

The state of psychiatry in the Czech Republic

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Abstract

This overview of Czech psychiatry begins with a brief review of its history; outlines its social, political and economic determinants and then describes the field itself. Both epidemiological and service-related information are discussed, together with the issues for mental health personnel, education and research. The heavy burden of communist history pervades most areas and must be taken into account in the specific characteristics that influence both the current situation and future prospects of Czech psychiatry. This consideration is essential for orientation in the field and to understand Czech particularities. The greatest challenges, however, originate from the fundamental changes that are going on in the world today. These challenges reach beyond national boundaries and include such phenomena as globalization, migration, ageing population, growing burden of mental ill health, the still prevailing stigma towards psychiatry, and the psychological roots and consequences of current financial and societal crises.

Background information

There are about 14 psychiatrists per 100,000 head of population, which is two more than 10 years ago. Those seeking help for psychological or emotional problems usually turn to GPs (73%), less often to psychiatrists (7%) or psychologists (7%). (OECD, 2011) Total health expenditure has climbed to 7.7% of GDP in 2009–2010. However, this is explained by the lower GDP in the years of economic crises, rather than by increased health investments. (IHIS, 2011a). The vast majority (91.5%) of public health expenditure is financed from public health insurance. Out-of-pocket health spending is rising moderately.

Historical introduction

Czech psychiatry originated in the Austro-Hungarian Empire, flourished between World Wars I and II, but declined during the ideological constraints of the Soviet Empire (Höschl & Libiger, 2002; Scheffler & Potůček, 2008). Social problems were represented as the legacy of the capitalist system, and were expected to diminish spontaneously in consequence of communism progressing. As a result, psychiatric research was primarily biologically orientated, mental health promotion was marginalized, and those, who suffered from severe psychiatric disorders were confined in psychiatric hospitals.

Despite these restrictions, Czech psychiatry maintained a relatively good level of expertise and

delivered some exceptional results, particularly in the field of psychopharmacology (LSD, lithium, anticholinergics, dosulepin, clorotepin, oxyprothepin, etc.) and electroencephalographic (EEG) studies. Clinical psychiatry also attained a relatively high level because of the outstanding tradition in university education. The foundation of the Psychiatric Research Institute (now Prague Psychiatric Centre) in 1961 is widely considered as a milestone in Czech psychiatry (Höschl & Libiger, 2002; Scheffler & Potůček, 2008).

The Velvet Revolution in 1989 dismantled both physical and ideological boundaries; Czech psychiatry and mental healthcare began to participate in global developments. Change was largely determined by the urgent need for systematic reform; particularly relating to de-institutionalization, de-stigmatization, re-integration, training, popularization, and public education. Professionals swiftly started to cooperate with western countries, universities, non-government organizations (NGOs), European and world psychiatric associations, and other institutions. Development in the field has been negatively influenced, however, by frequent changes in both the ministries of health and in healthcare policies. Furthermore, the mental health sector has been heavily under-financed as a consequence of neo-liberal ideology assuming all problems to be solved by spontaneous functioning of a free market (Scheffler & Potůček, 2008).

Our article serves as a recapitulation and reflection of the approximately 20-year-long journey of Czech psychiatry from behind the Iron Curtain towards

world class. What has worked well, what has not, and what needs to be done?

Legal framework

Detailed provisions on mental health are currently set by the following acts. Regulation of mental healthcare delivery is secured via general healthcare legislation, namely Act 372/2011 Coll. on medical services (which came into force on 1 April 2012, replacing Act 20/1966 Coll. on care of people's health), Act 48/1997 Coll. on public health insurance, and Act 258/2000 Coll. on protection of people's health (Scheffler & Potůček, 2008). Regulation on disability pension is regulated by Act 155/1995 Coll. on pension insurance, as amended by the Act 306/2008 Coll. Social services are regulated by Act 108/2006 Coll.; the Anti-Discrimination Act was enacted in 2009 (Act 198/2009 Coll.).

Policy – What is needed now?

A national programme of mental healthcare has been in development since 1992, but still has not been completed. The Concept of Psychiatric Care was accepted by the Czech Psychiatric Society (CPS) in 2000, approved by the Ministry of Health in 2002, and further revised by CPS in 2008 (CPS, 2008; Scheffler & Potůček, 2008). The revised Concept of Psychiatric Care observes that psychiatric care in the Czech Republic relies mainly on institutionalized services, while community care has not been sufficiently deployed. Care is rather fragmented and quite poorly coordinated. National mental health policy is missing and, as a result, development of care is unsystematic, psychiatric services are founded with little regard to regional needs, availability of care is uneven, the whole mental health field is significantly underfinanced and in comparison to some other western European countries somewhat delayed (CPS, 2008). This lack of a mandatory mental health plan containing specific priorities, aims, activities, responsibilities and financial allotments is the major obstacle to a well-performing mental healthcare system.

Finances

While the communist system of healthcare financed via taxes 'from the state budget' was replaced by the system of universal public health insurance in 1993, mental healthcare still does not have its own separate budget. Thus, it is difficult to identify the annual funding for mental healthcare in the Czech Republic (Scheffler & Potůček, 2008). However, several attempts have been made. The study of Dlouhý (2010) seems to be the most accurate, using slightly

modified Organisation for Economic Co-operation and Development (OECD) methodology to estimate that in the Czech Republic in 2006 a total of CZK 9.1 billion (average exchange rate in 2006 was 28.3 CZK for €1) was spent on mental healthcare. This corresponded to 4.14% of total health expenditure. More than half of that went to the psychiatric hospitals and psychiatric departments in general hospitals (61.5% labour costs). Anxiety, somatoform disorders and eating disorders (F40–F48, F50–F59) accounted for nearly one quarter of all expenditure. Although only the cheapest drugs in each therapeutic category are obligatorily covered by insurance (provided without patient's co-payment), approximately one quarter of all expenditure was spent on prescribed drugs (Dlouhý, 2010).

What is the true prevalence and disease burden?

The only study measuring true prevalence of mental illness in the adult population of the Czech Republic was conducted by the Prague Psychiatric Centre (PCP) in cooperation with the World Health Organization (WHO) in 1998–1999. The CIDI/ICD-10 National Probability Survey of Mental Health and Co-morbidity was used, and 1,534 interviews with respondents conducted, demographically corresponding to the general Czech population, except that urban residents were slightly under-represented. According to the study, lifetime prevalence of psychiatric disorders reached 27% (30% women, 24% men). The most frequent conditions were anxiety and behavioural syndromes associated with physiological disturbances and physical factors (18%), mental and behavioural disorders due to psychoactive substance use (13%), and mood disorders (13%, mainly depression). A total of 16.7% of respondents reported a single psychiatric disorder, 5.4% a history of three or more disorders (Džúrová et al., 2000).

The study also revealed that nearly 5% of women had a life-time prevalence of suicidal thoughts and 2% attempted suicide, increasing to 12% and 6% respectively for women with some psychiatric diagnosis. Men reported suicidal thoughts less frequently. According to the numbers provided by the Czech Statistical Office, however, the actual rate of completed suicide is in the opposite direction (men 22.7; women 4.3 per 100,000) (CZSO, 2012; Džúrová et al., 2000).

The European College of Neuropsychopharmacology (ECNP)/ European Brain Council (EBC) 2011 report is another viable source of epidemiological information. The most frequent disorders of the brain in the Czech Republic in 2010 were headaches (3,315,501 patients), anxiety disorders (1,449,842), sleep disorders (932,834), mood disorders (693,194),

and somatoform disorders (424,330). The most costly brain disorders were, however, stroke (1,609 million euro purchase parity power (€PPP)), mood disorders (1,341 million), psychotic disorders (1,087 million), dementia (923 million), and anxiety disorders (915 million). The overall bill for brain disorders in Czech Republic reached €10.2 billion in 2010 (Gustavsson et al., 2011).

Disability pensions and sick leave

The insured person can claim disability pension, if his or her capacity of work is reduced by at least 35%. Czech law defines three degrees of disability, dependent on the degree of incapacity (first degree for 35–49% loss of capacity, second degree for 50–69% loss, third degree for 70% and more). In total, 4,568 disability pensions were provided in 2010 (in 2009 it was 5,677; in 2008 it was 5,530, and in 2007 it was 6,042). The 20% decrease in disability pensions between 2009 and 2010 is explained by Act 306/2008, which came into force on 1 January 2010, and replaced a previous two-degree disability pension system with the three-degree disability system as described above (IHIS, 2008, 2009, 2010, 2011b).

In 2010, 33,277 cases of sick leave for psychiatric reasons were reported, 67% women. The most frequent diagnoses were neurotic stress and somatoform disorders (F40–F48; 48% men, 63% women), and mood disorders (F30–F39; 20% men, 24% women). Men also often received sick leave because of alcohol-related disorders (F10; 12%). Women were on sick leave on average 89.8 days, 4.6 days more than men. The total number of days spent on sick leave was 2.9 million (IHIS, 2011b).

Services

Overview of the organization of mental healthcare services is shown in Table 1.

State-provided services

Psychiatric hospitals. The number of beds in psychiatric hospitals was reduced significantly after the Velvet Revolution, from 11,958 beds for adults and 901 beds for children and adolescents in 1990 to 9,881 beds for adults and 485 beds for children and adolescents in 1995. Since 1995, the number of beds has decreased slowly but steadily. In 2010, there were 17 psychiatric hospitals with a total of 9,058 beds for adults (8.8 beds per 10,000 inhabitants), and three psychiatric hospitals with the total of 260 beds for children and adolescents (1.7 beds per 10,000 children and adolescents). Overall occupancy of beds in

2010 increased to 93.9%. (Höschl & Dragomirecka 2006; IHIS, 1993, 1996, 2001, 2006, 2011b).

For staffing and average length of stay, there are similar trends, evidence of some improvement. In 1990, healthcare in all psychiatric hospitals was provided by 370 physicians, whereas in 1995 it was almost 430 physicians and in 2010, 517 physicians. The average length of stay/treatment in 1990 was 101.3 days, whereas in 1995 it was 88.7 days, and in 2010 it was only 79.9 days (IHIS, 1993, 1996, 2001, 2006, 2011b).

Psychiatric units in general hospitals

The number of psychiatric units in general hospitals increased from 24 in 1990 to 31 in 2010, the overall number of beds, however, decreased from 1,649 to 1,374 in the same time period. This corresponds to 1.3 beds per 10,000 inhabitants. The overall occupancy of beds was 80.7%. Services in psychiatric units in general hospitals were provided by 139 physicians, and the length of stay/treatment averaged 23.3 days in 2010 (IHIS, 1993, 1996, 2001, 2006, 2011b).

In total, there were 59,169 hospitalizations recorded for inpatient care in 2010, corresponding to 562.6 hospitalizations per 100,000 inhabitants. A total of 18,136 hospitalizations were provided within psychiatric units in general hospitals, 38,762 within psychiatric hospitals for adults, 938 within psychiatric hospitals for children and adolescents, and 1,153 within other inpatient facilities. The most frequent hospitalizations were associated with mental and behavioural disorders due to psychoactive substance use (F10–F19; 15,336 hospitalizations, out of which 10,003 related to alcohol use); psychotic disorders (F20–F29; 11,402 hospitalizations), and neurotic, stress and somatoform disorders plus behavioural syndromes associated with physiological disturbances and physical factors (F40–F48 + F50–F59; 9,235 hospitalizations). The vast majority of hospitalizations lasted between 1–90 days; namely 18,852 1–14 days, 13,660 15–30 days, and 19,053 31–90 days (IHIS 2011b).

Outpatient psychiatric care

In 2010, outpatient care for psychiatric patients was provided in 981 units, out of which 453 units also provided care to patients with addictive disorders. The care was provided by 763 physicians to 495,383 patients (471 per 10,000 inhabitants). The overall number of investigation-treatments reached 2,665, 547 (2,534.5 per 10,000 inhabitants), 30% increase since the year 2000 (IHIS 2011b).

This increase in investigation-treatments is caused by a 43% increase of adult patients; the number of

patients aged 0–19 has, however, decreased by 2% in the same period. Approximately 60% of patients were female. The most frequent investigation-treatment was associated with neurotic, stress and somatoform disorders plus behavioural syndromes associated with physiological disturbances and physical factors (F40–F48 + F50–F59; 192,646 patients, 51,001 newly diagnosed disorders), mood disorders (F30–F39; 94,285 patients, 17,346 newly diagnosed disorders), organic, including symptomatic mental disorders (F00–F09; 54,009 patients, 15,502 newly diagnosed disorders), and psychotic disorders (F20–F29; 41,553 patients, 4,729 newly diagnosed disorders) (IHIS 2011b).

Considering the gender perspective, women are more often treated for mood and neurotic, stress and somatoform disorders plus behavioural syndromes associated with physiological disturbances and physical factors (from 62% to 68%). Men are more often treated for sex and psychoactive substance use-related disorders. More than 90% of those treated for compulsive gambling were male. Considering the age perspective, only 10% of all patients were aged 0–20, compared to 20% of people in this age range in the general population (IHIS 2011b).

Outpatient care for psychoactive substance users

In 2010, alcohol and illicit drug users received care in 428 and 370 ambulatory units, respectively. In total, 26,262 men (50.9 per 10,000 inhabitants) and 13,936 women (26 per 10,000) were treated in these units. More than half of men and 44% women were aged between 20–39 years. A total of 85.5% of all cases were treated for addiction, 9.8% for somatic and psychological harm, 6.1% for intoxication and behavioural disorders. Drug use by men was considerably higher except for sedatives and hypnotics where the women accounted for 65% of the total (IHIS, 2011b).

Alcohol use accounted for the majority of all cases (60% i.e. 24,182). Other frequent cases related to heroin (3,118), and methamphetamine (3,003). Cannabinoids accounted for 1,477 cases, which is a comparatively low number considering the 2010 prevalence of cannabis use (10–15% in the adult population; 20% in those aged 15–34). Overall, 2,936 cases related to polydrug use. A total of 37% of men and 24% of women reported intravenous application (IHIS, 2011b, CNMCDDA, 2011). Substitution treatment was provided by 45 registered facilities that provided services to 2,113 persons (1,500 men, 613 women). The length of treatment averaged 587 days. Buprenorphine (Subutex, Suboxone) and methadone were used as substitution drugs. However, as buprenorphine-like drugs may be prescribed

by every physician, even without patient's registration, the total number of patients using these drugs remains unknown (IHIS, 2011b).

Services, day clinics, crisis intervention centres provided by non-government organizations

After 1989 the political changes enabled new NGOs to serve as providers of health or social services, and mental health professionals established the first NGO in community mental health services, Fokus (Fokus, 2012), in 1990. Today there are 10 organizations under the Fokus brand in several locations of the Czech Republic, which provide psychiatric rehabilitation (work rehabilitation, activity centres, sheltered housing) for people with severe mental illness. During the period 1995–2000 several other similar NGOs were set up mainly with financial and organizational help from the Netherlands (e.g. Sdružení Práh, Eset-Help, Péče o duševní zdraví – Region Pardubice) (CMHD & Trimbos, 2001). These organizations operate in the social sector of services and they are mostly staffed by social workers. In 2007 the overarching organization for these NGOs, Asociace komunitních služeb (the Association for Community Services) (ASKOS, 2012), registered 29 organizations with 470 professionals providing psychiatric rehabilitation for 4,600 patients (Table 2) (CPS, 2012).

In healthcare there has been further development of day psychotherapeutic hospitals after 1989, most devoted to the care of patients with severe functional disabilities, and integrating psychotherapy with psychiatric rehabilitation (Kitzlerová et al., 2003; Pěč et al., 2003). At present there are 10 psychotherapeutic day clinics that combine day-treatment programmes with outpatient psychiatric and psychological care and link their care with psychiatric rehabilitation. A further 12 day-treatment programmes are combined with inpatient psychiatric care (ADSKC, 2012).

In 2010 residential facilities treated 430 mentally handicapped child and adolescent patients (aged 0–19), and 4,255 adult psychiatric patients. Crisis centres and psychotherapeutic residential facilities treated 9,037 psychiatric patients, most frequently neurotic, stress and somatoform disorders plus behavioural syndromes associated with physiological disturbances and physical factors (F40–F48 + F50–F59; 73% of both men and women). Nearly 70% of all patients were women, 96% of all patients were aged 20–64 (IHIS 2011b).

There are only two mobile crisis teams that operate under restricted conditions. One outreach community team began to work in Prague in 2010. From 2006, the healthcare system allowed participation of

Table 1. Organization of mental healthcare in the Czech Republic.

General practitioners	General hospitals	Community mental health services (formal, outpatient care)	Community based/intermediate services	Institutional mental health services
General practitioners	Psychiatric departments of general hospitals	Adult psychiatry	Day clinics	Psychiatric hospitals/mental hospitals
Services outside the health care system	Psychiatric departments of university hospitals	Child psychiatry	Case management	Social care homes
Diagnostic institutions for children and adolescents		Geriatric psychiatry	Crisis intervention centres	
Advisory pedagogic-psychological centres for children		Drug/alcohol-related problems specialists	Supported (sheltered) housing	
Advisory centres for family and human relationships		Centres for substitution therapy for drug addicts	Rehabilitation centres	
		Eating disorders specialists	Contact centres for drug addicts	
		Sexologists	Vocational rehabilitation and protected job training	
		Clinical psychologists	Supported (sheltered) employment	
			Self-help and consumers groups	
			Advocacy services	
			Family groups	
			Mental health NGOs	

Source: Scheffler & Potůček (2008).

community psychiatric nurses in provision of care (case management and individual rehabilitation in homes of the patients). Up to the present time, there are only three workplaces for community psychiatric nurses integrated in day clinics.

Accessibility of services and compulsory hospitalization

Although there are a relatively large number of psychiatric beds in the Czech Republic, the few available studies about accessibility services for psychiatric

patients note that this is problematic as an indicator of quality, especially in terms of travel distance or time. Catchment areas of 17 psychiatric hospitals, which provide the majority of inpatient care, permit a distance between home and hospital to range more than 100 km. Such distances make regular contacts of patients with their families, natural environment or community services difficult.

One study using focus groups with outpatient psychiatrists and general practitioners (Stuchlík & Wenigová, 2007) together with another study based on focus groups, in-depth interviews and 265 questionnaires completed by inpatient and outpatient psychiatrists (Raiter et al., 2004), suggest that outpatient psychiatric services are overloaded. Each psychiatrist makes 1,627 examinations per year on average, including 281 new admissions, but 10% of psychiatrists have more than 5,600 examinations per year. Some 39% of outpatient psychiatrists are forced to refuse new patients. The waiting time for a new examination ranged from 1–6 weeks. Capacity was scarcest for child outpatient psychiatrists.

Comparing the results of the latter study with a study based on in-depth interviews with patients (CMHCD, 2003), we conclude that there is a lack of access to adequate assistance in crisis. Only three

Table 2. Psychiatric rehabilitation provided by NGOs in 2007 (Pěč, 2012).

Area of support	Type of service	Number of organizations
Living	Sheltered housing	13
	Supported living	9
Work	Sheltered workshops	17
	Transitional employment	4
	Supported employment	6
	Day activity centres	25
Other	Case management	12
	Supported education	2
	Consultancy	16

crisis psychiatric centres work in the Czech Republic. Outreach community services or mobile crisis teams are only marginally developed. The attempts of families to get information and participate in a treatment plan are often refused. Access to day clinics or other community services is also limited in many regions. A very similar situation can be found for psychotherapy. A study on treatment satisfaction examining 428 questionnaires of patients from nine mental hospitals and nine psychiatric wards (Raiter & Žáčová, 2005) revealed that the interest of patients in receiving psychotherapy is about 15% higher than the actual use of psychotherapy.

Accessibility of services is to a large extent further hampered by the lack of communication and interlinking of services (CMHCD, 2003). In the treatment satisfaction study only half of patients released from inpatient services obtained information on where to turn for further health or social problems and patients were significantly less satisfied with recommendations for families or with ensuring home care after discharge (Raiter & Žáčová, 2005).

It is also necessary to mention the stigma of mental illness that discourages patients from seeking professional help and disclosing their problems (Raiter et al., 2004). Representative research 'Views on Schizophrenia' (DEMA, 2004), based on 667 face-to-face structured interviews with adults in the Czech Republic, showed that only 43% believe that people with schizophrenia can live and work normally, and 82% think that people with schizophrenia are erratic or unpredictable in their behaviour and manifestation.

The issue of compulsory admissions was a concern of the international multi-site research project EUNOMIA (European Evaluation of Coercion in Psychiatry and Harmonisation of Best Clinical Practice), analysing data concerning involuntarily admitted patients. The project was conducted between 2002 and 2006 in 11 countries, mostly European, including the Czech Republic. Respondents were compulsorily admitted patients (Czech $n = 202$) and their relatives (Czech $n = 48$). The study showed that Czech patients retrospectively viewed their involuntary admission as legitimate and their relatives perceived involuntary admission as intended to help the patient. On the other hand, relatives would have preferred some other form of treatment rather than admission to psychiatric hospitals, where a repressive component is assumed often to prevail over the treatment component, and patients are insufficiently respected. A role of relatives in the treatment process is generally poorly covered in legislation, not only in the Czech Republic, but throughout the surveyed countries (Kališová et al., 2010; Kitzlerová et al., 2008).

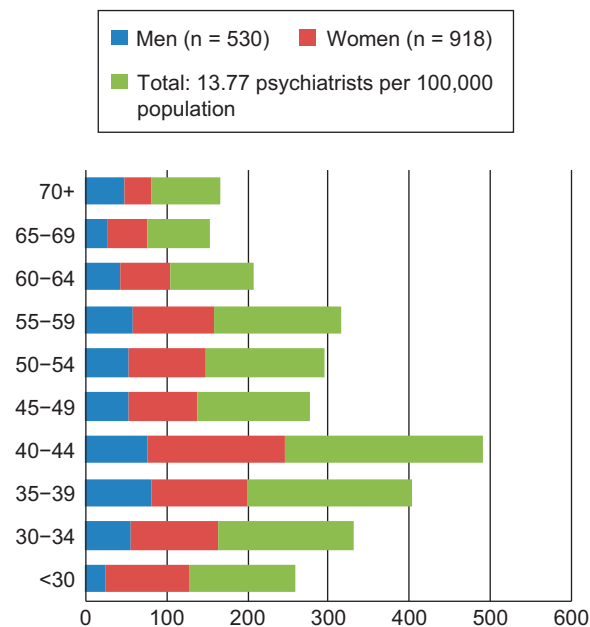


Figure 1. Psychiatrists by age and sex, 2010.

Personnel, education and research

The number of psychiatrists, their gender and age structure is shown in Figure 1. While the overall number of psychiatrists may seem relatively satisfactory, the number of medical students intending to pursue a career in psychiatry is insufficient in many European countries (Höschl & van Niekerk, 2010). Furthermore, as Scheffler & Potůček state 'the structure of human resources is completely at odds with the WHO recommendations' (Scheffler & Potůček, 2008). Considering the current division of mental healthcare between the social and health sectors, the low number of professional social workers is disconcerting and has far-reaching negative impact on patients and their families. Although NGOs are doing their best in this regard, they are not able to fill this gap on their own; they have only short history in the Czech Republic, and thus are still not well established. Broadly, the same applies to the whole field of social psychiatry, which, compared to other branches of psychiatry, is in a most under-developed state.

The burden of communist history rests also upon both education and research. Not just curricula and the mechanisms of knowledge transmission and development, but whole fields of knowledge were negatively influenced by the former ideology and practice. The field of social psychiatry had been the most neglected; for instance sociology was said to be a 'bourgeois quasi-science' and not supported at all; the first university departments of social work came into existence after the Velvet Revolution.

Discussion – What are the priorities?

Understanding the history of Czech psychiatry is essential to understanding its current difficulties, hopes and prospects. Although the challenges faced arise from contemporary trends and future expectations, they are superimposed on previous problems in socio-political development.

The transformation of mental healthcare from big institutions towards community based services must continue. So too must the evaluation and tackling of the real psychiatric burden and preparation of society for an ageing population and associated psychiatric issues, such as increased prevalence and burden of depression, neurodegenerative diseases including dementias, etc. These challenges should be addressed systematically across the EU. Therefore, it is of the utmost importance both to adopt a mental health plan on a governmental level and integrate mental health into governmental research and development strategy.

The mental health plan should not just identify specific priorities and aims, but also contain strategies and activities to tackle them. Timeframes, resources, competences and responsibilities should be specified. The issues that should definitely be encompassed by such a plan include harmonization of legislation, harmonization of health and social services and their agenda, cooperation among stakeholders, mental health promotion and prevention in the workplace and schools, investments in the non-governmental sector, social inclusion, de-stigmatization, assessment of value as quality of life or satisfaction of patients and their relatives, special attention to the most disturbed and most vulnerable (child, adolescent, geriatric) patients, and last but not least, accessibility of services and related increase in the number of psychiatric wards of general hospitals, day clinics, crisis intervention services, community psychiatric nurses, psychotherapists, services designed to support patient housing and case management teams.

Increase in funding for psychiatric research is also essential. Psychiatric research must be strengthened at both national and European levels. It is of the highest importance to build interfaces between biological, epidemiological and social sciences in basic and translational research (e.g. to clarify gene–environment interactions), to connect research and innovation (e.g. to deepen the understanding of determinants of under- and over-treatment and accelerating access to novel diagnostic and therapeutic agents), and to collect the evidence and use it in strategic decision-making regarding choices in public health related to tackling stigma, suicide, addiction, problems in childhood, adolescence and associated with employment.

Success in meeting the challenges will, of course, largely depend on the qualities and faculties of

mental health professionals. Their characters, attitudes and skills must be patiently nurtured. Considering the nature, overall burden and trends in psychiatric disorders, psychiatry has to be integrated into modern medical curricula reflecting changes in society and medicine (Dogra et al., 2010). It is absolutely appropriate to require all physicians to gain core psychiatric skills to help those who seek their assistance for undisclosed psychiatric reasons. Appropriate high quality educational programmes at undergraduate or post graduate level should also be available for the training of psychiatric nurses, social workers, as well as for psychiatrists or clinical psychologists.

Negative attitudes towards psychiatry by medical students, health staff and the broader public cannot be underestimated. The image of psychiatry has to be greatly improved and scientific evidence should be used to inform and recruit more young people into the field. Secondary schools as well as universities are appropriate targets of recruitment and anti-stigma campaigns. As both research and experience show, the field of psychiatry attracts liberal and open-minded people, who need to be supported in psychiatry as a field that sees disorders as complex problems that are not supposed to be fixed just by medication, but have to be viewed in a multidisciplinary and multi-paradigmatic manner.

Conclusion

Understanding the history of Czech psychiatry is essential to understanding current difficulties and prospects.

New pressures arising, for example, from globalization, migration, ageing and the financial crisis require new coherence and commitment in mental health strategic priorities for service delivery, building resources, education and research.

Future directions

A national mental health plan must be finalized to address many issues, including those for harmonization of legislation, cooperation among stakeholders including NGOs, de-stigmatization, mental health promotion, attending to the most disturbed and vulnerable, investing in services and increasing their accessibility, strengthening research.

Meeting the challenges will require improved training and nurturing of mental health professionals and the provision of better information to attract young people to the field.

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