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Forensic Treatment Services in the Czech Republic– Current State and Future Challenges

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Protective Treatment Services in the Czech Republic – Current State and Future Challenges

In the Czech Republic (CR), Forensic Treatment (FT) is provided to approximately 600 individuals per year. FT services consist of Protective Treatment (PT) provided in healthcare services, and quasi-compulsory treatment and Secure Detention (SD) provided by prison services. Currently, there are 13 facilities providing inpatient PT treatment; meanwhile, 386 clinics provide outpatient PT treatment. 950 patients receive inpatient and 2300 outpatient treatment; there are 85 patients placed in Secure Detention. Czech psychiatric care is currently undergoing a reform that aims to develop community care services and improve psychiatric hospitals. PT system development must be part of this reform process. The long-term aim should be to separate PT systems from the rest of psychiatric care, build Protective Multidisciplinary Teams providing community care, and support outpatient PT care. There is a need to implement risk assessment using structured professional judgment tools to ensure routine risk assessment is undertaken in all phases of the treatment system, and to adjust interventions and management plans to these risks. Furthermore, as a part of the care system transformation, it is necessary to build special services for minority populations to target their specific needs. There is also a need to improve data collection in regard to FT.

Keywords: Protective treatment, risk assessment, secure detention, analysis

Introduction

The mental health system in the Czech Republic (CR) is currently undergoing significant changes, shifting from a hospital-based model of care towards a community-orientated approach (MZČR, 2013). (This process has raised questions about the future position of Forensic Treatment (FT), especially Protective Treatment (PT) services, as a specialised field within the mental health and prison systems; as such, the Ministry of Health of the Czech Republic have requested a report on the Protective Mental Healthcare field. Protective services need to be developed to cooperate with recently implemented services such as community teams using a recovery-oriented approach. This approach is not always easy to apply to FT due to the need to maintain a secure environment and to manage risks, as well as to provide psychiatric care. Important factors for recovery from psychiatric illness, such as social integration and protective factors mobilisation, must be carefully managed and balanced with the patient's potential for further criminal activity (Völlm et al., 2018; Schaufenbil, Kornbluh, Stahl, &Warburton, 2015) Maintaining a balance between addressing the safety of the patient and ensuring the protection of the public whilst refraining from an overly restrictive approach is one of the challenges in the transformation of an institutional care model to a community-based one.

There is a lack of up-to-date data about the FT population and treatment systems, making direct system comparison difficult (Edworthy, Sampson, & Völlm, 2016a). In studies of Forensic Treatment services, those in CR were not covered at all (Blüml, Waldhör, Kapusta, & Vyssoki, 2015; H. J. Salize & Dressing, 2004; H. J. and D. H. Salize, 2005;

Sampson, Edworthy, Völlm, & Bulten, 2016a) or only partially (Mundt et al., 2012; Vevera et al., 2009); therefore this publication attempts to provide some of this missing information.

We aim to describe the current state of Forensic Treatment services with a focus on their procedural and structural aspects, leaving aside other issues such as professional education or multiagency cooperation. This report aims to review contemporary practice, determine the extent of current services including their strengths and weaknesses, and identify areas in need of deeper analysis. There is also a need for different experts and resources to share their knowledge and opinions to find that careful balance between public safety on one side and offenders' human rights on the other. The findings of this report should serve as a basis for decision making in the further development of protective care in inpatient and outpatient services in the Czech Republic. We believe this may also be beneficial for experts in other countries analysing their FT systems when aiming to transform them from institutionally-based to a more community-oriented approach.

Methods

We obtained data regarding court-ordered Protective Treatments from the Ministry of Justice. The Institute of Health Information and Statistics of the Czech Republic (UZIS) provided outpatient FT data from the National Registry of Paid Services. Due to the relative incompleteness of data from those sources (penal statistical sheets evidence are only part of FT sentences), we amended data sets with the Ministry of Health cross-Sectional survey, mapping the extent and some parameters of protective care in the inpatient facilities by

1.7.2018. Additional data were obtained from The Prison Service of the Czech Republic and its units such as The Secure Detention facility and its database. Lastly, a literature search in PubMed and Google Scholar databases was conducted using the terms "protective," "forensic", "psychiatry", and "services", identifying studies focused on system description, legal frameworks, or service provisions. Our primary focus was on European studies for legal affinity and similarity of practices. We also used outputs from the Ministry of Justice's Protective Treatment Working Group, and in some areas we consulted with key experts.

Results

The Czech mental health system and Protective Treatment services overview

The total population of the CR in 2017 was approximately 10.5 million people; there are currently 82 psychiatric beds per 100 000 inhabitants, a reduction from 99 per 100 000 in 1999; this change is similar to a decrease in psychiatric beds in other European states- from an 11% decrease in Croatia to a 51% decrease in eastern Germany between 1989-1999 (Mundt et al., 2012). The most frequent ICD 10 diagnoses for an individual with a psychiatric hospital admission in 2017 were for mental and behavioural disorders due to psychoactive substance use (F10 – F19): 14 513 (9067 related to alcohol abuse); psychotic disorders (F20 – F29) accounted for 10420 hospitalisations; and 9948 admissions were due to neurotic, stress and somatoform disorders (F40 – F48, F50 – F59) (Nechanská et al., 2018). These statistics are almost identical with those from a previous study published several years ago (Höschl,

Winkler, & Pěč, 2012), demonstrating the relative stability of inpatient mental healthcare services.

In the Czech Republic, there are 1317 beds provided by 31 university clinics and psychiatric departments situated in general medical hospitals. There were 19 594 individuals hospitalised in 2017 (Nechanská et al., 2018). These small capacity facilities provide "acute" or short-term care. They are operated by local municipalities, private companies, or are part of state university clinics, and provide psychiatric care and some short-term substance abuse programs.

Fourteen state-operated general psychiatric hospitals (PH) and two smaller hospitals operated by local government in 2017 comprised of 8709 beds for adults and 210 beds for child and adolescent patients (Nechanská et al., 2018). They provide primarily "long-term" or rehabilitative care, mid-length substance abuse programs, and old age psychiatry wards alongside some proportion of "acute" or short-term care. The majority of inpatient care is thus provided in large PH; this institutional care is predominant in CR, as in all states in Central and Eastern Europe with unreformed mental healthcare systems (Páv, Kališová, & Hollý, 2017; Höschl et al., 2012). Psychiatric care reforms aim to limit long-term stays in these facilities. The inpatient PT takes place exclusively in psychiatric hospitals, controlled by the Czech Ministry of Health; the obligation to provide Protective Treatment is anchored in their founding charters. Currently, thirteen facilities provide specialised inpatient PT, which include psychiatric and substance abuse programs, and six of these offer a sex offender treatment program (Figure 2).

According to UZIS data, in CR in 2017, there were 1200 outpatient clinics (Nechanská et al., 2018), providing care to 652 780 psychiatric patients. In 2018, there were five multidisciplinary assertive teams providing community care in the CR. The most frequent diagnoses treated in outpatients clinics are neurotic disorders (F40–F48, F50–F59) with 250 289 visits, affective disorders (F30–F39) accounted for 130 556 visits and organic mental health condition like dementia for 72 750 visits (Nechanská et al., 2018). There are no outpatient clinics specialized for PT treatment patients; these patients get treatment alongside other patients in general outpatient clinics.

Legal framework

Protective Treatment in the Czech Republic began in the middle of the 20th century, when Penal Code No. 86/1950 Coll was introduced. Currently, conditions for the imposition, duration, and termination of FT and its conversion to a period of Secure Detention are set out in the Criminal Code no. 40/2009 Coll., as amended, and – for children under the age of 15 – in the Juvenile Justice Act no. 218/2003 Coll, as amended. The procedure for imposing and executing FT is regulating Criminal Procedure Code no. 141/1961 Coll., as amended (and in Juvenile Justice Act in cases of children under 15). The conditions of the treatment, including patients´ rights and duties in the course of treatment, are set out in the Specific Health Services Act. No. 373/2011 Coll., as amended. Secure Detention as a specific and relatively new type of FT is also set out by the Criminal Code (it does not apply to the children under

15) and governed by a special law, the Secure Detention Execution Act no. 129/2008 Coll., as amended.

Trial and criminal responsibility

Civil law (inquisitorial) principles underlie the Czech system of law, which stems from the moral Roman law tradition (Volf & Marle, 2018). The system regarding mentally disordered offenders emphasises the psychological element of this offense, implementing the concept of insanity in the Czech system in a similar manner to other countries applying a "psychopathological" approach, e.g., Germany (Edworthy et al., 2016a; Edworthy, Sampson, & Völlm, 2016b). When a criminal offense has been committed under the influence of a mental disorder, then the court decides if there is diminished or absent responsibility of the perpetrator in the case (Karabec, Vlach, Hulmáková, & Zeman, 2017a). There is a gradation of criminal responsibility with non-significantly reduced, significantly reduced or absent responsibility leading to an unconditional acquittal, such as in some cases of patients with schizophrenia; a concept also used in Austria, Belgium, France or Bulgaria (Volf & Marle, 2018). The reduced responsibility depends on the appreciation of two parameters: firstly a "recognition" ability (a test of cognition) and also a "control" ability (a test of volition); this approach is similar to some European praxis (Volf & Marle, 2018). E.g., if an individual's sense of reality is impaired severely by a psychotic disorder, then those abilities can be considered absent. In another case, if somebody knows that a given act is illegal, but he is not able to control the impulse to commit it, his "recognition" ability could be considered

preserved, but his “control” ability can be significantly reduced, e.g., in paraphilia. There is a requirement of the relationship between disorder and offense (Karabec, Vlach, Hulmáková, & Zeman, 2017b). The system thus allows for the mentally ill to be “diverted” from the criminal justice system to (protective) mental health services either before or after sentencing. The age of partial legal responsibility is 15 years, with full responsibility being granted from 18 years. Regardless of this, FT can be imposed from 14 years of age. For a more detailed description of criminal law proceedings, see (Karabec et al., 2017b).

Pre-trial proceedings and the role of the psychiatric expert

The principal authority responsible for detecting and investigating crimes is the Police of the Czech Republic (Karabec et al., 2017b). Investigations are conducted by the Criminal Police and Investigation Service. If the suspected perpetrator of a crime shows signs of mental disturbance, has a history of previous psychiatric treatment or substance abuse, they will then have an assessment from a psychiatrist or clinical psychologist; if required, an expert in the field of treating addictions or sexual disorders will be provided. The expert assesses the mental health status of the perpetrator, assesses his ability to stand a trial and suggests therapeutic measures; this system is similar to that of other European countries such as Germany (Edworthy et al., 2016a). Assessment is based on clinical evaluation and the professional opinion of the relevant expert. The predominant approach is, therefore, unstructured clinical judgment. The whole investigation process is under the supervision of

the Public Prosecutor Office, regulated by Act no. 283/1993 Coll., on the Public Prosecutor's Office.

The County Court or the Ministry of Justice appoints these forensic experts; they must be fully qualified in their field. The expert can give their opinion in an outpatient or inpatient setting, depending on the mental condition of the offender, crime severity, and legal conditions in the specific case. Lacking, diminished, or full criminal responsibility then determines further placement. If the offender lacks criminal responsibility in a given case, (s)he is usually placed in a general psychiatry hospital or a Secure Detention facility in the most serious cases. A professional witness in criminal cases is usually commissioned by the police and supervised by the prosecutor. However, the defendant can also request an independent expert opinion; in cases of conflicting results the court can commission an institutional expert opinion, usually undertaken by a university psychiatric clinic or hospital.

Forensic Treatment sentencing

Forensic Treatment can be imposed on offenders whose criminal responsibility is reduced due to a mental disorder, or to substance users having committed a criminal offense under the influence of an addictive substance or in connection with abuse (Karabec et al., 2017b). The main condition for the imposition of FT is that it would be dangerous to let the perpetrator loose (i.e., without treatment). FT is, therefore, a criminal sanction; this aspect distinguishes the Czech management approach from that of other countries. The vast majority

of offenders with imposed Forensic Treatment have treatment regardless of their will – on the basis of the court's decision (Blatníková & Zeman, 2013). FT can be imposed either in the inpatient or outpatient setting and can be ordered separately, in addition to punishment or instead of a punishment. Although no legal standard specifies them, FT is traditionally ordered in four areas: a) psychiatry b) sex offender treatment (that is, in offenders with paraphilias and other sexual disorders) c) substance abuse (Vevera et al., 2009) and d) pathological gambling. These treatments can also be imposed in combinations, e.g. sex offender treatment together with substance dependence treatment. Whether treatment is ordered as an inpatient or outpatient depends on the forensic expert's recommendation, severity of the crime, and current risks. Inpatient (institutional) Protective Treatment should be ordered by the court whenever it is apparent that the outpatient form of treatment would be insufficient in achieving the desirable risk reduction.

PT treatment placement and termination.

The court supervises PT; Protective Treatment should continue until it "does not fulfill its purpose" and has significantly reduced the danger for society or the person himself. Inpatient PT is usually provided for a two-year period; this can be extended, terminated early or converted to outpatient treatment or Secure Detention as the risks dictate. Outpatient treatment has no set time-period; it lasts as long as treatment is required.

Secure (preventive) Detention placement and termination

Secure Detention is the most restrictive form of Forensic Treatment. Its main purpose is to protect the public against particularly dangerous offenders with a dissocial personality disorder or other mental disorders (sexual aggression, dangerous psychopathy or psychosis, or repeated violence) who are not able or willing to undergo Protective Treatment imposed by the court.

Conditions for imposing this sanction are stated in Criminal Code no. 40/2009 Coll., and include the committing of severe crimes with reduced or absent criminal responsibility. SD is subsidiary to Protective Treatment: PT can be converted to SD if the patient severely violates the treatment plan; equally, SD can be converted to PT if the patient cooperates and makes good progress. The court reviews the conditions for further continuation of SD at least once a year (once every six months in the case of juveniles) and decides on whether to extend the SD or to release the individual from this. For SD in the context of international law, see (Škvain, n.d.).

Protective Treatment services provision

Pre-trial facilities

Psychiatric hospitals do admit offenders during a pre-trial phase if they show signs of a severe mental health condition, on the basis of a civil detention order. This placement could

be for immediate treatment, assessment purposes, or sometimes to provide time for clinical observation. In the case that custody is required immediately after the crime, then the assessment is performed there. In cases of diminished responsibility and unconditional acquittal, patients are moved to a general psychiatry hospital to await their PT disposal.

Inpatient FT

Healthcare facilities (psychiatric hospitals) provide inpatient PT treatment within the regional responsibility determined by Court Office Regulations issued by the Ministry of Justice. Hospitals are regionally distributed and are roughly equally divided between rural and urban areas (see Figure 2). Concerning inpatient PT, the majority of patients are treated together with other patients; only a minority of this care is provided on specialised wards (hospitals reported 416 beds in 7 hospitals in 2018). Most of these wards are not secure; staffing is only slightly higher than on ordinary care wards. The majority of hospitals thus report having no specialised units with trained staff to deal adequately with high-risk patients.

A survey conducted in July 2018 showed that there are 950 PT patients in inpatient treatment (650 psychiatry, 145 sex offender treatment, and 142 substance abuse), see Table 1. This PT population accounts for 9.5% of all psychiatric inpatients, and 10.9% of beds in psychiatric hospitals (Nechanská et al., 2018). There has been a significant reduction in the number of psychiatric beds in the Czech Republic in recent decades (from 140/100 000 in 1990 to 82/100 000 in 2017); with protective beds dropping from 15.3/100 000 in 1990 to 7.2/100 000 in 1999 (Mundt et al., 2012) and rising to 8/100 000 in 2018 (Table 1). The

reduction in bed numbers in the 1990's is attributable more to societal changes and subsequent legal changes after the Velvet revolution, than service provision itself; for an overview of CR psychiatric services development see (Höschl et al., 2012).

There is a significant regional imbalance in the PT numbers with regards to the population in the catchment areas. While the average number of PT is 8/100 000, a similar number to other countries with comparable law and healthcare systems such as Germany or Austria, (H. J. Salize, Lepping, & Dressing, 2005; Chow & Priebe, 2016), it is three times higher than the average in PH Dobřany (23) and twice as high in PH Horní Beřkovice (15). However, PH Lnáře or PH Kroměříž show below the average number of beds for PT patients (4).

Facilities that have a relatively high number of PT patients (including those with a treatment period longer than two years) also have the highest number of patients where the local court rejected the proposal of the hospital for the release of patients to outpatient care, or to place them in Secure Detention.

There is a continual increase in inpatient FT beds in some states (Belgium, Austria, United Kingdom, Germany) while in others numbers are steady (Ireland, Spain) or even in decline (Italy, Switzerland) (Chow & Priebe, 2016). Our PT numbers show a slight rise in the last decade (7.0 to 8/100 000), we think reflecting treatment prolongation caused by a societal demand for detention and greater court restraint in dismissal by media cases. The treatment is the longest in the hospitals with above-average PT numbers, in 290 cases (30% of the total number of all inpatient PT) it lasts longer than two years. Those patients constitute the long-

stay PT patient cohort, hospitalised with other mentally ill individuals on the common long-term wards, blocked from using the usual dismission pathway into community psychiatric rehabilitative services by an Inpatient Protective Treatment sentence. The Czech Republic is, therefore, one of the countries where long-term hospitalisation is performed without clear criteria or a defined standard, resulting in a low quality of life for one-third of the inpatient PT population as described by (Sampson, Edworthy, Völlm, & Bulten, 2016b; Kalisova, Pav, Winkler, Michalec, & Killaspy, 2018). Sex offender treatment (especially paraphilia) lasts on average 450 days; some long-stay patients belong to this cohort (Nechanská et al., 2018).

Data from the registry of the Ministry of Justice does not show a significant rise of FT sentences in the past decade; the numbers of ordered (both outpatient and inpatient FT) oscillate around 600 treatments a year (Figure 1). Since 1990 there has been a rise in ordered FT- 476 cases in 1991 to 592 in 2007; this rise is probably due to increased substance abuse treatment (Vevera et al., 2009). There has been only one prevalence study regarding ordered PT diagnosis; this showed on the sample of PH Bohnice (catchment area 1.2million) between the 2002-2007 a rise of PT patients with substance abuse with reduction of PT ordered for schizophrenia (Vevera et al., 2009). More recent data is not available.

Forensic treatment in prison;quasi-compulsory treatment

In the Czech Republic, there were 21 806 prisoners in 2017 (Diblíková, 2018a). Criminal records show 14 000 violent crimes in 2017 (Diblíková, 2018b). Offenders can undergo Forensic Treatment in prison if there are conditions for such a treatment in a given

facility. Medical facilities of the Prison Service of the Czech Republic provide Forensic Treatment during imprisonment in so-called “Specialized Departments for Protective Treatment” (SDPT), which are regulated by the General Director of the Prison Service Regulation No. 41/2017 (Karabec et al., 2017b). The prisoners are assigned to the SDPT programs only if FT is ordered together with a prison sentence (that excludes all cases of, for example, psychotic disorders when absent responsibility leads to an unconditional acquittal); the majority of individuals have been diagnosed with substance abuse problems, personality disorders, and paraphilia. The medical and allied healthcare professionals employed by the prison service provide the healthcare to prisoners subject to this treatment including the SDPT therapeutic programme. At present, SDPT´s are located in 4 prison facilities (Kuřim, Opava, Rýnovice, Znojmo) with an overall capacity of approximately 130 persons (Blatníková & Zeman, 2019).

Outpatient PT

There are around 350 new outpatient PT sentences each year (Figure 1.); outpatient clinics also follow up patients after inpatient PT completion. There are no specialised outpatient clinics for PT treatment patients; these patients are treated with the other adult psychiatric patients. There is also the same reimbursement of care as for patients without PT; reimbursement therefore does not include administrative acts or in-court proceedings participation. Unlike the inpatient PT, with a catchment area defined by Annex 8 of the Code of Administrative Procedure, the outpatient treatment does not have regional regulation.

Outpatient psychiatric facilities may accept or refuse to take care of a patient for outpatient treatment on their consideration about excessive workload given by the diction of Act 371 / 2011Sb. The extent of this care segment is not precisely known, as data from outpatient PT clinics is not collected centrally. There is a signal code in the healthcare registry to record outpatient PT patients visits, which should be entered into the system with each outpatient PT patient visit. Despite the optionality of this reporting (and inevitable underreporting), in 2017, there were 386 outpatient clinics identified which provide care for PT patients totalling 2316 outpatient visits (Table 2). Diagnostic data concerning outpatient PT population is not available.

Secure Detention

Since 2009 the legislation introduced the Institute of Secure Detention (SD) as a new type of penal sanction, designed for mentally unstable dangerous offenders. It is the equivalent of High Secure facilities abroad; these facilities were set up by the Prison Service of the Czech Republic. Currently, there are two SD facilities in the Czech Republic, in Brno and Opava (Figure 2), with a capacity of 45 beds (38 of which were occupied in January 2019) and 50 beds (47 of which were occupied in January 2019) respectively; overall occupancy of both security detention facilities is 90%. SD facilities are institutions of a predominantly non-medical nature with therapeutic, psychological, educational, rehabilitative, and occupational programs. Medical care is provided by nursing staff present during the day, with patients receiving medications, psychological and psychotherapeutic care.

In the period January 2009-January 2019, an SD order was given to 173 people (Figure 3). Among these offenders with an SD sentence, a total of 56 are currently serving a prison sentence, and they are supposed to be referred to the SD facility at the end of their sentence. Two of them have been sentenced to life imprisonment (in the Czech Republic, an offender convicted to life imprisonment can apply for conditional release after having served 20 years or in specific circumstances 30 years of their prison sentence) (Ministry of Justice, 2018). In January 2019, the total number of inmates in SD facilities was 77 men and eight women; the average age was 38 years. From 172 offenders cohort ordered to SD, nearly 32% suffer from a severe personality disorder, around 14% from a psychotic disorder, 3% from an organic mental disorder, nearly 20% were diagnosed to have a paraphilia, 10% are mentally disabled, and in 21% of cases SD was ordered for substance misuse problems. The crimes committed by these individuals are homicide in 33% of cases, other violent crimes in 25%, sexual offenses in 36% of cases, and 6% were ordered for other crimes. In 27%, SD was ordered for lack of treatment response in PT, severe PT violation in 25% of cases and in 48% SD was ordered directly after committing a crime or a prison sentence- therefore bypassing PT. To illustrate this in context, in 2017 the Czech courts imposed a prison sentence in 8402 cases; among them were 21 prison sentences from 15 to 25 years, and one lifelong sentence.

Passage of the patient through the FT care system

Protective Treatment or Secure Detention are both subsidiary to imprisonment (Karabec et al., 2017b; Blatníková & Zeman, 2013). PT (or SD) thus follows the prison sentence; its length is adjusted in the case of diminished criminal responsibility. A proposal for PT or SD is given from an expert opinion obtained during a pre-trial investigation or the trial with FT proposal, which is a prerequisite for the FT sentence. Offenders with substance misuse problems and sex offenders usually receive both prison sentences and court-ordered treatments. Prisoners suffering from severe mental illnesses (e.g. schizophrenia or bipolar disorder) are in the vast majority not sentenced to prison but court-ordered treatments if the crime is committed when the offender was acutely unwell.

To demonstrate the FT care pathway, we provide an example of a patient with paraphilia committing a serious sexually motivated offense. When the offender is in custody he will be examined by experts in the fields of psychiatry, psychology and sexual offences. If the finding is that the offense was committed under a paraphilic motive, he is found to only be partially responsible for that crime and a recommendation is made for inpatient sex offender Protective Treatment, and this is usually ordered together with prison penalty. During the imprisonment, he can ask to be placed in a prison facility with the sexual offender program (quasi-compulsory treatment, serving as a pretreatment), and after sentence termination is placed in a regional hospital with a sex offender treatment program. Due to long-standing Czech traditions, therapeutic programs in the area of sex offender treatment are quite comparable across facilities; sex offender Protective Treatment is ordered exclusively to offenders with some form of paraphilia (Zimanová, Weiss, & Bílková, 1987; Weiss, 1997). If the offender cooperates adequately and successfully fulfills criteria for inpatient PT

termination, the proposal is given to the local court for a conversion to outpatient treatment; here the expert opinion may be revoked. If there is a severe PT regime violation (together with the condition of the continuing public thread), a proposal for SD placement can be given to the court, after the expert opinion approval court converts FT to SD placement. Then after a one-year period his mental health status is reassessed; if there is an improvement, the SD is changed back to inpatient PT.

Protective Treatment services funding

The Czech Republic healthcare spending (by OECD data) is 3033 USD per capita in 2017 (*Health at a Glance 2017*, 2017). 3.8% of the healthcare budget is allocated to mental health, while the total burden of mental health problems was estimated to be as high as 2.5% GDP in 2015 (*Health at a Glance: Europe 2018*, 2018). A large part of these costs are due to lower employment rates and productivity of people with mental health issues; deinstitutionalisation is calculated to be cost-effective compared with care in psychiatric hospitals in the Czech Republic (Winkler et al., 2018). The health system is funded through compulsory health insurance paid to insurance companies, which then contract healthcare facilities. Another part of the mental healthcare system financing is via social care services, which do not serve PT patients. The Ministry of Justice funds part of the care provided in prison facilities. The largest part of FT care is, however, reimbursed by health insurance coverage within the health care system.

The reimbursement of inpatient PT care services is achieved by an all-inclusive inpatient day payment including ward running costs (e.g., heating, laundry, nutrition, material), expenditures on therapeutic staff (e.g. psychiatrists, psychologists, social workers, occupational therapists) and nursing staff employed on the ward, medication, complementary therapies offered outside the ward (e.g. therapeutic workshops, kinesiotherapy) and overhead costs (management, maintenance). Payments in 2018 ranged between 80-92 € according to the hospital; the total estimated cost for an inpatient day in a psychiatric hospital is 1504 CZK (€59) (Broulíková, Winkler, Páv, & Kondrátová, 2019).

Comparison of the CR system of financing forensic services with those of other European countries (H. J. and D. H. Salize, 2005) reveals that in the majority of European states funding is multi-sourced; a combination of the Ministry of Justice contributing together with the Ministry of Health (Belgium, France, Nederland, Germany). Funding predominantly by the Ministry of Justice is used in Austria, Spain, or Portugal; coverage from the health care budget (National Health Service) is used in the United Kingdom (H. J. Salize et al., 2005). Both medical and judicial approaches in financing the protective services can, however, lead to specific problems in cooperation and development of joint projects between the protective setting and general psychiatry (van Lier & Tort-Herrando, 2018a). A general recommendation is ensuring protective care funding through national standards, comprehensive service provision including both hospital and community services, guaranteed continuity of care and the same level of care for protective and general psychiatry (van Lier & Tort-Herrando, 2018b).

It is difficult to get investment data from other states; in the Czech Republic in the last 50 years, there have been no substantial investments into the inpatient Protective Treatment system. Within the range of the last 20 years, there have been individual cases of investments from the Ministry of Health to the Forensic services (Specialised department in Bohnice Psychiatric Hospital); however in the last five years, there has been no investment in the PT facilities or system as a whole.

Discussion

The shortcomings in the system of recording and reporting data on sentencing and treatment in FT present a serious issue. The Ministry of Justice does not collect data on important decisions relating to the FT, such as the decision to change the type of treatment, or the change from PT to the SD or the termination of Protective Treatment. Likewise, the Ministry of Health doesn't collect data relating to this population. To illustrate this difficulty, take, for example, inpatient PT. This population consists of individuals directly sentenced to PT as inpatients (around 200 patients a year, Figure 1), individuals under PT converted from outpatient treatment (numbers unknown), those under SD converted to inpatient PT (up to 10 patients a year), and those being treated under PT after the termination of their prison sentence termination (numbers unknown). Some patients are not even in a secure facility, but on a "waiting list" for one of these facilities, admitted after the capacity in treatment programs

is released (numbers unknown). The resulting number of 950 inpatients thus reflects only currently hospitalised FT patients, not all the individuals sentenced to FT. Medical data are not systematically collected for those being treated under PT, so it is not possible to collect these numbers from a UZIS registry. This means that detailed information about the FT population is not known and this hinders the development and improvement of these services.

Furthermore, the ability to effectively treat PT patients is inhibited by the fact that in most psychiatric hospitals there are limited numbers of specialised PT beds, with most of the PT patients being treated in the general wards. There is therefore no defined network of facilities able to provide care for patients with higher risk levels in a secure setting; in other words, there is no possibility to stratify patients accordingly their risk levels. Within the frame of the action plan in the psychiatric hospital development process, it is necessary to reserve a part of the capacity of a hospital bed fund for protective care. A network of specialised medium-security facilities or departments seems essential for the functioning of the whole FT system (H. J. Salize et al., 2005; van Lier & Tort-Herrando, 2018b). Such wards have to be equipped with trained staff capable of handling even the most challenging high-risk patients with specific needs. During the management period, the wards should encourage the completion of a complex therapeutic program with specialised supervision (Seppänen, Törmänen, Shaw, & Kennedy, 2018).

At present, some facilities tend to refuse individual patients due to the lack of trained staff, protective field expertise or security considerations, despite an obligation to treat every PT patient ordered to this facility; this leads to a strain on better-equipped units. Patients with

substance abuse problems in some hospitals remain on the "waiting list" for inpatient treatment for several months or even years. One reason for this is the absence of specialised treatment programmes for FT patients with predominant substance abuse disorders in some facilities.

There is a broad regional diversity in the number of PT patients calculated on the population of the catchment area (3-23), reflecting differences in the services capacity, local court decisions, sociodemographic regional specifics (such as substance abuse user prevalence) and in the specifics of treatment regimes in different hospitals. The same variation is evident in the transition from inpatient to outpatient treatment and vice versa. Some hospitals report more frequent court disagreement with inpatient-outpatient treatment transition than others (Table 1). Other problems include a difficult transition of patients from Secure Detention to other services and vice versa; placement without a risk assessment or risk management plan can be seen as inadequate; hospitals are not able to cope with the riskiest part of the patient population due to inadequate equipment and staffing, as stated in some reports (Ombudsman, 2019). Furthermore, there are seemingly other complex factors behind prolongation of inpatient PT in some facilities, such as a lack of access to community teams in given catchment areas (and community care in general, especially in some regions), and an absent defined structure of inpatient PT programs, structured treatment plans and regular risk (re)assessment.

Another substantial weakness of the FT system as a whole is the outpatient PT functioning, where the sole responsibility for any problems is placed on the psychiatrist

without any clear support from other agencies. Treatment failures are discussed amongst professionals (Žukov, Ptáček, & Fischer, 2013), but they can also raise public interest; and often the psychiatrist is seen as responsible in these cases. The result is a limited willingness from the outpatient teams to care for this population, especially if there is a lack of compulsory training in forensic issues in postgraduate education. Another problem is the fact that PT patients do not bring any financial advantage to the healthcare facility compared to patients without PT, even though extra work is required, for example the completion of court reports. Courts in some regions are therefore struggling to locate an outpatient provider when sentencing outpatient PTs. The only responsible stakeholders, the health insurance companies, , are not always able to provide sufficient outpatient treatments due to a lack of specialists in that region, for example sex offender therapists.

There is therefore an urgent need to start to build a system of community care able to adequately deal with a challenging PT population. Routine outpatient facilities are not obliged to work with the inpatient PT providers in their region, resulting in insufficient care coordination. The problem worsens with the absence of official communication and lack of transmission of sufficiently detailed information concerning problematic cases between institutional and outpatient care (absent structured care planning and risk re-assessment). To support outpatient PT services development, we suggest the introduction of a new service: Protective Multidisciplinary Teams, which should serve as a bridge between outpatient and inpatient care for patients with PT. In the service pilot design, we have been inspired by pre-existing assertive community treatment models for the protective population (Marquant, Sabbe, Van Nuffel, & Goethals, 2016). Alongside this we also advise the use of structured

professional judgment risk assessment tools HCR-20, SVR-20, SAPROF, and SAVRY (Singh et al., 2014a).

Multiagency cooperation is also far from functional models like MAPPA in the UK or the "Round Table" in Germany (Thomson, Goethals, & Nedopil, 2016); at present in CR no standardised procedures links legal, healthcare, societal, educational, police, social security, prison, probation, and employment services together. It is therefore necessary to search for inspiration from a suitable model abroad which we can adapt to our country to help develop our services. Multiagency cooperation is essential not only for public protection, but also helps to protect mental health services from stigmatisation and media attacks.

Another problematic area identified in our report is the fact that there are no specialised facilities available to provide inpatient PT care in the field of child and adolescent psychiatry. Child and adolescent patients are treated with adult patients; there are no specific treatment programmes targeting their specific needs. We call for the establishment of programs or facilities that will provide separate and specialist treatment for child and adolescent offenders with mental health needs; these treatment programmes will need to also include educational and developmental components. The same requirement for specialist treatment is also needed for the transgender population. Currently there are no separate facilities for women, as the number of PT patients is too small to justify the cost of a separate ward. This means that these female PT patients are treated amongst other patients in the routine inpatient treatment programmes. Finally, people with intellectual disability are also treated alongside other patients, which causes problems as these programmes are not designed

for their needs, and they are at risk of abuse from other patients. This population is highly heterogeneous in terms of psychiatric profile, and its needs are specific (Vicenzutto et al., 2018).

There is no systematic risk assessment requirement for patients under the FT services; this does not reflect the global developments in the last 20 years in the field of risk assessment development and use (Singh et al., 2014b; de Vries Robbé & de Vogel, 2018). Absence of risk assessment can contribute to differences in expert opinion recommendations regarding FT and to regional heterogeneity in placing patients into different treatment pathways. It also causes difficulties for healthcare professionals in communicating with the justice system concerning risk level in a given patient and management proposals. Risk assessment is strongly recommended in the context of providing expertise to courts, as well as in the planning of interventions and risk management for the protective population within treatment as contemporary standards indeed recommend (Völlm et al., 2018). There is a necessity to implement The Risk-Need-Responsivity model based on the use of risk-based instruments into the treatment system (Andrews et al., 1990), as effective treatment consists of programs that follow risk, need, and responsivity principles. Use of instrument such as SAPROF counterbalancing risk assessment helps to map protective factors and incorporate them into the treatment plan (de Vries Robbé, de Vogel, & de Spa, 2011). There is also a need to integrate recovery principles into the field, supporting user participation in all stages of the treatment process (Drennan, 2012). Without evidence-based risk assessment systems, there is a danger of transinstitutionalisation of the severely mentally ill from long-term care FT to the Forensic Treatment services.

Discussions regarding the funding of this system must be had (Heitzman & Markiewicz, 2017). Separating inpatient protective care budgets from other psychiatric care (at least for part of the protective population) and reporting them differently to stakeholders is one way to get reimbursement from sources other than health insurance coverage (e.g., Ministry of Justice). It is obvious that the system of PT services should not be built solely by insurance companies, while elsewhere in Europe strong state participation regulation and participation in this area is normal (Edworthy et al., 2016b; H. J. Salize et al., 2005; van Lier & Tort-Herrando, 2018b). These additional resources should improve funding of the underfinanced care sector and also serve to provide continuous staff training and development of new treatment programs. Of paticular importance is investment in unsatisfactory inpatient protective units.

There are also some minor flaws in the regulation of FT, e.g., law and regulations do not provide a list of patients' rights, and obligations, the governmental concept of protective treatment is lacking, etc. (Ombudsman, 2018). Protective Treatment is regulated by several laws, which makes adjustment difficult; there are suggestions to start work on a specialised law "Performance of Protective Treatment" to overcome these difficulties. There is an absence of official guidelines for FT as well. There is no decree issued by the Ministry of Health regulating PT, and Czech psychiatric society guidelines also do not contain any dedicated guidance to PT. We have only been able to find one guideline published concerning inpatient PT (Švarc, Páv, Papežová, & Hollý, 2018).

The absence of clear treatment parameters in PT, in general, has led the Ombudsman's office to a discussion regarding the development of recommendations addressing specific issues in protective care. Their report also states that many hospitals are overburdened; there is no government plan to satisfy capacity requirements, many departments are unsafe, and restraints use due to insufficient staffing is prolonged (Ombudsman, 2018). The Ombudsman's office also points to some issues in the Secure Detention functioning including strictness in their regimes, lack of free time activities and lack of regular risk (re)assessment (Ombudsman, 2019).

Study limitations

Data accessibility limits the power of this study as this cross-sectional design gives only a current "snapshot" and is not able to indicate trends or provide a thorough comparison of services over time. The Ministry of Justice keeps records regarding the number of FT patients on the national level as a part of the Central Statistical Information System (CSLAV) database. But only some of the cases where Protective Treatment is ordered enter the justice database CSLAV; in the cases where the FT is ordered in the case of criminal irresponsibility, the penal statistical sheet is not completed. There are also cases where multiple FT sentences have been given to one patient; for example we discovered one case where three FT sentences had been given to a single patient, which further distorts the data because the Justice system records Forensic Treatment data and the Healthcare system records individual patients.

UZIS data collected on healthcare does not differentiate PT patients from other inpatients in hospital, therefore there is no available evidence regarding the exact extent of care. As stated previously there is also a lack of outpatient PT data, as the current method of data collection certainly underreports the true numbers of patients.

Regarding the prison services data provision, there are limitations as well; details concerning, for example, currently diagnosed mental disorders in people who have been ordered to SD cannot be ascertained from the available evidence system; currently it is not possible to even get the total number of inmates. At present, there is a project currently running aiming to solve the problems of FT and security detention data evidence "System of data recording on the application of the institutes of a quasi-compulsory treatment and security detention in CR."

We were unable to precisely calculate hospital catchment area populations, and, therefore, average PT numbers in some areas. Regional responsibility for PT determined by a Court Office Regulations Decree issued by the Ministry of Justice does not fully match the system of the districts used by the Czech Statistical Office; this can cause a small distortion of the PT numbers in given catchment areas. Reconciliation of these regional inaccuracies is another challenge in FT reporting.

Conclusion

The results of our analysis thus show that the medical treatment in the FT system in the Czech Republic is to a certain extent, unregulated. Data regarding Protective Treatment populations and service provision are not collected, and there is no data-based service development and funding. Regarding changes in the mental health field within the development project, it is, therefore necessary to examine the protective psychiatric care field. Experience shows that if changes in general psychiatry and FT services do not occur in parallel, this could lead to an increase in the number of patients in the forensic services, so-called transinstitutionalisation (Jüriloo, Pesonen, & Lauerma, 2017), albeit this process does not occur in all situations (Blüml et al., 2015; Marquant & Torres-Gonzalez, 2018). In CR, the process of deinstitutionalisation has not yet fully started and it is thus necessary to address the needs of forensic services systemically. The necessary systemic measures include the introduction of a Risk Assessment System, the allocation of protective care beds within the hospital segment, the monitoring of the extent of care and the need to start a discussion of regulation at the national level. Another required measure is the development of community-based protective clinical care teams, as this service could help with the smoother transition of patients from the institutional care to care in the community and also to provide better public protection than standard outpatient clinic care. Within this FT treatment transformation it is also necessary to pay attention to specific patient subpopulation needs, from the child and adolescent population, minority and ethnic minorities to intellectually disabled people.

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Conflict of interest

Authors declare that they have no conflict of interest. The funding agencies had no role whatsoever in identification, design, conduct, or reporting of the analysis.

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