to identify an insufficient capacity of health and social workers in providers of aftercare in the field of psychiatry, who could provide intensive individualized social work for the benefit of patients. At present, the role of health and social workers in providers of aftercare in the field of psychiatry is mostly administrative and there is no capacity left for social work with the patient. Health and social workers at providers of aftercare in the field of psychiatry are overloaded with the agenda of pensions, manipulation of clients' funds and handling of their other affairs. The job position of a health and social worker is not systematically used for mapping and arranging services in the natural community for a patient leaving inpatient aftercare, nor for individualizing support in the health facility itself, although the given areas are part of the professional qualifications of health and social workers.

At the same time, the lack of standards of social work for providers of aftercare in the field of psychiatry and medical facilities dealing with mental health issues is a major problem. There is a lack of the content definition of basic competencies to be performed by social workers in

modern care for the mentally ill, as well as a definition of standards in education, which would define both undergraduate teaching and the content focus of basic levels of lifelong continuous learning, and would include mental health issues, individualized care and a multidisciplinary approach.

Social service workers

The qualification and performance of the activity of a worker in social services is regulated by Act No. 108/2006 Coll. A more detailed specification of the role of a worker in social services in the field of mental health is given in Recommended Procedure No. 2/2017 for the social sector of Mental Health Centres of the Ministry of Labour and Social Affairs. However, it should be noted that the recommended practice does not specifically address the role of a worker in social services, but rather integrates it with the role of a social worker, despite different qualifications.

Mental health under the auspices of the Ministry of Education, Youth and Sports

Education in kindergartens, primary, secondary and higher vocational schools is regulated by Act No. 561/2004 Coll., on Preschool, Primary, Secondary, Higher Vocational and Other Education (the Education Act), as amended, and its implementing regulations. The content and goals of education in kindergartens, primary and secondary schools are defined by framework educational programs, on the basis of which schools create their school educational programs, taking into account the specifics of individual schools. The vocational training of teachers takes place at universities, especially at pedagogical faculties, but there are also departments preparing future teachers at faculties with a different specialization. Act No. 111/1998 Coll., on Higher Education Institutions and on amendments to other acts (the Act on Higher Education Institutions), as amended, provides higher education institutions with self-governing competence in the creation and implementation of study programs. However, educational content that is in line with the public interest can be widely integrated into the training of future teachers through a government decree.

The Education Act and its implementing regulations establish a legal framework for the

provision of support to children, pupils and students (hereinafter referred to as pupils) with psychosocial burdens and mental illness. The amendment to the Education Act No. 82/2015 Coll. introduced in 2006 a system of entitlement support measures for all pupils who need them "*to fulfill their educational opportunities or to exercise or apply their rights on an equal basis with others*.[1]" The support measures consist of the necessary adjustments in education and school services that correspond to the pupil's health, cultural environment or other living conditions. With regard to the breadth of the definition of the group of pupils entitled to support in education and other school services, it can be stated that this support is also intended for pupils with mental illness or a psychosocial burden, although they are not explicitly mentioned in the act. In Section 16, the Education Act defines groups of pupils for whom independent schools, classes, departments or groups can be established. This includes, but is not limited to, students with mental disabilities, autism spectrum disorders and severe developmental behavioural disorders. These categories of special educational needs are introduced for the purposes of education, the type of special educational needs is determined by the school counseling facility, pedagogical-psychological counseling centre or special pedagogical centre. School counseling facilities should determine special educational needs (SEN) on the basis of the health diagnoses of pupils, but this is not always so in the case of the category of a severe developmental behaviour disorder. The number of pupils with this SEN quadrupled in primary schools between 2005 and 2017, while in the school year 2018/2019 it reached 15,855 *(source: Czech Professional Society for Inclusive Education, 2018)*[1]. However, the increase in the number of pupils with this category of SEN does not correspond to the actual increase in the number of pupils with mental and behavioural disorders (F90-F98). The number of pupils with severe developmental behaviour disorders (10 children per 1,000 in primary schools) mostly corresponds to the number of clients of educational care centres and the number of cases of children under the age of 15 with educational problems registered by youth curators. The number of cases of children who committed crimes solved by youth curators is significantly lower (2 children per 1,000 in primary schools). The same applies to the number of children admitted to children's homes with a school due to behavioural problems (less than one per 1,000 children) or to the number of children hospitalized in psychiatric inpatient facilities for the treatment of diagnosis F90-F98 (1.1 children per 1,000 in primary schools).

The number of pupils with a registered severe developmental behaviour disorder varies considerably in the individual regions of the Czech Republic. In the 2016/2017 school year, it was 15.3 children per 1,000 in primary schools in the Karlovy Vary region, while in the South Bohemian region only 3.6. Such significant differences are due to different procedures in the assessment of SEN in school counseling facilities in the individual regions, which are largely associated with the subjective expectations of teachers in relation to the behaviour of students in the school environment.

Several representative surveys[1] have shown that developmental behavioural disorders and mental illness are the most challenging categories of special education needs for teachers in schools. Teachers do not consider themselves to be sufficiently prepared to educate these pupils. At the same time, teachers and principals of primary schools have shown interest in further education and methodological support in this area. The analysis of the needs of schools in the field of further education carried out by the National Institute of Further Education also shows that this is a topic in which teachers feel they most lack competencies[1]. The thematic report of the Czech School Inspectorate[1] showed that the predominant way of resolving the problematic behaviour of pupils in Czech schools is currently the use of disciplinary punishments (notices, reprimands of the class teacher, principal, reduced grade for behaviour, etc.). Some schools are setting up separate rooms to which they send pupils who disrupt instruction with their behaviour.[1] Measures applied in the school environment are therefore largely repressive. Problematic behaviour at school is also one of the reasons for placing a child in a facility for institutional and protective education. Identification of the causes of problematic behaviour in pupils and the resulting pedagogical and special pedagogical interventions in Czech schools are not systematically applied. Schools also haven't developed the early identification of vulnerable children, including children with CAN syndrome (child abuse and neglect). These children spend a significant part of the day in schools and school facilities, yet their difficulties are often discovered only after several years of inappropriate treatment. Following the adoption of the amendment to the Education Act in 2016, thanks to a system of support measures, the number of special educators in schools and school psychologists who could play an active role in the early detection of children with psychosocial threats and support their involvement in appropriate forms of intervention is beginning to

increase.

The implementation methodology of the primary prevention of risk behaviour (according to the terminology of the Education Act, socially pathological phenomena) in primary and secondary schools is the responsibility of prevention methodologists. Pursuant to Decree No. 72/2005 Coll., on the Provision of Counseling Services in Schools and School Counseling Facilities, as amended, they provide methodological, coordination and counseling activities in the field of the prevention of risk behaviour of pupils (bullying, substance abuse, self-harm, eating disorders, risk behaviour associated with violence, vandalism, truancy, risky sexual behaviour, etc.). However, these are not staff who are solely in charge of the primary prevention agenda. This position is held by teachers who have undergone specialized training, but their direct teaching duty is not reduced for the performance of preventive activities. According to the thematic report of the Czech School Inspectorate[1], this work is taken into account financially in only 15% of the teachers. Ensuring the primary prevention of risk behaviour is, thanks to the way the conditions are set, mostly insufficiently effective in schools.

DESTIGMATIZATION AND PREVENTION

Destigmatization and prevention are essential for reducing the burden of mental illness, as they enable people to recognize the symptoms of mental illness in good time, seek professional help and better deal with the social consequences of mental illness.

IIICompared to the original EU member states, the Czech Republic has an extremely high stigma, both among the public and among specific subpopulations, such as health professionals (Winkler et al., 2015a, Winkler et al., 2016a).

Destigmatization activities have a long tradition in the Czech Republic, but they usually remained without proper evaluation. However, in 2017, the nationwide Destigmatization project was launched as part of the psychiatric care reform, financed (along with other implementation projects of the psychiatric care reform) from the European Structural and Investment Funds. The Destigmatization project and its initiative “Na rovinu” (Frankly) focuses exclusively on evidence-based destigmatization measures for six strategically selected target

Prevention in the Czech Republic focuses mainly on secondary phenomena, such as bullying, truancy, drugs, etc., but universally targeted prevention focused on mental health is not systematically available. The WHO recommends the inclusion of school-based psychosocial skill programs applied by teachers as part of the prevention of pathological phenomena (WHO, 2013a). Research shows that pupils' psychosocial literacy is essential for academic achievement at school, a lower incidence of risk behaviour, completion of primary education and continuing university studies and an overall higher probability of becoming a responsible citizen (Jones et al., 2017). Because universal programs are positively set up and independent of the presence of risk in a given group, they are not stigmatizing, and are therefore easily acceptable and implementable (Greenberg et al., 2001). There are two components of effective destigmatization programs. First, destigmatization programs must be systematic and long-term. Second, destigmatization activities must involve people with an experience of mental illness (Thornicroft et al., 2016).

One of the six basic principles of the *European Mental Health Action Plan* (WHO, 2013a) which we emphasize in this document is the life cycle principle. The purpose of this principle is that all mental health policies, plans and services take into account health and social needs at all stages of a person's life, including childhood, adolescence, adulthood and old age. In relation to prevention, in addition to old age, which is largely addressed in two other strategic documents (MoH 2016, MoLSA, 2013), and the aforementioned prevention of mental illness in children and adolescents, it is necessary to focus on the period of productive age and specifically the area of employment.

groups, which are health professionals, social workers, public administration, communities around mental health care facilities, people with mental illness and their family members. The Destigmatization project is nationwide and operates in all regions of the Czech Republic. In addition to the aforementioned target groups, it also focuses on supporting the user movement. Funding for the project ends in 2022. Due to the restrictions imposed by the MoLSA on the relevant call, it was not possible to target other relevant population groups such as the police, teachers or the general population in the Destigmatization project.

Mental health in relation to employment is defined as the ability to work productively and creatively, to engage in strong, stable and positive relationships, fulfill personal and social goals and thus contribute to the community and gain/maintain a sense of meaningfulness of one's work.

At a general level, it is recognized that "work is good for people" and contributes to a sense of fulfillment and financial and social prosperity, but also to better mental health. For people with experience of mental illness, maintaining/returning to work is a vital part of the recovery process, through building self-reliance, self-confidence, social security/status, and inclusion in society (Kondrátová and Winkler, 2017). Improving working conditions can increase the percentage of employed people with mental health problems or illnesses - on the contrary, if this does not occur, government costs for the social support for people who would themselves prefer to be employed increase (Barbato et al., 2016).

It should be noted that the general statement that work is good for people only applies if the work itself is "good." In the case of "bad" work, we already have a significant amount of data documenting the negative impact of work-related burdens on the mental and physical health of employees in the general population, together with the associated negative effect on productivity and performance of businesses and society. Though, of course, the physical environment in which work is performed can have a direct negative effect on mental health, it is the psychosocial work environment (associated with the characteristics of work organization), which creates significant health risks, especially through work stress (OECD, 2012, OECD, 2015).

Currently, in addition to surveys that confirm the high degree of the subjectively-perceived negative impact of employment conditions on employees' health, we observe an increasing incidence of work-related mental illness and higher rates of early retirement and incapacity for work in connection with stress. In addition, the incapacity for work of one employee leads to an increase in work pressure and stress on the rest of the team. In addition to relatively well-measurable absenteeism, employers are increasingly confronted with so-called presenteeism (low work performance due to discomfort at work), where studies suggest up to a five-fold effect on lost profits compared to absenteeism. Presenteeism is also risky for mental or physical

(cardiovascular or metabolic) diseases in the future, which further contributes to the economic loss of the employer (Barbato et al., 2016, OECD, 2015).

Thus, focusing on improving psychosocial employment conditions will not only improve employee productivity, but also reduce employee migration between employers, improve employee dialogue, enhance creativity and innovation, which are essential for dynamic business, and improve the employer's reputation. Furthermore, it is significantly cost-effective. According to an analysis conducted in 2009 (NICE, 2009), a comprehensive approach to strengthening mental well-being in the workplace will reduce the loss of employee productivity due to excessive stress by approximately 30% and save $ 473,000 in excessive costs for 1,000 company/employee.

DEFENDING THE RIGHTS AND INTERESTS OF CLIENTS AND THEIR FAMILY MEMBERS

Involving clients and their families in decision-making

Although it may seem obvious to us that the involvement of people with mental illness and their families in the decision-making processes is obvious, we are only at the beginning of this process in the Czech Republic. The fact that we are at the beginning is due to several factors, such as a relatively short tradition of involving people with an experience of mental illness that began in the early 1990s, a not-so-strong and influential user movement that consistently promotes the involvement of people with a mental illness at all levels of decision-making, and a small number of users of care who want to be personally involved in these processes.

However, it must be objectively admitted that these problems are not specific only to the Czech Republic, but are faced by many countries around the world, even on a general level of citizen involvement in decision-making processes. In 1969, the article "A Ladder of Citizen Participation" (Arnstein, 1969) was published, in which the ladder of citizen participation in decision-making first appeared. This ladder can also serve as a tool for evaluating the current state of involvement of people with mental illness and family members in decision-making in the Czech Republic. From the lowest rung of the ladder to the highest, the individual steps are arranged as follows:

- Citizen control
- Delegated power
- Partnership

- Ukonejšení (Placation)
- Konzultování (Consultation)
- Informování (Informing)
- Terapie (Therapy)
- Manipulace (Manipulation)

On this ladder, Manipulation and Therapy belong to the "Non-participation" domain; Informing, Consultation and Placation together represent the various degrees of tokenism; Partnership, Delegated Power and Civil Control together represent the different degrees of civic influence. More on the individual rungs of the ladder at: www.partnerships.org.uk/part/arn.htm. [IV V]

Current state

Users of psychiatric care and representatives of their families are members of the Patient Council, which was established in 2017 as an advisory body to the Minister of Health with the aim of increasing the protection of patients' rights.

V As part of the psychiatric care reform, the Expert Council for the Professional Guarantee of the Psychiatric Care Reform Strategy (hereinafter referred to as the Expert Council) was established, which is a professional advisory body of the Ministry of Health. The Expert Council comments on and opposes conceptual materials related to care for people with mental illness.

V Both users of psychiatric care and representatives of family members are represented on the Expert Council.

The psychiatric care reform is managed by the Executive Committee for the Management of the Implementation of the Psychiatric Care Reform Strategy (hereinafter referred to as the Executive Committee). Its task is to operatively solve problems arising during the implementation of the psychiatric care reform and to manage the projects of the

V Regional steering groups play an important role in the reform. The purpose of the work of the Regional Steering Group is to create a functioning network of care for people with mental illness in the regions and to manage the mental health care reform in the region. Members of these Regional Steering Groups include users of care and representatives of informal caregivers.

Representatives of people with experience of mental illness are also members of all the working groups set up by the Expert Council, which focus on proposals for solutions to sub-areas in relation to the care system for people with mental illness (the Working Group on Education in Psychiatry, the Working Group for the Services Network, the Working Group for Material and Technical Standards of Acute Inpatient Care in Psychiatry, etc.).

At the level of individual psychiatric hospitals, people with experience of mental illness are members of hospital transformation teams.

People with mental illness and their families are at the heart of the reform. Therefore, it is an important step that their representatives are members of all the aforementioned bodies, always in the number of 1 to 2 representatives.

V A Working Group on Users of Care began to function as part of the psychiatric care reform in 2019. The purpose of this working group is to discuss the challenges posed by the mental health care reform and to create and provide sound opinions of the people with experience of mental illness, which reach the Executive Committee and the Expert Council and reflect the views of people with experience of mental illness. The working group may invite experts in the field to discuss given topics during the formation of sound opinions.

An important function of this working group is to inform people with experience of mental illness in the regions and to obtain feedback for its further activities. Regional meetings of

Implementation of the Psychiatric Care Reform Strategy.

The Executive Committee is composed of experts in the various areas affected by the mental health care reform, and people with experience of mental illness also have representatives here. In practice, the Executive Committee also serves as an expert platform, where the problems posed by the implementation of the reform can be discussed.

people with experience of mental illness within the emerging user movement serve to inform people with an experience of mental illness.

V At present, people with mental illness are invited to make decisions at the regional and national level, but their involvement is often formal. These are often not, for example, invitations to create documents, but only to comment on those already created. In order for the emerging documents to include the real needs of people with a mental illness and their families, the participation of people with a mental illness and family representatives in the production of documents is essential from the outset. This is the only way to establish active cooperation on the documents produced between people with a mental illness, their families and professionals (Convention on the Rights of Persons with Disabilities, Article 4 General Obligations, paragraph 3). The involvement of people with experience of mental illness also doesn't cover all levels of management of the care system, e.g. the level of the the management of individual services, evaluation of the quality of care provided, etc.

Mutual informing of the professional public and representatives of psychiatric care users is considered a priority, the aim of which is to connect two worlds, namely the world of psychiatric care users and the world of professionals. The interconnection of these views will help to significantly improve the state of care for people with experience of mental illness in the Czech Republic.

Decision-making by psychiatric care users at the level of an individual

One of the most important areas of decision-making for people with experience of mental illness is decision-making at the individual level, as this level of decision-making will affect everyone with experience of mental illness, whether it be the decision to look for work, complete studies, be an equal partner to your psychiatrist or the decision to start a family.

The informing of a person with experience of mental illness performed by a professional in the field of mental health care is very important in order to create a partnership with one's psychiatrist. Such informing also provides a space for shared decision-making where, in addition to professionals, both the person with experience of mental illness and his/her family are involved in the treatment. Although it is evident that a sense of partnership helps a person with a mental illness develop a positive relationship toward the treatment of the mental illness,

people with a mental illness and their family members often state that this partnership is not the norm in the current mental health care system.

Little attention is paid to therapeutic planning both in acute care, where there is evidence of the benefits of structured care planning, and in structured planning with the active involvement of patients in long-term care. The current practice is also insufficient, as crisis plans are not developed with the participation of patients, their relatives and supporters, and for patients to whom restraints have been applied, prevention plans for the application of these restrictive measures.

Due to the insufficient number of staff in inpatient aftercare providers in the field of psychiatry, the space for the individual support of a person in an acute state of mental illness at providers of inpatient aftercare in the field of psychiatry is often limited.

People who experience mental illness are often unaware of their rights, such as the right to assistance when making a decision. Decision-making assistance enables the support of a person with a mental illness by another person - a support person in any decision-making process of personal life. The supporter is anyone who is freely chosen by the person with experience of mental illness, on the basis of a contract approved by the court. The supporter advises and assists the supported person, participates in negotiations, etc.; the supported person decides on his/her own. The Civil Code allows the supported person to have several supporters. The supporter must not unduly influence the supported person or enrich him/herself at their expense. During a written meeting, the supporter may attach his/her signature, stating his/her position. The court will terminate this relationship at the request of the supported person or supporter. Although the courts try to apply decision-making assistance in practice, families very often insist on a restriction of legal capacity.

Another form of supported decision-making is the support of a guardian without limiting the ward's own legal capacity. The guardian acts together with the ward. If the guardian acts independently, he/she acts in accordance with the will of the ward, and if it cannot be ascertained, the court will decide on the guardian's motion. The guardian must therefore take care, among other things, to protect the best interests of the ward and to fulfill his/her rights. It works relatively well in the practice of the district courts.

The issue of informal carers

Qualitative research conducted by researchers at the National Institute of Mental Health on the stigmatization and discrimination of family members of people diagnosed with schizophrenia (Krupchanka et al., 2018a) has shown, among other things, that family members are exposed to high stress as a result of the often unlimited care and support of their sick loved one.

Family members complain intensively about the lack of support from the state in their role of informal carers, including the lack of financial support for themselves or their sick relatives, where, for example, the granting of care allowances is not sufficiently adapted to people with mental illness.

Another problem that informal carers often mention is the situation when they are not sufficiently involved in the treatment of their sick loved one and are often not given information about the mental state of a relative with an experience of mental illness, e.g. during hospitalization. Sometimes this situation is due to the patients' wish not to provide information about their health to the family. This situation is often very difficult for family members because they do not know the current health status of their sick relative.

The role of guardians

The questionnaire survey of the Ministry of Health for the National Action Plan for Mental Health revealed the need to support guardians in the performance of their duties, including educational programs on their obligations. The problem is often in the formal performance of the guardian's function, which does not reflect the needs of the ward. Other problems include:

- the insufficiently defined role and competence of the guardian, including a defined function of guardians (for guardians - family members);
- non-cooperation of family members and guardians, even if the guardian is a family member;
- the methodical guidance of public guardians is insufficient.

In 2018, a comprehensive training of public guardians took place, which was attended by employees of municipal authorities. However, the mayors of the municipalities, who often act

as a public guardian, were not trained. Another problem is the frequent ambiguity of judgments on the limitation of legal capacity.

The role of peer consultants in the psychiatric care system

Although the help of peer consultants (people with personal experience of mental illness helping people battling mental illness) has a therapeutic effect on people experiencing mental illness, their employment status is not anchored in the law, it is not defined as a type position in the National Classification of Occupations. In most cases, providers of inpatient care in the field of psychiatry do not have the possibility to create an official job position of peer consultant for an indefinite period.

Involving psychiatric care users in research

People with experience of mental illness have specific needs and desires with regard to the system of psychiatric care provided and are experts in their mental illness. At the same time, they can provide a complementary view and feedback on the psychiatric care system, as they go through it themselves. Therefore, it is a great advantage if people with mental illness are involved in evaluating the psychiatric care system and planning its development. The role of people with experience of mental illness in research, which is a cornerstone of the development of services for people with experience of mental illness, is currently beginning to develop. All the more so it is now necessary to focus on developing the necessary competencies and knowledge for this involvement, as well as finding legal mechanisms and financial resources to support this process.

Educating people with mental illness

As mentioned above, the full involvement of people with mental illness in decision-making and research requires the education of people with mental illness in order to equip psychiatric care users with the necessary knowledge and skills they will use for these activities.

Therefore, the Ministry of Health, together with psychiatric care users, has prepared an annual training cycle for people with mental illness as part of the Deinstitutionalization project, now primarily for psychiatric care users who are members of transformation teams at aftercare

inpatient psychiatry providers, and psychiatric care user representatives, who are in the Regional Steering Groups in each region and who participate or will participate in the planning of services and the creation of concepts for the care of people with mental illness in the regions. Participants in this education should pass on the acquired knowledge among people with experience of mental illness in individual regions. Regional meetings of users within the user movement being created are an ideal place for this transfer of experience, knowledge and skills.

Unless the competencies of people with experience of mental illness in decision-making are increased to a greater extent, they will not be able to effectively defend their rights, whether at individual or other levels of decision-making. The basis of decision-making competencies for each individual in society is the knowledge of necessary information. Therefore, if it is not possible to educate people with experience of mental illness, they will never be able to play an equal role at any stage of decision-making, and their position in the decision-making process will always be weakened and more or less formal. For these reasons there is a great need to create, in cooperation with professionals, people with mental illness and informal carers, a comprehensive educational program, preferably modular, whose graduates (whether professionals or people with experience of mental illness or informal carers) will be equipped with skills to build partnerships at all levels of mental health decision-making.

A **"Recovery College"** could serve as a place for professionals, people with mental illness, family members and other people interested in mental health to work together. These colleges already operate abroad and are based on the following principles:

- **Providing recovery-based empowering education** for anyone interested in the area of mental health.
- **The mutual cooperation** of people with mental illness experience, family members, friends and mental health professionals based on mutual respect and partnership. The purpose of this collaboration is to jointly design, jointly experience and jointly evaluate all aspects of the recovery college.
- **A community development approach**, where the recovery college seeks to develop a partner and support network in the community in order to develop a culture of recovery. The goal of the recovery college is to include its students in all areas of community life (social, educational, cultural and work) and to inform members of the community in such a

way that it becomes more inclusive, respectful and aware of the principles of recovery.

- **Adult education**, where each student can choose a training course according to their interests and needs in order to develop their potential for recovery. The recovery college is not a place for treatment or therapy, but provides a friendly and non-judgmental environment where it is possible to learn from each other, cultivate mutual respect and a sense of connection.

More about Recovery College at, for example:
https://transfomativecollegewestmeath.wordpress.com/about-us-4/;
https://www.sussexrecoverycollege.org.uk/

Recovery College programs have a demonstrated positive impact on participants' recovery, skills and knowledge. There is also evidence of a higher quality of life and lower use of professional services in connection with attending the program. The principle of co-production also has a direct influence on the attitudes of professionals participating in the programs (Bourne, Meddings, & Whittington, 2018).

IMPROVING QUALITY

At the international and national level, steps are now being discussed and intensively taken to implement the human rights of people with disabilities and to enhance the quality of health services. In 2009, the Czech Republic ratified the Convention on the Rights of Persons with Disabilities (hereinafter the "Convention"), which declares the rights of persons with disabilities, and therefore of persons with mental illness, that are to be taken into account in the provision of public mental health services (UN, 2006).

In the field of mental health care, it can be said that the area of providing quality care concerns people/patients with a high need for individualized support, with a high rate of incapacity for work and disability. Given their high vulnerability and reduced social adaptability due to disease, it is not possible to approach care without a comprehensive view of the person and individualized care. On the contrary, the absence of individualized care in practice may result in a violation of the patients'/clients' rights. The provision of care for people with mental illness

is demanding on the professionalism of staff, the need to identify the specificity of support and also on funds that are underestimated in the field of psychiatric care compared to other countries (see the chapter on funding for more details).

Legislative definition and control

The area of legislative definition of the issue of quality and the human rights of persons with disabilities/mental illness in relation to the issue of quality is reflected in the Czech Republic through two key areas: The first of these is the legislative framework of quality and human rights. This is included in the applicable legislation in the relevant laws and decrees, including related documents and ministries, and this framework is legally binding on the relevant entities. The second area is the definition of standards and the implementation of quality and human rights assessments by non-state actors, such as service associations. The standards, evaluation methodologies and related documents developed by them in these cases are usually published on their websites and are not legally binding. These entities also offer the allocation of their own types of certifications, the aim of which should be a public declaration of quality of the certified entity, and can serve as an indicator of whether a particular service is provided for those interested in it, users and e.g. also superior authorities.

V In the area of the implementation of quality and human rights in health services in the Czech Republic, the aforementioned area is addressed in particular by Act No. 372/2011 Coll., on Health Services and on Conditions of their Provision, and Act No. 108/2006 Coll. and their implementing regulations.

On the issue of quality and human rights, the Ministry of Health of the Czech Republic (hereinafter referred to as the MoH) published in the Ministry of Health Bulletin No. 16/2015 the Minimum Requirements for the Implementation of the Internal System of Evaluation of Quality and Safety of Provided Health Services (hereinafter referred to as the "Minimum Requirements"). These are described in Annex No. 2 to Decree No. 102/2012 Coll., on Minimum Evaluation Standards and Indicators of Quality and Safety and the Method of their Creation and Monitoring (hereinafter referred to as the "Minimum Standards"), which, however, merely mention human rights issues but do not reflect on them in more detail. Similarly, they fail to provide more specific tools for the implementation of human rights.

V In the field of healthcare in the Czech Republic, there exist independent certification bodies with their own evaluation systems, focusing on the quality of health services. The aforementioned systems of standards and quality evaluation in the field of health services are implemented in accordance with Section 98 of Act No. 372/2011 Coll., on Health Services and on Conditions of their Provision. According to paragraph 2 of the aforementioned Section, they consist of a set of requirements for selected processes and indicators assessed in the healthcare facility in terms of ensuring the quality and safety of the provided health services.

The creation of the first minimum set of measurable indicators of healthcare quality, including its methodology, was published as part of the methodological recommendations of the National System for Reporting Adverse Events. However, these indicators do not reflect in detail the fulfillment of the rights of people with disabilities or recovery principles. In the area of primary care, health insurance companies use data obtained from providers to some extent for quality assessment and capitalization bonus, however, even health insurers do not normally reimburse healthcare based on data on cost-effectiveness, quality of the reimbursed service (including quality in relation to human rights) or desirable behaviour of the care system, and the impact on its users.

Based on the above, it can be stated that in the field of mental health care, there is no uniform methodology at the national level for assessing the quality of services or national recommendations for uniform procedures in the field of quality and fulfillment of human rights in the field of mental health services. At the same time, good practice is not systematically collected.

This issue is partially addressed by ongoing psychiatric care reform projects, where the Deinstitutionalization project includes the collection of good practice, the development of a methodology for assessing the quality of care and its certification in psychiatry (both in inpatient facilities and in the outpatient sector) and the introduction of recommended procedures and methodologies within individual types of services, but only in the healthcare system.

Quality of care and satisfaction with care

In the Czech Republic, regular surveys of satisfaction with care among users of mental health

care services have not yet been conducted on a larger scale. However, by the end of 2019, a large-scale survey among users and family members will be conducted as part of the psychiatric care reform to determine the quality of services and needs of people with mental illness and their family members. People with mental illness and family members co-created the Care User Questionnaire and the Family Member Questionnaire. However, this is a one-off survey without reference to established service evaluation systems.

In the Czech Republic, there is a long-term project called "Quality through the eyes of patients", the purpose of which is to evaluate the quality of care provided by the patients themselves. The history of the project dates back to 2000/2001. Inpatient and outpatient facilities are evaluated within its framework. Both areas are evaluated separately. This is a questionnaire survey among patients and the project also involves providers of inpatient care in the field of psychiatry. The evaluation of a specific facility in a given year can be found at the project website: www.hodnoceni-nemocnic.cz, where it is possible to find more detailed information about the project. The data collection standard was issued in the Bulletin of the MoH 2008/3. The output of the evaluation of a facility is the certification “Satisfied patient.” However, the participation of individual facilities in this project is voluntary; in 2018, 3 psychiatric hospitals participated in the project.

Although people with experience are involved in decision-making processes, they are less invited to design, create, provide and evaluate the interventions needed for them. Involving people with mental illness in such a process brings the desired effectiveness (Chamberlin, 2005; Thornicroft & Tansella, 2005) in the form of interventions reflecting people’s own experience with mental illness.

Quality of care in psychiatric hospitals

In its Quality Rights for Mental Health project (WHO, 2018b), the World Health Organization (WHO) identified shortcomings in the implementation of the Convention on the Rights of Persons with Disabilities in institutions providing long-term care for adults with intellectual and mental disabilities across Europe, including three selected facilities in the Czech Republic. For this reason, a comprehensive survey of the quality of compliance with the Convention on the Rights of Persons with Disabilities in psychiatric hospitals in the Czech Republic providing long-

term care was conducted as part of the implementation of the Psychiatric Care Reform Strategy (PCRS). The aim of the mapping was to obtain valid materials for work on improving the quality of care provided and fulfilling the human rights of their users in these institutions. The project description and results are published on the psychiatry reform website (http://www.reformapsychiatrie.cz/2019/04/01/zprava-z-mapovani-kvality-pece- ve-smyslu-naplnovani-umluvy-o-pravech-osob-se-zdravotnim-postizenim-v-ceskych- psychiatrickych-nemocnicich/).

The results of the survey showed that compliance was initiated by providers of aftercare in the field of psychiatry with Article 28 of the Convention (adequate standard of living and social protection); Article 25 (highest possible level of health); Articles 12 and 14 (equality before the law, freedom and personal security); and Article 19 (independent living and community involvement). Compliance with Articles 15 and 16 (protection against torture and other cruel, inhumane or degrading treatment or punishment and protection against exploitation, violence and abuse) has been partially achieved. The most problematic areas included taking into account recovery plans formulated with care users, taking into account the preferences of care users in terms of location and treatment, using alternative methods for de-escalating crisis situations instead of isolation and restraints and last, but not least, ensuring access to education and employment opportunities.

In the next phase of the reform, the employees of the Ministry of Health will work together with psychiatric hospitals to eliminate the identified shortcomings within the key activity Quality of Care of the project Deinstitutionalization of Services for the Mentally Ill (hereinafter Deinstitutionalization). Some shortcomings can be remedied relatively easily and quickly, while others are the result of long-term structural discrimination against people with mental illness and require changes in the care system itself for this target group that include funding, legislation, education and systematic deinstitutionalization.

Current psychiatric practice does not significantly reflect the specifics of care for people with mental disabilities. Psychiatric hospitals and clinics substitute for the insufficient network of social services for people with special needs and their spaces and operation are not adapted to the needs of people with mental disabilities. Despite the existence of programs to support the

return of long-term hospitalized people with mental disabilities to the natural community, people with mental disabilities and behavioural risks are often hospitalized for decades due to the inadequacy of the network of services.

The quality of care for patients with prescribed protective treatment suffers from the absence of indicators mapping the risks of the patient (risk assessment), as well as protective factors (based on the principles of recovery) and insufficient incorporation of recommended procedures in this area of care.

Quality of care in general hospital psychiatric wards

The quality of acute care provisioning is defined by the standard of acute psychiatric care published in the Bulletin of the Ministry of Health 5/2016. At present, the fulfillment of the objectives of the standard is not systematically monitored. The statements of performed procedures, number of patients, length of hospitalization for health insurance companies and data obtained from the IHIS system can serve as a certain guide. Quality in the sense of fulfilling human rights or cooperation with other components of care is not, as described above, methodically addressed or monitored.

Quality of care in psychiatric outpatient clinics

The quality of care in the outpatient area is not systematically monitored, it is partly addressed by health insurance companies, which monitor whether the procedures described in the List of Health Procedures have been fulfilled as part of outpatient care. For outpatient specialists, compliance with the recommended procedures prepared and regularly updated by professional societies (Psychiatric Society of the Czech Medical Association JEP) is not mandatory.

In connection with the Decree on Dispensary Care (Decree No. 39/2012 Coll., the Decree on Dispensary Care) and the definition of dispensary care (Section 5, Act No. 372/2011 Coll., on Health Services and on Conditions of their Provision), the purpose of outpatient treatment is the active and long-term monitoring of the health status of a patient at risk of or suffering from a disease or deterioration of health, for which a change in health status can reasonably be expected according to the development of the disease, the early detection of which can significantly affect its further treatment and development. It can be said that not all psychiatric

outpatient clinics fulfill the legal obligation to provide dispensary care. On the other hand, the methodological instruction of the MoH for the implementation of dispensary care of 22 May 2012 does not reflect the specifics of psychiatry and does not address in detail the procedure for patients who do not cooperate in outpatient care. Even in connection with the development of community services, taking into account the assertive approach of communication with patients, it is necessary to legislatively enshrine dispensarization (including its enforceability) in the law.

The patient/client with ordered protective treatment is subjected to treatment on the basis of a court order, where methodical instruction is completely missing. A working group for potentially dangerous patients/clients with prescribed protective treatment is being set up at the Ministry of Health, where this issue should be addressed.

In a regular psychiatric outpatient clinic, the care of a patient/client with protective treatment cannot be provided well, the outpatient psychiatrist has no tools to supervise the patient/client, it is merely obliged to inform the court and police in the case of non-compliance with the treatment regime.

Quality of care in MHCs

Mental Health Centres are being established since 2018 as part of pilot projects of the MoH of the Czech Republic.

These are multidisciplinary teams composed of health professionals and social workers. Legislatively, this is a combination of the provision of healthcare and social services by one multidisciplinary team. Mental health centres were first defined in the *Psychiatric Care Reform Strategy* in 2013. The operation of the service was further enshrined in the *Standard of Care provided in the MHC* (Bulletin of the Ministry of Health of the Czech Republic 5/2016) The MoLSA subsequently issued *Recommended Procedure No. 2/2017 for the Social Sector of Mental Health Centres*. The last methodological material is the document *Basic Principles of Care Provided in the MHC*, published by the Ministry of Health of the Czech Republic in 2018.

The legislative requirements of the Act on Health Services and on Conditions of their Provision 372/2011 apply to MHC health services. Quality assessment is mainly dealt with by Bulletin No. 5/2012, which sets out the minimum requirements for the implementation of an internal

system for evaluating the quality and safety of provided health services. In this material, these are mainly safety and hygiene criteria; guidelines specific to outpatient field services of the MHC type cannot be found here.

The legislative requirements of the Social Services Act No. 108/2006 apply to MHC social services. Quality assessment is carried out in accordance with the Standards, which are contained in Annex No. 2 to Decree No. 505/2006 Coll., and is carried out by the Ministry of Labour and Social Affairs. At present, the real risk is that emerging MHC-type services will undergo external, independent quality assessments according to different legislative standards and with different binding obligations. This can burden the functioning of these services and also go against the concept of an MHC as a team-based service.

Quality of care in residential social services

When providing social services, the provider is obliged to fulfill the obligations and quality standards of social services, which are defined by law. They focus primarily on the process of providing social services and the protection of the rights of persons to whom the social services are provided. In the case of registered providers of social services, an inspection is performed by the Inspectorate for the Provision of Social Services, implemented by the Ministry of Labour and Social Affairs.

In the field of the implementation of quality and human rights into social services in the Czech Republic, this area is addressed by Act No. 108/2006 Coll., on Social Services and their implementing regulations. Act No. 108/2006 Coll., on Social Services, regulates the area of human rights first in Section 2 of the Act, where paragraph 2 defines that “social services must be provided in the interests of persons and in an appropriate quality in such a way that the observance of human rights and fundamental freedoms of persons is always consistently ensured.” Furthermore, in Section 88 the obligation of social service providers is defined in paragraph c): "to create in the provision of social services such conditions that will enable persons to whom they provide social services to fulfill their human and civil rights and which will prevent conflicts of interests of these persons with the interests of social service providers" and in paragraph h): “to comply with the quality standards of social services.” The quality standards of social services are annexed to Decree No. 505/2006 Coll. and regulate the

obligations of providers in the area of the quality of social services and the extent of fulfilling the quality of social services is assessed by the Inspectorate for the Provision of Social Services, which is implemented under the state control regime and is defined by Act No. 108/2006 Coll. One of the main reasons for the insufficient impact of inspections on improving the quality of social services is the ambiguous legislative definition of the content of the provisions that are subsequently subject to inspection, and the lack of definition of methodological procedures dealing with individual areas in such a way as to avoid different interpretations of the inspected criteria. The individual areas of implementation of the Convention on the Rights of Persons are not elaborated in any legislative or methodological way and the system does not take into account the issue of mental illness. The current concept of quality is defined in the law mainly on the basis of the target group. However, in the field of mental health it turns out that taking into account the issues of the target group is not reflected; within the performance of inspections of social services, experts with direct experience in the field of mental health are not invited to the inspections, i.e. there is no objective assessment and reflection of practice on the basis of expert knowledge of the issue.

In practice, there is a lack of professional capacity and methodology based on dual diagnoses (e.g. mental disability and mental illness), as well as the actual capacity of social services. The fact that the process of deinstitutionalization of social services in the Czech Republic is still not fully completed means that there is not a sufficient network of community services, while inpatient bed capacity for both people with disabilities and the elderly continues to be fixed in large-capacity residential services, where the same institutionalization takes place as for people with mental illness residing with long-term inpatient care providers in psychiatry. A key impact of the insufficient transformation of social services on the quality of services is also the fact that the possibility of close specialization on the needs of specific target groups (e.g. people with autism or behavioural risk), where there is an opportunity to build specific target services, is not used in practice, and at the same time the bed capacities of social service facilities are provided to people who do not need this care 24 hours a day throughout the year and for whom it would be sufficient, when individualizing care in community services, to ensure a lower level of support with regard to their abilities. For this reason, people with a high level of support who do not receive social services due to insufficient knowledge of professional methodology,

although they are the target group, remain with providers of inpatient aftercare in the field of psychiatry.

INFORMATION SYSTEMS

The information background for monitoring modern psychiatric care is being built on the platform of the reconstructed National Health Information System (NHIS), in accordance with the established Act No. 372/2011 Coll. as amended (amendment of 2016). The newly built NHIS components have the following benefits for the evaluation of mental health care:

- National Register of Paid Health Services (NRPHS) - is being built as of key importance an information system enabling the evaluation of the scope and distribution of health services, the morbidity of patients and the results (quality) of health interventions; an essential capability is also the evaluation of the costs of health services and modeling of impacts on the public health insurance budget.
- National Register of Health Service Providers (NRHSP) - is built as a representatively edited system monitoring all providers, the availability of their network and other attributes, including the share of care for the mentally ill.
- The National Register of Healthcare Professionals (NRHP) is a basic system for quantifying the personnel capacities of providers and planning human resources needs.

The aforementioned areawide information systems are further supplemented by the following data sources within the reconstructed NHIS:

- **Statistical surveys through the annual report on the activities of psychiatric outpatient clinics** are filled in separately by each outpatient department of all psychiatric disciplines, i.e. psychiatry, AT outpatient workplaces, sexology, gerontopsychiatry, partial hospitalization facilities, crisis intervention facilities, drug treatment facilities and outpatient workplaces of a psychiatric hospital. This report monitors the staff capacity of individual providers and the number of patients treated according to groups of psychiatric diagnoses. Data have been available in electronic form since 1994 and

allow the evaluation of long-term trends. Whether protective treatment is ordered for a given patient is also recorded.

- **Statistical surveys as part of the annual report on the activities of psychotherapeutic hospitals and crisis centres** - are filled in separately by each of the above facilities for all healthcare providers, regardless of their founders. The report is also filled in by care centres that are not defined as a separate facility. This report monitors the personnel capacity of individual providers, information on activities (number of places, number of admissions and status of patients/clients, number of treatment days, etc.), on patients/clients (broken down by disability and age groups), on the number of treated patients/clients in the observed year according to the diagnoses groups in Chapter V of the ICD-10, sex and age groups, and on the type of facility.

The National Register of Inpatients (NRHOSP) as a nationwide population register, which registers persons who were hospitalized in inpatient wards and whose hospitalization was terminated in the monitored period. Information on hospitalized patients/clients in psychiatric inpatient facilities (i.e. in psychiatric wards of hospitals, in psychiatric hospitals/clinics, etc.) and psychiatric patients hospitalized elsewhere can be obtained from the register. Inpatients are monitored for marital status, occupation, municipality of residence and EU membership. In relation to treatment, the register records who recommended admission, the date of admission, reason for admission, basic diagnosis, whether the patient/client was hospitalized for the first time in his/her life, the external cause of injury, four secondary diagnoses, a list of performed procedures, information about surgery, if performed, information about DRG, number of treatment days, date of release, reason for release, need for further care, information on mortality diagnoses if the patient/client died during hospitalization, and others.

National Register of Drug User Treatment (NRDUT) tracking information on patients/clients starting and ending addictology treatment. The register consists of two parts, namely opiate/opioid substitution treatment reports, which are reported with

full patient identification (identification number), and other treatment reports, which are performed using an anonymous identifier. The register collects basic socio-demographic data on clients/patients, data on the addictive substances used, risk behaviour, health and social impacts of their use, etc. Data on substitution treatment have been available in electronic form since 2000, data on other treatments since 2015.

Since the beginning of 2019, the newly reconstructed NHIS has been fully functional in terms of the functionality of the above-mentioned components and provides a comprehensive and regional information service. Thus, the basic information infrastructure for the evaluation of mental health care in the Czech Republic is complete.

The advantages and already fulfilled tasks of the reconstructed NHIS are, in terms of care for the mentally ill:

- the capacity of the afprementioned systems to monitor selected phenomena and processes prospectively as well as retrospectively (hospitalization since 1994, healthcare in general since 2010); this creates a system that allows the evaluation of the development of the system even with long-term trends, without the need to wait for time data for many years;
- evaluation of the regional availability of health services and mapping of the distribution of these services in the system;
- the possibility of stratifying the assessment of care outcomes with regard to disease risk;
- monitoring not only the health aspects, but also the personnel and infrastructure capacities of the system.

The main problem to be solved is the still incomplete interconnection of all sub-components of the NHIS with eGovernment services. This would significantly strengthen the protection of personal and sensitive data and make the NHIS a highly secure system, minimizing the risk of personal data misuse. It is already beginning to be used intensively in terms of the production of indicators of the health status of the population, but this is a form that requires a significant commitment of human capacity (especially due to the high number of ad hoc analyses).

In the area of providing information, the priority is to build a reasonable degree of automation of outputs, i.e. reporting in the form of an online functioning analytical portal.

An important step in strengthening the functionality and sustainability of the NHIS for mental health care is its new legislative anchoring in the forthcoming Act on Electronic Healthcare (prepared in the form of a substantive plan), where, among other things, the category of Departmental Reference Statistical Indicators is defined. These indicators will, to a significant extent, include indicators of mental health capacity and care outcomes. These indicators will be defined as statistics that

- are always generated based on NHIS central data sources;
- are obligatorily published in the set mode by the NHIS administrator and the publication is supplemented by the interpretation of the NHIS administrator and the reviewers or professional guarantors designated by it;
- are provided by the NHIS administrator as national reference data for international statistical surveys or international comparative data sources;
- are published on the basis of a legal authorization up to the level of individual health service providers (if the nature of the indicator allows it).

The legal enshrinement of the “reference statistics” will significantly increase the availability of this information for the lay and professional public.

RESEARCH AND EVALUATION OF POLICIES AND SERVICES

Research and evaluation of mental health policies and services are a basic precondition for the development of an evidence-based system, i.e. a system that uses available resources to the greatest possible benefit of the population.

Research and evaluation of mental health policies and services requires A) data sources; B) a system of adequate, legal and transparent use of data sources; C) research methodology for evaluating policies and services; D) resources for analysis and research in the field of the evaluation of mental health policies and services.

A) **Data sources** can be data collected routinely and data collected extraordinarily. Sources of routinely collected data include the National Register of Inpatients, the National Register of Paid Health Services and new clinical registers (Psychiatric care for children and adolescents, Psychotic diseases, Mood disorders, Mental health disorders in the population aged 65+). The collected sources include a population survey of the CZEMS type (CZEch Mental health Study) (Winkler et al., 2018b).

B) **A system of adequate, legal and transparent use of data** relates primarily to data sources from routinely collected data. Routinely collected data are associated with the following ethical issues:

1) Impossibility of consent

Information about an identified or identifiable person (hereinafter subject) is considered personal data. It is, for example, their name, identification number, residence, etc. A special category of personal data are so-called sensitive personal data, i.e. the use of which may potentially jeopardize fundamental personal rights, personal integrity and the freedom of the subject. Such information concerns race or ethnicity, political opinions, religion, sexuality and sexual orientation, and health. Sensitive personal data, in this case health data, need to be used for the research and evaluation of policies and services in the mental health care system. However, this is not legally possible without the consent of the subject to whom the evaluation or research applies. The subject should be able to withdraw his/her consent at any time.

However, for the research and evaluation of policies and services using registers, we cannot get the subject to consent to the use of his/her sensitive personal data. The research and evaluation of policies and services using registers will have the best validity if carried out on the largest possible share of the population. Requiring consent from subjects would lead to a reduction in the analytical sample of subjects, a sampling bias, and thus a significant distortion of the validity and/or accuracy of the results. In many cases, the research and evaluation will be carried out retrospectively for a longer period when the subject is no longer alive and therefore cannot grant consent.

2) Impossibility of anonymization

The research and evaluation of services on anonymized personal data (such data that cannot be linked to the subject) is preferred because it does not compromise the personal integrity of the subject. Research on anonymized data does not require the approval of the ethics committee. However, in order to make maximum use of the complex information contained in the registers, different data sources must be interconnected. This can be achieved by linking the registers to each other using an identification number. This means that registers cannot be anonymized and only pseudo-anonymization is possible, during which the researcher or worker evaluating the service receives data with an encrypted identification number. The decryption key is not available to him/her, but is stored separately in another institution, usually the register holder. This means that pseudo-anonymized data can be traced back to the subject. Research using pseudo-anonymized data is subject to the approval of the ethics committee and is associated with a certain risk of compromising the personal integrity of the subject.

3) A purpose other than the primary purpose of data collection

Personal data should be collected for a specific purpose and not further processed in a way that is incompatible with the primary purpose. Personal data collected in registers are collected for administrative reasons and are not primarily intended for research. Specific questions for the purpose of research and the evaluation of services will often be different from the primary purpose of data collection.

The three basic issues mentioned above which relate to consent, pseudo-anonymization and the use of personal sensitive data for a purpose other than the primary purpose of data collection may jeopardize the personal integrity of the subject. However, these risks can be outweighed if the research and evaluation of policies and services in the system of mental health care, or otherwise oriented academic research, will have a clear benefit in the public interest.

However, there is currently no system for the adequate, legal and transparent use of data, which makes it largely impossible to use existing data sources for the research and evaluation of mental health policies and services.

C) **Methodology for the evaluation of the mental health care system and services** concerns a) the evaluation of the psychiatric care system as a whole, through macro indicators,

b) the evaluation of individual psychiatric institutions and organizations, through meso indicators, c) the evaluation of the effectiveness of individual psychiatric services and interventions through micro indicators. The MERRPS (Methodology for Records Respecting the Development of Psychiatric Services) project developed a methodology for evaluating the psychiatric care system as a whole (a) and methodologies for evaluating the effectiveness of individual psychiatric services and interventions, through micro indicators (c). The methodology for the evaluation of individual psychiatric institutions and organizations (b) is not fully developed.

D) At present, no **financial resources** are specifically allocated for the **analysis and research** of mental health policies and services. Although the Ministry of Health devotes resources to research through funding for the Czech Health Research Council (CHRC) and the NIMH, none of these financial resources have a specified minimum amount of resources that must be devoted to research on (mental) health policies and services.

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