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REGIONAL OFFICE FOR Europe

COUNTRY VIGNETTE

CZECHIA

Transforming primary health care during the pandemic

COMMUNITY-BASED MENTAL HEALTH SERVICES: A LIFELINE DURING COVID-19

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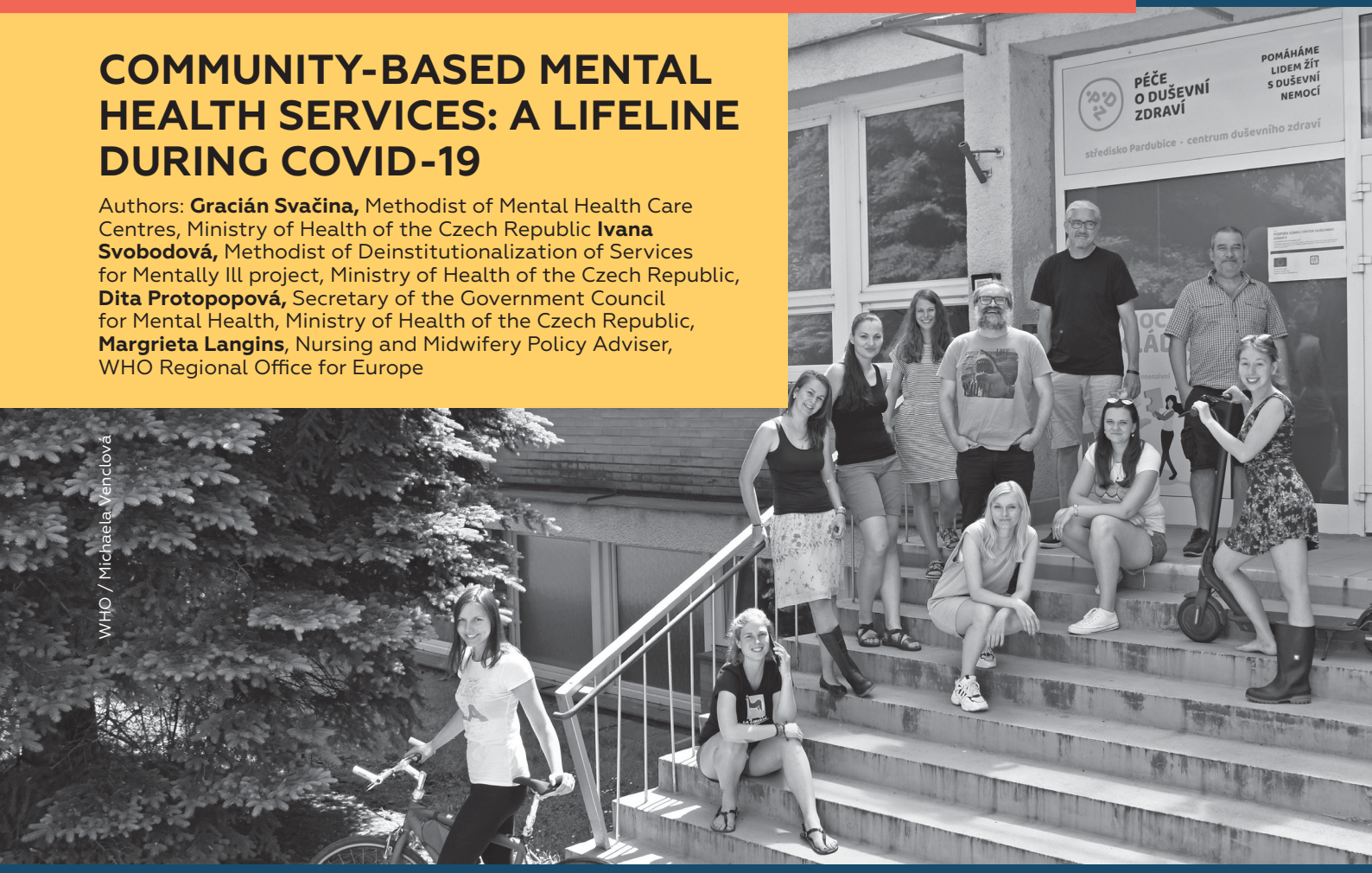


WHO / Michaela Venclová

MOTIVATION FOR CHANGE

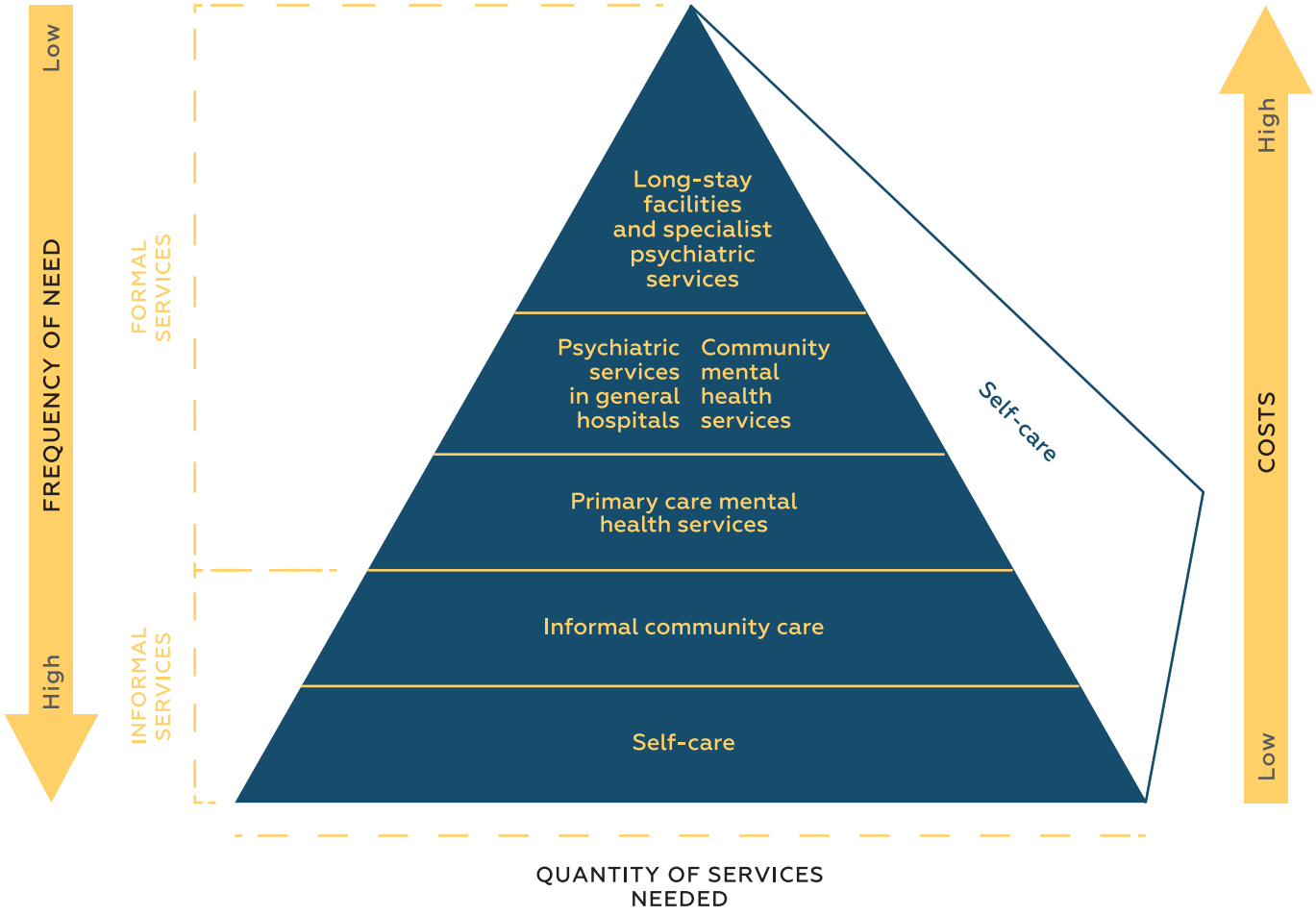
Health systems across the WHO European Region are striving to meet an unprecedented surge in demand for mental health services. The need to maintain continuity of treatment for those with pre-existing conditions at a time of unprecedented stress on the system has been compounded by exacerbation from unmet needs, including those triggered by the pandemic. The challenge for health systems has been to provide timely interventions as close to home in the community and avoid admissions to hospitals or institutions. In Czechia, the prevalence of symptoms of mental disorders in the general population increased from 20% in 2017 to 30% in 2020. These numbers are anticipated to only increase as the prevalence of major depression and the risk of suicide have already tripled and the prevalence of anxiety disorders has almost doubled.

Recent reforms and investment in mental health services in Czechia, however, have positioned the government to meet this challenge. These reforms have given priority to expanding the ability of community services to care for people close to home, making use of a range of professionals to deliver multidisciplinary people-centred mental health services. Further, given the evidence that deinstitutionalization both reduces the number of people dying by suicide and the mortality gap between people with mental disorders and the general population *(1)*, this reform seems especially vital during this time. In 2017, a population survey in Czechia showed that about 4 people died by suicide per day in 2017 *(2)*.

A NEED FOR MENTAL HEALTH REFORM

Mental health services in Czechia have traditionally been delivered within large psychiatric facilities with repeated hospitalization for acute care needs or prolonged long-stay hospitalization, some lasting more than 20 years *(3)*. The WHO service organization pyramid for an optimal mix of services for mental health (4) has proposed integrating mental health services with general health care (Fig. 1). Integrated primary mental health care is a fundamental component of this model and is supported by other levels of care, including community-based and hospital services. The WHO model is based on the principle that no single service setting can meet all population mental health needs. Support, supervision, collaboration, information-sharing and education across the different levels of care are essential to any system. The model also assumes that people with mental disorders need to be involved in their own recovery planning. This promotes good use of resources, the involvement of individuals in their own mental health care and a human rights and community-based orientation.

Fig. 1. Composition of a primary care team for an average primary care zone



Source: *Improving health systems and services for mental health (4).*

The model of care in place in Czechia before the reform was inverse to the optimal mix of services for mental health. It was very costly, absorbing the majority of financial resources dedicated to mental health services, with more than half of the funds from public health insurance being used for long-stay facility-based care. Further, reliance on institutions has contributed to very uneven regional distribution and a lack of investment in options to seek care and treatment and rehabilitation in the community. This has also led to service users increasingly depending on hospital services, leaving them unable to cope with life in the community and deemed at odds with the Convention on the Rights of People with Disabilities *(5)* and assessed as in need of reform using the WHO QualityRights Tool Kit *(6)*. In addition, the number of psychiatric acute care beds in general hospitals is inadequately low, according to the WHO service organization pyramid, and mental health services for children are underdeveloped.

The reform of mental health care at the national level began in 2013 with the approval of the psychiatric care reform strategy. The strategy outlined plans to fundamentally change the delivery of mental health services towards a bio-psychosocial model that incorporates the importance of the psychosocial environment as both a risk factor and enabler of mental health.

The implementation of this strategy began in 2017 with the piloting of new community-based models of care that engage multidisciplinary teams based on what were called the mental health care centres. The roll-out of these pilot projects was made possible with the help of the European Union's European Structural and Investment Funds.

In the first stage of the pilot project, the plan was to focus the mental health care centres on people with serious mental disorders such as schizophrenia or bipolar disorder and gradually include an early intervention approach and pilot the specialized services for people with substance use, older people, children and criminal offenders with mental disorders. By the end of 2030, Czechia's Ministry of Health plans to have 100 mental health care centres, distributed evenly throughout Czechia, to cover catchment areas of 60 000 to 140 000 inhabitants and to establish the mental health care centres as standard health and social services. They will be funded through public health insurance, the state budget, the budgets of regions and municipalities or other sources.

To ensure a smooth transition, the government has taken several measures (Box 1) that were implemented in parallel with mental health care centres. To implement the first stage of this reform, the government committed a total of CZK 3 billion of European Structural and Investment Funds. The 18-month pilot operation has rolled out 29 mental health care centres in some of the communities with the fewest resources.

Box 1. Enabling measures for rolling out mental health care centres

1. **Preparing transformation plans for participating hospitals that specify how the care and resources will be reorganized**
2. **Adjusting regional plans to the network of services**
3. **Modelling new funding mechanisms**
4. **Developing a destigmatization campaign**
5. **Establishing an evaluation process**
6. **Rolling out training for new and existing team members**
7. **Preparing new clinical and referral guidelines**
8. **Drafting and preparing enabling legislation**
9. **Establishing the model of patient participation at all levels of decision-making in the reform**
10. **Redesigning scaled-down acute mental health care facilities**
11. **Building new community service facilities**

Sources: NHS England et al. *(1)*; National Association of Primary Care *(2)*.

Mental health care centres: a new multi-disciplinary model of care

The mental health care centres have teams representing professions from both the health and social care sectors. Psychiatrists, clinical psychologists, general nurses and/or mental health nurses are responsible for the service users' clinical care needs, and social workers carry out social rehabilitation. Social workers also connect the service users with any relevant local authorities responsible for, for example, assessing housing allowances and allocating social housing, curators, guardians, local and state police and other local services. The composition of multidisciplinary teams is based on the individual needs of service users.

The team works closely with service users to help them take responsibility and ownership of their recovery by developing a care plan.

One responsibility of the mental health care centres is to contact health-care facilities in the mental health care centre's catchment area to inform them about their services. The mental health care centres have focused on improving cooperation with outpatient psychiatrists who are connected to psychiatric hospitals and acute wards of hospitals. As a result, outpatient psychiatrists have begun to perceive mental health care centres as partners that can help with difficult cases.

The mental health care centre teams also work closely with general practices, local government, social services, police and others to identify and deliver care to service users or share information about the centres with potential service users. Intensive joint work plans are set up across the country between mental health care centres and general practices to secure the assistance of the centres for general practices when and where help is needed to prevent hospital admission or to provide support to service users on discharge. When necessary, the mental health care centre team also provides crisis intervention. This can mean intensified support; involving more team members, including psychiatrists; initiating intensive home care support care plans; placing the person in a crisis bed; or developing care plans to prevent further crises.

In addition to receiving referrals from hospitals and general practices about service users with known needs, mental health care centre teams actively seek out people who might not be aware of the services.

A person-centred approach

The mental health care centres provide very person-centred support. Service users are supported to shape their own care plan and recovery path. This includes selecting rehabilitation services they would like to pursue, whether they would only like to work with the mental health care centre team or a combination of this team and their outpatient psychiatrist. Support also includes home visits when and as needed. At least 50% of the direct work is carried out in the service user's community environment. For example, the mental health care centre team helps them in dealing with public authorities, schools, providing basic health care or finding a job and focuses on ensuring that a person with a mental health condition can use resources that are commonly available in the community. Transition plans are also developed to phase out dependence on the mental health care centre services to empower service users to gradually resume using commonly available services, such as their general practitioner or outpatient psychiatrist. The service users are already preparing for the transition when entering the service, but even so, in some cases service users have difficulty in disengaging from the mental health care centres with which they have established such a high level of trust. Further, mental health care centres often have difficulty in finding any outpatient psychiatrist who could assume care for service users.

The role of protocols

The development of protocols has been instrumental in guiding the system and teams in implementing the mental health care centres. These protocols contain the vision and basic principles and methods of work, including a proactive approach, integrated care and the involvement of general practitioners and schools in detecting and preventing the development of mental disorders. Service users play a very important role in creating protocols to ensure that their needs are met. The development of these protocols has helped to better define care pathways, which in turn can guide the areas in need of legislative support and financial investment. The protocols also define basic requirements for services and staffing needs that, because of the possibility of a gradual increase in the number of employees, will enable the development of these services even in a situation of a personnel crisis in health care.

"SERVICE USERS ARE SUPPORTED TO SHAPE THEIR OWN CARE PLAN AND RECOVERY PATH."

MENTAL HEALTH CARE CENTRES RISE TO THE CHALLENGE DURING THE COVID-19 OUTBREAK

A series of resources have been released during the outbreak to assist in coping with the surge of mental health issues. The government approved a plan to establish a series of new crisis centres, health insurance companies increased the contributions for those requiring support and a strong government-led mental health awareness campaign was rolled out (Fig. 2) *(7)* to support stress management during the pandemic among both service users and health and care workers.

Fig. 2. Mental health awareness campaign website in Czechia

Source: Aliev et al. *(7)*.

The existing mental health care centres already piloted in the country have proved essential for responding to the needs of current service users and managing care for those hospitalized or ready for discharge. Service users identified benefits of mental health care centres according to statements made in an external evaluation of the project supporting the creation of mental health care centres (Fig. 3).

Fig. 3. Benefits of mental health care centres according to service users

CONFIDENCE

Service users tend to be more honest with employees, because they know them well thanks to regular and intensive contact.

MOTIVATION

Mental health care centres have a motivating effect on service users. Someone is regularly interested in them, and in addition to the disease itself, solves other aspects of life with them. This motivates service users.

AVAILABILITY

Care is more available, because thanks to mental health care centres, the service user gets to the experts much more often, for whom the usual waiting times are much longer.

REGULARITY

Mental health care centres brought the setting of regular habits into the service user's life and the resulting better health.

WHAT DID MENTAL HEALTH CARE CENTRES BRING TO THEIR SERVICE USERS?

MEDIATION

Mental health care centres help service users provide the service they currently need.

SOCIALIZATION

Thanks to mental health care centres the service user has the opportunity to create a new network of contacts, what can be beneficial in other areas of life (partnerships, careers, recommendations for services, etc.)

DECREASE OF DAYS OF HOSPITALIZATION

Impact demonstrable on data. It follows that service users, who are intensively cared for within the mental heath care centres, are able to work with their illness in their own environment for a longer time.

Source: External evaluation of the project supporting the creation of mental health care centres, Evaluation Advisory Central Europe.

Increased networking between providers during the outbreak

With the onset of the pandemic, mental health care centres increased cooperation with outpatient psychiatrists. During the first wave of COVID-19, outpatient psychiatrists began to increase the number of contacts with the mental health care centres to help provide care for service users at risk of their health deteriorating because of missed appointments, missing medication or skipping vaccinations.

Circumstances associated with COVID-19 have also forced some psychiatric hospitals to discharge long-stay patients. Mental health care centres immediately started working with the discharged people to provide them the necessary support outside the hospital.

Making use of digital platforms

Another very important development during the pandemic was the use of online tools for communication between mental health care centres and wards in psychiatric hospitals. Access to psychiatric hospitals was reduced and online collaboration became the only means of communication. Long after the first wave, however, online communication remained the preferred means of communication, given how effective it proved to be in mobilizing rapid and meaningful cooperation. Some meetings in person have nevertheless been re-enabled.

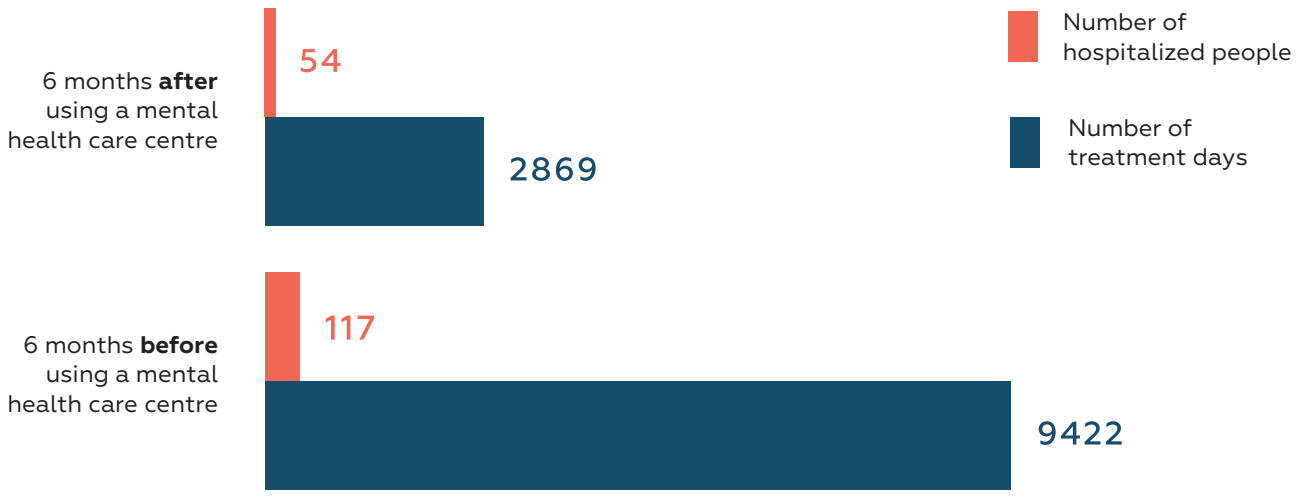
Keeping service users safe through increased home visits during COVID-19

Although the communication with psychiatric hospitals and their service users was online, data from the largest domestic insurance company show that mental health care centres increased the number of home visits during the first wave of the pandemic. Most outpatient specialists were allowed to provide their services during the lockdown, but group outpatient services were reduced to prevent exposure to COVID-19 and mental health care centres were able to quickly adjust and shift visits away from the centres and outpatient clinics to provide more home visits.

RESULTS

The functioning of the mental health care centres has already shown positive results. This model has contributed to the increased numbers of outpatient consultations. Since 2017, mental health care centres have contributed to the long-term trend of discharged patients avoiding readmission and remaining in their communities. This is reflected in the declining number of days spent hospitalized (Fig. 4).

Fig. 4. Impact of the first five mental health centres on the rates of hospitalizations



In addition, service users' perception of the quality of care is changing. An evaluation using the Assessment of Quality of Life (AQoL) 6D + 8D questionnaire *(8)* showed an increase in value, for example, in the perception of happiness, housing independence and relationships.

SUSTAINABILITY PROSPECTS AND NEXT STEPS

The evaluation of the mental health care centre project has identified several areas needing future attention. These include the exchange of information between the social and health sectors, both the information systems used by each sector but also across team members. Embedding the model of mental health care centres in the legislation and standard funding mechanisms, the use of remote forms of care and strengthening the relationship between community and outpatient services are crucial for the continued functioning of the mental health centres.

LESSONS LEARNED

1. People first. Involve a range of stakeholders but, most importantly, the people who experience mental illness or deliver services (health and care professionals). This helps focus the purpose of the reform and ensure the acceptability of reform.

2. Establish clear and rewarding milestones. Pursue quick wins to shown change in action and sustain stakeholder participation and motivation to continue with the reform.

3. Establish mutual benefits. Invest in dialogue to achieve mutual understanding and support among providers (primary care physicians and outpatient and hospital specialists). This support can be built by engaging stakeholders in various steps — engaging these stakeholders at the beginning of the reform and in developing protocols and through to evaluating services, offering help in implementing new models of care, including with the support of service users when their resources are insufficient.

4. Design mental health service delivery around the pyramid of need. Introduce a range of services according to the pyramid of need. This means phasing in services from self-help and disease prevention from general assistance to more specialized help of experts. Otherwise, the capacity of experts could be overwhelmed.

5. Deinstitutionalization takes perseverance. Deinstitutionalization efforts are being made around the globe, including Czechia. Do not give up. A moment will eventually arrive when the benefits become apparent and there is greater will to introduce them into the system.

6. A matter of human rights. Emphasize the application of human rights in every situation and provide support for these services — especially in a pandemic, the rights of individuals must not be neglected and violated.

7. Communication with the public is vital to success. Invest in public campaigns that communicate the goals of the reform and its benefits. Mental health awareness and literacy in this area are vital. Destigmatization campaigns must focus not just on the mental illness itself but on destigmatizing those who seek help and work in the services.

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