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Dobiášová Karolína[1], Tušková Eva[1], Hanušová Pavla[1], Angelovská Olga[1], Ježková Monika[2]

The Development of Mental Health Policies in the Czech Republic and Slovak Republic since 1989

ABSTRACT: *The article aims to describe the key events in the development of mental health care policies after 1990 in the two countries and identify the main reasons for stagnation or incremental changes to the institutional setting in the field of mental health care. The process of mental health care reform is explained using the framework of historical institutionalism. The explanation shows that the lack of political interest in combination with the tradition of institutional care resulted in poor availability of psychiatric care, outdated network of inpatient facilities and critical lack of community care facilities in both countries. Even though Slovak Republic adopted national programme at the governmental level, it still struggles with its implementation. The ongoing reform attempt in the Czech Republic may bring some change, thanks to a new approach towards strategic governance of the mental health care system and the mechanism of layering that the promoters of the reform use.*

KEYWORDS: Mental health care, health policy, healthcare reforms, Czech Republic, Slovak Republic

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INTRODUCTION

The system of mental health care in the Czech Republic (CR) has not seen any fundamental systematic change since the 1990s. The field faces the consequences of a continuing lack of financial resources (Ministry of Health 2013, Dlouhý 2014). The CR has no national policy of mental health care approved by the Government. The lack of political interest together with insufficient funding result in poor availability of basic psychiatric care, outdated network of inpatient facilities and a critical lack of community care facilities (Ministry of Health 2013).

In addition, the current rules for healthcare expenses reimbursement from the public health insurance motivates outpatient psychiatrists to see a high number of patients without taking the time to provide a proper therapy. The current system stimulates quantity at the expense of quality (Raboch & Wenigová 2012).

While there has been a steep rise in the number of psychiatric patients in outpatient care, the number of outpatient psychiatrists rises very slowly (IHIS 2013). A vast majority of psychiatric patients are treated only with psychopharmacotherapy, which does not correspond with the bio-psycho-social approach of today's psychiatry (Raboch & Wenigová 2012). The main sore point of the whole system lies in the absence of functional relations between outpatient and inpatient facilities, insufficient collaboration with general practitioners (GPs) and clinical psychologists (Ministry of Health 2013).

The Ministry of Health is currently working on plans for implementation of the new *Psychiatric Care Reform Strategy* which addresses the above mentioned problems. The implementation of the reform depends on various factors, both within and outside the field of psychiatry. In this respect, the CR could learn from the experience of other countries. We decided to compare the development of mental health care policies in the CR and Slovak Republic (SR), as both countries have very similar healthcare systems, which provides for easier transfer of policies (Marmor et al. 2005).

Our article aims to describe the key events in the development of mental health care policies and explain the main reasons for stagnation or incremental changes to the institutional setting in the field of mental health care in both countries.

[1]**Dobiášová Karolína, Tušková Eva, Hanušová Pavla, Angelovská Olga**: Institute of Sociological Studies, Faculty of Social Sciences, Charles University, Prague, Czech Republic. Email: karolina.dobiasova@fsv.cuni.cz

[2]**Ježková Monika**: Faculty of Economics and Administration, Masaryk University, Brno, Czech Republic.

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METHODOLOGY

The analysis itself uses a comparative method and builds on the examination of crucial political events. It was preceded by an extensive desk research, scrutinising documents and other available data in order to identify the relevant areas of mental health care in the CR and SR. The desk research focused on expert reports in the field (such as *Mental Health Care Reform in the Czech and Slovak Republics, 1989 to the Present* from 2008, edited by Scheffler and Potůček), formal and informal documents, relevant legal standards, strategies, policies and programmes (e.g. the Czech *National Psychiatric Programme* or the Slovak *National Programme on Mental Health*) and other available documents. Statistical data were obtained mainly from the Institute of Health Information and Statistics of the CR, the Public Health Authority of the Slovak Republic, and international comparisons are based on the World Health Organisation's (WHO') Mental Health Atlas (WHO 2005, 2011).

The CR and SR shared their history until 1992, but afterwards, they took different approaches towards the reforms in the area of mental health care. Therefore, we used the method of agreement (Karlas 2008) in our comparison. The selection of two entities and the comparison of a high number of instances allows us to see the problems in more detail and avoid excessive generalisation (Mills et al. 2006, Clasen 1999). The comparison looks at the period from 1989 to the present. We intended not only to describe the situation but also to explain the key events in the development of mental health care policies. That is why we chose the method of event analysis – so that instead of focusing on one selected event, we could methodically investigate all events within the relevant area and period of time (Purkrábek 1994). The method allowed us to observe all changes (or attempts at changes) made to the institutional setting, as well as the interaction between individual stakeholders in the area of mental health care in the CR and SR since 1989.

THEORETICAL FRAMEWORK

Our analysis of the development of mental health care policies in the CR and SR is provided within the framework of historical institutionalism (HI). We rely on this explanatory framework because the institutional setting of the area has been very stable for more than 25 years, despite all the changing internal and external conditions (Oliver & Mossialos 2005, Kümpers et al. 2006). This corresponds to the 'path dependency' theory which shows how previous political decisions limit the options for later ones because it is difficult to change political tendencies that became a part of the institutional structure and discourse. Although HI admits that the political process is occasionally disturbed by 'critical junctures' that make decision makers choose a particular institutional setting, after the choice is made, the selected alternative will limit future institutional changes because it is easier to follow the set direction than change it radically (Pierson 2000).

HI is one of the three streams of the so-called new institutionalism. It allows for the influence of time and history on the development of the political processes and decisions (Hay & Wincott 1998, Immergut 1998). In the context of HI, an institution means either a formal organisation or any informal rules or procedures that shape the structure of human actions (Steinmo & Thelen 1992). HI presumes that on one hand, institutions can substantially influence the creation and implementation of political strategies, while on the other hand, institutions themselves are products (either intentional or accidental) of the strategies created within the political struggle (Steinmo & Thelen 1992, Hay & Wincott 1998).

HI theorists explain the incremental changes in policies (that means, formal institutions) using five fundamental causal mechanisms: displacement, layering, drift, conversion and exhaustion. Displacement is a process in which the dominant institution is gradually replaced with a new alternative institution. The new institution consequently generates a discord within the institutional framework that opens the way for incongruent actions and gradual development of a new institutional logic. The new institution may come from suppressed historical alternatives or may coexist along the dominant institution or may be promoted by some external powerful actor. Layering is a process that adds a new, potentially transformative element in the old structure. It's a gradual process, usually the emergence of a new element does not provoke countermobilisation of defenders of the status quo. This may occur so that the new institution is growing faster and takes resources the old institution. The new arrangement can also destabilise an existing institution, and compromise between the old and the new institutions can gradually change in the defeat of the old one. Drift denotes the consequence of deliberate negligence – an institution that is required to adapt to new conditions (e.g. new demographic trends) deliberately chooses not to, and as a result, the institutional structure becomes outdated and it loses its meaning or functionality.

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Conversion occurs when old institutions are required to take up new functions or roles, when the reinterpretation of old rules serves to fulfil new goals. Finally, exhaustion denotes a gradual collapse of an institution that undermines itself (Streeck & Thelen 2005).

These five mechanisms show that institutions can be gradually transformed even when we can see only incremental, if any, changes. In their elaboration of this theory, Mahoney and Thelen considered the general prerequisites that increase the probability of success for particular kinds of strategies or changes. By doing this, they specified the analytical framework combining the characteristics of political context with the characteristics of the targeted institution. They assessed to what extent the political context allows the supporters of status quo to veto decisions and how much space for implementation of the changes is granted by the examined institutions (Mahoney & Thelen 2010).

KEY INDICATORS OF MENTAL HEALTH CARE IN THE CZECH REPUBLIC AND SLOVAK REPUBLIC

Within the European region, WHO estimates the mean share of mental health care expenses at 6% of the overall healthcare expenses (Jacob 2007 quoted by Dlouhý 2014). In this respect, both the CR with estimated 3% and SR estimated 5% rank among countries with considerably underfunded mental health care (Dlouhý 2014).[1]

In terms of the network of psychiatric facilities, SR started to develop community mental health centres in 2002 within the pilot project "Transformation and integration of mental health care system" (Potůček & Scheffler 2008), but since then, only a few other pilot centres emerged. CR has been unable to anchor community mental health centres firmly in its mental health care system (Raboch & Wenigová 2012). The CR has a higher number of day-care centres for people with mental illness and more outpatient psychiatric facilities per 100,000 inhabitants (Table 1). There is a critical shortage of day-care centres in the SR. According to experts from practice, crisis day-care centres with mobile teams, rehabilitation facilities and psychiatric home care are insufficiently available or unavailable in some regions (Bražinová et al. 2011). In terms of inpatient care, most psychiatric beds in the CR are in psychiatric hospitals, although the number has slightly decreased between 2005 and 2011 (Table 2). SR has seen a substantial drop in the number of beds in psychiatric hospitals, balanced with a growing number of beds in psychiatric departments of general hospitals (Table 2). Both countries differ significantly in terms of the average number of beds per institution. While the CR with its 502 beds places the highest of all EU countries (Winkler et al. 2013), SR's 182 beds per institution correspond to the EU average (193 beds per institution in EU 15 and 218 in EU 27) (WHO 2011 quoted by Winkler et al. 2013). In terms of human resources in mental health care, the CR has more psychiatrists, but both countries are below the average of the EU 15. Compared with the EU 15 and EU 27 average, both countries have significantly lower number of psychiatric nurses (Table 3).

TRANSFORMATION IN THE CZECH REPUBLIC AND SLOVAK REPUBLIC

In the period before the Velvet Revolution of 1989, the psychiatric care in former Czechoslovakia gradually moved from long-term care to the more efficient acute care. This was facilitated by the development in psychopharmacology and the growing number of physicians specialising in the area of mental health care. Between the years 1960 and 1989, the number of physicians in psychiatric hospitals increased by 60%, in psychiatric departments of general hospitals by 319% and in outpatient services by 479%. This might look like a favourable development in psychiatric care, but it can also be interpreted as a result of serious neglect of the psycho-social aspects of mental disorders and narrow focus on their medical aspects in that period. The upward trend in the number of psychiatrists corresponds to the increasing number of contacts with outpatient facilities (Potůček & Scheffler 2008: 33)

[1]Regarding the WHO data, used in this article, they should be interpreted with caution. WHO statistics do not show a significant difference in the quality of psychiatric beds in the monitored countries (Winkler et al. 2013). It is also necessary to take into account the varying reliability of the information that the states provide (Muijen 2008 quoted by Winkler et al. 2013).

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Tab.1: The number of psychiatric facilities per 100,000 inhabitants in 2011

	Outpatient care	Day-care centres	Community residential facilities	Psychiatric hospitals
Czech Republic	7.92	0.74	Unavailable data	0.18
Slovak Republic	6.39	0.33	4.93	0.17

Source: WHO 2011

Tab. 2: Number of psychiatric beds per 100,000 inhabitants in 2005 and 2011

	Year	Czech Republic	Slovak Republic	EU 27	EU 15
Beds in psychiatric hospitals	2005	98	60	68*	57*
	2011	92	31	62**	53***
Beds in psychiatric departments of general hospitals	2005	15	30	23****	26****
	2011	13	38	24*****	24****

Source: WHO (2005, 2011), quoted by Winkler et al. 2013
** Except for Denmark, the United Kingdom and Sweden. ** Except for Denmark, the United Kingdom, Sweden, Italy, Estonia and Hungary. *** Except for Denmark, the United Kingdom, Sweden and Italy. **** Except for Denmark and United Kingdom. ***** Except for Denmark, the United Kingdom, Estonia and Lithuania.*

Tab. 3: Number of psychiatrists and psychiatric nurses per 100,000 inhabitants

	Year	Czech Republic	Slovak Republic	EU 27	EU 15
Psychiatrists	2005	12	10	11*	13*
	2011	12	11	12**	14**
Psychiatric nurses	2005	33	32	47***	60**
	2011	28	19	42****	57*****

Source: WHO (2005, 2011), quoted by Winkler et al. 2013
** Except for United Kingdom. ** Except for Belgium and the United Kingdom. *** Except for Belgium, the United Kingdom and Estonia. **** Except for the United Kingdom, Belgium, Luxembourg, Denmark, Greece, Finland, Austria, Estonia, Lithuania and Bulgaria. ***** Except for the United Kingdom, Belgium, Luxembourg, Denmark, Greece, Finland and Austria.*

As of[1] January 1993, Czechoslovakia split into two independent states. The new countries adopted the basic international human rights documents in 1992. The CR endorsed the Charter of Fundamental Rights and Basic Freedoms – in terms of mental health care, the most relevant articles are those about freedom and equality, dignity, rights, and protection of health for everyone, as well as protection against torture and inhumane or humiliating treatment. The SR incorporated stipulations on fundamental rights and freedoms into the new Constitution which says that nobody is to be tortured or subject to any similar cruel, inhumane or humiliating treatment or punishment, and everybody has the right to dignity, personal honour, good reputation and respect. In the early 1990s, both countries switched from the Semashko model of health care delivery (centralised and fully funded by the state) to the health insurance system (with the compulsory health insurance and partial liberalisation of the ownership of health care facilities). In the following years, the CR focused on the economic and political transformation and neglected most other areas, including mental health care; while SR made the first steps of mental health care reform already in 1991 (see below).

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THE DEVELOPMENT OF MENTAL HEALTH CARE IN THE CZECH REPUBLIC

The new Framework of Psychiatry

An informal work group was appointed in 1992 to create the *Framework of Psychiatry*. In 1995, the group was officially confirmed by the Committee of the Psychiatric Association as the Commission for the Creation of a Draft Framework of Psychiatry. The Psychiatric Association endorsed the Framework proposed by the Commission in 2000, and in 2002, the new *Framework of Psychiatry* was acknowledged by the Scientific Council of the Czech Ministry of Health. The *Framework* proposed to shift the acute psychiatric care from mental hospitals to psychiatric departments of general hospitals. Consequently, the number of beds in both types of facilities was to be reduced, and patients were to be preferably placed in home care or community mental health centres. The number of beds gradually decreased, but there was no transfer of the acute care to psychiatric departments and the community services where not developed (Raboch & Wenigová 2012). The *Framework* also tackled the problems of several vulnerable groups (the elderly, children and youth, persons with addiction, people with chronic diseases, people with eating disorders, and criminals with mental illness). The *Framework* identified the essential problems and included a list of goals, but failed to specify methods of implementation and distribute responsibilities (*Framework of Psychiatry* 2000). Two years later (responding to a constant pressure from the Centre for Mental Health Care Development (CMHCD)), the Ministry of Health decided to support the implementation of the *Framework* by appointing the Implementation Committee which included representatives of all the segments of mental health care, the Psychiatric Association, CMHD and, representatives of psychiatric patients and their families. The Implementation Committee was authorised to propose specific methods and processes of implementation. Within the workshop called *Does our Level of Mental Health Care Match the EU?* held in the Chamber of Deputies of the Czech Parliament in 2004, the *Framework* was discussed by numerous specialists and politicians, both local and international. In 2005, several members of the Implementation Committee published a document titled *Mental Health Care Policy – Roads to Implementation* (Centre for Mental Health Care Develpment… 2005). The document offered three alternatives of the reform: (1) diversification of services provided in psychiatric hospitals (in order to maintain the capacity and staff of the hospitals while lowering the number of hospitalised patients, (2) closing of selected departments in psychiatric hospital, (3) closing of selected psychiatric hospitals. The authors of the document clearly stated that any changes in the field of mental health care depend on multilevel coordination of policies and the existence of '"political will"' supported by a clear vision. Authors believed that the reform should be supported by active lobbying (especially by experts in psychiatry) both at the regional and national levels. The implementation was to draw from intense negotiations with other stakeholders (e.g. health insurers, care providers), extensive public discussion which could effectuate a change in the general attitude towards psychiatry and people with mental illness, and a shift of responsibilities from the Implementation Committee to the national government (Centre for Mental Health Care Develpment… 2005). These goals, however, remained unfulfilled, and the Implementation Committee was dissolved by the Minister of Health Tomáš Julínek (2006–2009).

Implementation of the Health 21 strategy in the field of mental health

WHO's *Health 21 strategy* tackles a wide scale of health aspects. One of its goals concerns a complete transformation of the mental health care system, including the transfer of a large part of psychiatric care from psychiatric hospitals to psychiatric departments in general hospitals, home care and field mental health centres. The goal was acknowledged by the government of Vladimír Špidla which set the '"Health 21"' Committee within the Czech Government's Health and Environment Committee. This tool, however, proved entirely inefficient, and the Committee carried out only a formal evaluation of the programme. The programme was not legally binding and no funds were allocated to its implementation (Kříž 2013).

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The National Psychiatric Programme of 2007

In reaction to the negligible effect of all the actions taken since 2000, the Committee of the Psychiatric Association decided to publish a new strategic document in 2007. The *National Psychiatric Programme* was created in collaboration with the regional WHO office and it responded to two important WHO and EU documents of 2005 – WHO's *Mental Health Action Plan for Europe* and the EU Commission's *Green Paper*. The publication of the *National Psychiatric Programme of 2007* was supported by a workshop held in the Senate of the Czech parliament under the patronage of its chairman. The document focused on the support of the primary psychiatric care, development of community care, innovation of inpatient facilities, and encouragement of the bio-psycho-social model combining pharmacotherapy, psychotherapy and social intervention. The programme listed general goals and tasks, but failed to tackle the question of implementation and responsibilities (*National Psychiatric Programme* 2007).

The Revised Framework of Psychiatry of 2008

The work on the review of the *Framework of Psychiatry* began in 2006, partly in response to the dissolution of the Implementation Committee by the Minister of Health Tomáš Julínek. The Congress of the Psychiatric Association appointed the Commission for the Revision of the *Framework of Psychiatry*. Before it started to work on the review, the Commission asked all mental health care providers to submit their own proposals for changes. In 2008, the Congress of the Psychiatric Association endorsed the *Revised Framework of Psychiatry*. The *Revised Framework* describes all the segments of mental health care and assesses their needs. It advocates the model of balanced care (in Czech environment, this refers mainly to the strengthening of community care). The Psychiatric Association published the document on its website and allowed an online discussion. Unfortunately, the *Revised Framework* does not specify intended methods and timeline of implementation (*Revised Framework of Psychiatry* 2008).

The current strategy for the reform of mental health care in the Czech Republic

The creation of the current reform strategy began in late 2012 by the decision of the Czech Minister of Health. The *Psychiatric Care Reform Strategy* (PCRS) (Ministry of Health 2013) addresses the problems identified in the *Revised Framework of Psychiatry* of 2008 and responds to earlier strategic documents, as well as many international documents, primarily the UN *Convention on the Rights of Persons with Disabilities* of 2008, which was ratified by the Czech Parliament and the President of the Czech Republic, incorporated in the Czech legal system, and the *European Mental Health Action Plan* (2013), a guideline for the creation of national mental health policies, endorsed and ratified by WHO (Hollý 2014).

Adopted as part of the *National Reform Programme* in March 2013 (Ministry of Health 2013), PCRS specifies the basic assumptions and lists the consensual proposals for changes in the psychiatric care system for the next decade (Hollý 2014). Unlike earlier documents, PCRS was co-authored by a vast majority of key stakeholders: the Ministry of Health, the Ministry of Social Affairs, health insurers, professional associations, representatives of healthcare facilities, the Association of Regions in the Czech Republic, patients and non-governmental organisations (NGOs) (Duškov 2013, Ministry of Health 2013). The implementation plan of PCRS assumes a close collaboration between various stakeholders, especially the Ministry of Health and the Ministry of Social Affairs. Since the funding of social services will be governed by regional authorities as of 2015, the implementation also includes cooperation with the Association of Regions in the Czech Republic (Ministry of Health 2013). Because various aspects of mental health care relate to the responsibilities of other authorities, such as the Ministry of Regional Development (sheltered and supported housing), the Ministry of Justice (detention), the Ministry of the Interior (education of the police, involuntary treatment assistance), the Ministry of Culture (the Council for Radio and Television Broadcasting, control of mental illness connotations in public media, education), the Ministry of Finance (incentives for employers of people with mental illness) etc., the later stages of PCRS implementation is expected to be managed on the level of the Government, with the Ministry of Health coordinating the individual processes (Duškov 2013).

The transitory costs (i.e. the costs of the modifications to the structure of the system) are planned to be partly covered from the European Structural and Investment Fund (Duškov 2013). The costs of other individual steps in the process will be determined based on the economic analyses (Ministry of Health 2013). The funding will require an agreement with public health insurers (Hollý 2014).

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The central objective of the *Psychiatric Care Reform Strategy* is to improve the quality of life for people with mental illness. To do this, it will be necessary to:

- improve the quality of psychiatric care through a methodical change of the mental health care system;
- moderate the stigmatization of psychiatric patients and the field of psychiatry in general;
- improve the satisfaction of patients with the provided psychiatric care;
- increase the efficiency of psychiatric care via early diagnosis and pro-active identification of hidden cases of mental disorders;
- support the integration of people with mental illness in the society (especially through better employment conditions, education, housing, etc.);
- improve the communication between healthcare and social services and other related services;
- make the psychiatric care in the CR more humane. (Ministry of Health 2013)

Finally, the fulfilment of the aforesaid goals should result in a complex change to the Czech system and shift the general character of the system from the current institutional model towards an arrangement that balances community and hospital care (Hollý 2014). The most dramatic change to the current system concerns the establishment of complete new institutions – Mental Health Centres (MHC), facilities located in ordinary residential areas that provide complex healthcare and social services to clients with a serious mental illness (SMI). MHCs are intended to help people with mental illness to live in their homes and community. MHCs should employ interdisciplinary teams that are able to respond to the complex needs of their clients and procure-related services within the region. These facilities should also collaborate with other providers of healthcare and social care services (Hollý 2014).
Unlike earlier attempts, the authors of the PCRS aspire to systematically create a comprehensive implementation plan and detailing individual steps in each area of the reform. At present, several work groups are discussing various aspects of the document's implementation (Ministry of Health 2013).

There are still several questions that need to be solved in relation to the new institutions: Who will run MHCs? Big hospitals, experienced NGOs or newly established institutions? The new system needs to secure stable financial resources because the funding from ESIF only concerns the reform itself, and after the reform has been finished, the newly created system should fully depend on national resources (Třešňák 2014). Furthermore, up to now, deinstitutionalisation and reduction of the number of beds in mental hospitals is not specified. PCRS plans to carry out economic analyses in order to assess the future costs of the new system which will be the basis for the creation of a new model of psychiatric care funding (Ministry of Health 2013).

Unlike the international academic and political discourse (WHO, EU), the field of mental health promotion and protection as specified in the *National Strategy for Health Protection, Health Promotion and Disease Prevention –- Health 2020* is rather marginalised in the before mentioned reform attempts of mental health care.

THE DEVELOPMENT OF MENTAL HEALTH CARE IN THE SLOVAK REPUBLIC

Reform of Psychiatric Care

In 1990, a group of experts from the fields of psychiatry and psychology prepared a document titled *Reform of Psychiatric Care*, which was endorsed by the Slovak Ministry of Health in 1991. The suggestions conveyed in the document were later used in the creation of the *Framework of Psychiatry*, published in 1997. Unfortunately, the Ministry never gave the *Framework* an official status and the document served merely as a source of inspiration, especially with respect to the need for greater role of the community care within the system. Although there was some increase in the overall number of outpatient psychiatrists and the accessibility of outpatient psychiatric services in some critical regions improved in the years following the publication of the *Framework*, it could not match the steep rise in the number of psychiatric patients (Breier 2005, *Framework of Psychiatry 1997*).

Neither the *Framework of Psychiatry* nor the *Reform of Psychiatric Care* specified the timeline of implementation, the distribution of responsibilities or any proposal for funding, which led to the failure of their implementation and the continuing absence of a national mental health care policy (*National Programme on Mental Health* 2004).

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2004 – National Programme on Mental Health

At the time of SR's entry into the EU, the country went through extensive reforms of the healthcare[2] and social systems, creating completely new socio-economic conditions. At the same time, the country experienced a steep rise in the rate of certain somatic conditions and there was an urgent need for the prevention of mental disorders. All this led to the creation of the Slovak *National Programme on Mental Health* which reflected the economic and social situation of the country, its cultural heritage, demographic specificities and the desired development of the society.

The Slovak Government approved the *National Programme on Mental Health* in 2004, with the following goals for the period 2005–2015: to reduce the stigma associated with mental illness; to establish homecare agencies; to set up intervention services and mental health programmes; to improve the general availability of prevention (primary, secondary and tertiary); promotion of mental health; active participation of people with mental illness and their families in the planning; to implement execution and evaluation of mental health care processes; adequate funding and authorisation of mental health care providers. The goals of the programme respond to the dialogue between EU Member States and the EC (*Green Paper on Mental Health*) and their further development is discussed in several EU documents. The Slovak Ministry of Health adopted several strategic documents concerning mental health care and drug addiction treatment in 2006 (European Observatory on Health System and Policies … 2011).

Unlike the *Framework of Psychiatry* and the *Reform of Psychiatric Care*, the *National Programme on Mental Health* was accompanied with a comprehensive implementation plan, including a detailed timeline, distribution of responsibilities and proposal of methods of funding. The plan was prepared in collaboration with various stakeholders. The key principles include decentralisation, demand-oriented management and patient-oriented design of services (National Programme on Mental Health 2004). The general plan for the decade 2005–-2015 is supplemented with plans for shorter periods of two or three years which allows to more detailed specification of individual tasks for each year (Ministry of Health 2015).

Implementation plans of the National Programme on Mental Health for the period 2006–2007

The implementation plan for the period 2006–2007 included a number of particular tasks, e.g. to define the optimum and minimum network of mental health care facilities in the regions, to establish health-social departments in the psychiatric inpatient facilities, to develop the concept of the establishment of psychiatric home care and, to create the regional plans of mental health care in selected regions. Majority of the 54 tasks were fulfilled. (Ministry of Health 2015)

Implementation plans of the National Programme on Mental Health for the period 2008–2010

The main priority of the plan for the period 2008–2010 was to improve the mental health of the general population, reduce the incidence of mental disorders, and cut the mortality rates related to mental disorders. The proposed tasks included activities in various areas of psychological intervention in all age groups and related to the prevention of mental disorders and elimination of their most frequent causes; improvement of the conditions for psychosocial well-being; and improvement of people's ability to manage stressful situations that might lead to mental disorders. Their implementation involved complex solutions requiring the contribution and participation of various ministries, NGOs, regional authorities and associations (Meeting of the Slovak Government 2008). The institutional framework was selected carefully to maintain the stability and development of mental health policies. The individual steps of the implementation of the *National Programme on Mental Health* were approved by government decrees (ibid 2008).

[2]The reform of the Slovak healthcare system in the period 2002–2006, launched by the government of Mikulas Dzurinda, is generally considered the most radical market-driven reform that was ever seen in Europe. The concept of the reform is regarded as globally unique. The healthcare reform was a part of a larger reform plan labelled 'Slovak Republic's neoliberal turn' (European Observatory on Health Systems and Policies 2011).

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Implementation plans of the National Programme on Mental Health for the periods 2011–2013 and 2014–2015

The plan for the period 2011–2013 focused on youths' mental health education, prevention of depressions and suicides, protection of mental health at work and within the society, but it also addressed the questions of mental health amongst older adults and proposed actions against stigmatisation and social exclusion. These tasks responded to the EU Council's *Conclusions on the European Pact for Mental Health and Well-being* (2011/C202/01), published in the *Official Journal of the European Union* on 8 July 2011 (Meeting of the Slovak Government 2012a, Meeting of the Slovak Government 2012b).

The implementation of the *National Programme on Mental Health* in the period 2014–2015 focused on various projects of mental health support, prevention of risk behaviour, encouragement of social integration of people with serious physical or mental health illness or behavioural disorders and creating conditions for better accessibility of high-quality social services for people with mental illness. The objective is to provide services that respect the individual needs of the clients and minimise the need for institutional care (Ministry of Justice 2013).

In the period 2011–2013, the implementation of the National Programme on Mental Health was hindered by insufficient funding. The allocated funds could not cover the planned activities (Ministry of Justice 2013). Activities planned for the period 2014–2015 have already had financial support (Ministry of Health 2015).

2007 – The establishment of the Council for Mental Health

The Council for Mental Health was established in 2007 as an advisory body to the Slovak Ministry of Health. Its tasks are related to the creation and implementation of the *National Programme on Mental Health*. The Council is an interdisciplinary body – the individual members are appointed by ministries and other governmental institutions, NGOs and regional authorities and associations, and their appointment is confirmed by the Ministry of Health. The Council monitors, coordinates and evaluates the fulfilment of individual tasks and analyses the overall success of the *National Programme on Mental Health*. Beside this governmental body, there are numerous NGOs that influence the creation of the mental health policy, especially by raising the general awareness of various aspects of mental health. These organisations, however, are less likely to influence the allocation of resources (Dlouhý 2010).

DISCUSSION AND CONCLUSIONS

The CR and SR still struggle with the burden of the totalitarian regime. Even 25 years after the Velvet Revolution, there are serious deficiencies in the social and economic area, including health care in general and mental health care in particular. After 1990, both countries started to develop new mental health policies (Table 4), but because of a long tradition of care concentrated into large psychiatric hospitals (i.e. the influence of the path dependency) neither has managed a thorough reform of the mental health care system. The crucial event for both countries was their joining of the EU in 2004 and the subsequent adoption of WHO and EU documents of 2005 – WHO's *Mental Health Action Plan for Europe* and the EU Commission's *Green Paper on Promoting the Mental Health of the Population* – which propose to shift national policies towards deinstitutionalisation of mental health care, and their incorporation into the national policy frameworks.

SR was the first to adopt changes to the mental health care institutional framework. In terms of the theoretical concept of HI, it was an attempt to change the mental health care policy by incorporation of new elements into the existing system (layering). The mental health care policy in SR was most notably influenced by the *National Programme on Mental Health* adopted by the Slovak Government in 2004. The programme includes a comprehensive plan of implementation, detailed timeline, distribution of responsibilities between individual stakeholders and proposals for a funding framework. The development in SR was considerably furthered by the Council for Mental Health of the Slovak Ministry of Health established in 2007. The Council monitors, coordinates and evaluates the fulfilment of individual tasks within the *National Programme on Mental Health* and analyses its overall success. The plans for the implementation of the National Programme and the assessment of its fulfilment are overseen by the Slovak Government. The central problem of the implementation lies in insufficient funding.

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Tab. 4: Key events in the development of mental health policies in the CR and SR

Czech Republic		Slovak Republic	
1992–2000	Informal work group was appointed in 1992 to create the Framework of Psychiatry. The Framework of Psychiatry was published by the Psychiatric Association in 2000	1991	A document titled Reform of Psychiatric Care was endorsed by the Slovak Ministry of Health
2002	The national strategy Health 21 was acknowledged by the Czech Government; the Framework of Psychiatry was acknowledged by the Scientific Council of the Czech Ministry of Health	1997	The Framework of Psychiatry was published
2004	The Ministry of Health appointed the Framework of Psychiatry Implementation Committee	2004	The Slovak Government approved the National Programme on Mental Health.
2005	Several members of the Implementation Committee published a document titled *Mental Health Care Policy – Roads to Implementation*	2005	The Slovak Government adopted the National Programme on Mental Health implementation plans for 2005–2015. The general plan was divided into shorter periods of two or three years The National Programme on Mental Health for the period 2006–2007
2007	The National Psychiatric Programme was created by the Committee of the Psychiatric Association in collaboration with the regional WHO office	2007	The Council for Mental Health was established as an advisory body to the Slovak Ministry of Health
2008	The Congress of the Psychiatric Association endorsed the Revised Framework of Psychiatry	2007	The National Programme on Mental Health for the period 2008–2010
2012	The Czech Minister of Health established a team to produce a new Psychiatric Care Reform Strategy	2010	The National Programme on Mental Health for the period 2011–2013
2013	The Psychiatric Care Reform Strategy was adopted as a part of the National Reform Programme	2013	The National Programme on Mental Health for the period 2014–2015

Source: Authors

Professional associations together with providers and users of mental health care in the CR have created numerous strategic documents that described the current state, identified the key problems and defined the essential goals but failed to address the question of implementation. The documents were intended to serve as an expert background for political decisions but were largely neglected by politicians. In 2013, the Czech Ministry of Health created the *Psychiatric Care Reform Strategy*, including a plan of implementation, outline of the individual steps, and proposals for a funding framework. The key aim of the reform is to incorporate a new model of care – the aforementioned mental health centres – into the existing system. It is assumed that these centres will gradually become a key element of the mental health care system and contribute to its transformation from current model based on inpatient care towards the balanced care model (an arrangement that balances community and inpatient care). Similarly to the SR, the Czech policy makers are also trying to change the existing system through the mechanism of layering. The theory presupposes that a careful incorporation of a new institutional element into an existing system might successfully change the old institutional structure under the proviso that the new element does not threaten the existing institutional regime (and, hence, does not provoke counteraction of defenders of the status quo). It is probably the case of the Czech approach towards the reform, because the exact form of deinstitutionalisation (i.e. a reduction of beds in inpatient facilities) is still not properly scheduled. Although the current reform document was created in close cooperation with all relevant stakeholders, the interdisciplinary character of the proposed reform will make it necessary to have the reform managed on the level of the Government. In order to secure the funding of the new institutional framework, it will be vital to create new mechanisms of sustainable funding. As the document concentrates on the reform of the system of psychiatric care

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institutions and pays little attention to the need for prevention and mental health promotion, the Czech Government will need to follow the example of the Slovak Government and adopt a complex national programme on mental health.

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