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Cent. Eur. J. Public Policy 2019; 13(2): 15–27
DOI: 10.2478/cejpp-2019-0007

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Decision Making in Psychiatric Reform: A Case Study of the Czech Experience

ABSTRACT: *This study examines the initial impact of a broadly participatory planning process in the Czech Republic during 2016–2017, aimed at both reducing inpatient care and expanding community mental health systems, on policy and programmatic decision making. A central focus of the study involves the trade-offs between and efforts to integrate shared decision making with evidence-based planning methods within the context of a national psychiatric reform strategy, particularly one involving a former Soviet bloc state.*

Given the uniqueness of the Czech experience, an exploratory case study methodology is used, one involving ten interviews with key informants and examination of a wide variety of documents. Results include the development of broad new decision and oversight structures, and the initial implementation of community mental health services. The nation faces some of the same trade-offs found elsewhere, such as in the United States, between an inclusive participatory process, and one that systematically incorporates empirical rational and evidence and best practices within bounded parameters.

Implications for new psychiatric deinstitutionalization initiatives are identified, including development of a national mental health authority, a professional workforce, new funding strategies, multi-level service coordination, mechanisms to assure transparency, among others.

KEYWORDS: Psychiatric reform; psychiatric deinstitutionalization; community mental health; participatory decision making; policy development; bounded rationality

RECEIVED 14 April 2019; **ACCEPTED** 31 July 2019.

INTRODUCTION

Because of the increasing attention to global mental health policy issues, especially psychiatric deinstitutionalization and mental health system development, there have been numerous national efforts to update mental health programmes through psychiatric reform initiatives (Shen & Snowden, 2014). This has been particularly the case in the former soviet bloc nations (Dobiasova, et al., 2016; Tomov, Van Voren, & Keukens, 2007) such as the Czech Republic, which have been working to overcome many years of over reliance on institutional care and neglect of community support services (Dlouhy, 2014; Dlouhy, & Bartak, 2013). These efforts have faced numerous challenges such as the need to balance the multiple lines of economic and social development, and to overcome the effects of entrenched professional and institutional interests, as well as the post-communist syndrome (Klicperová-Baker, 2010).

In the Czech Republic, a major reform initiative, supported by the European Union's Structural Funds (ESF) programme, has focused on the reform of decision-making processes, and thus, key questions addressed in this research involve the current and envisioned systems for allocating and planning public mental health resource deployment, and the strategy for its reform. A central issue involves the ways that government officials have navigated the complex tradeoffs between expanded stakeholder participation in decision-making and a commitment to professionalize and utilize systematic and empirically-based methods. The research undertaken and reported here has utilized a case study methodology to examine decision-making procedures used in their psychiatric reform initiative. It has focused on the initial period of implementation of the psychiatric reform, from 2016 through 2017, in the context of various preliminary initiatives. While the scope of this research involves publicly supported mental health services, these also include various private NGOs involved with the current efforts. Prior to a review of the initial results, this article will now turn to a discussion of the most pertinent theoretical and historical context of this initiative.

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BACKGROUND

Theoretical Perspective. A central issue in mental health policy has involved debates over the deinstitutionalization of psychiatric care, about the role of psychiatric inpatient care in the systems of mental health care (Hudson, 2016). These debates have been largely ideological, however, an emerging perspective is that decisions on the deployment of mental health resources should aim at a balanced system of care that is guided by the best available evidence. Despite this, the extensive body of research on policy, administrative, and professional decision making has been largely ignored. This may be because traditional models of decision-making, such as what is known as the rational-comprehensive model, are highly rationalistic, and assume a consensus among stakeholders on goals and an ability to identify alternative means for achieving them and predicting their success, all assumptions that can rarely be met in most fields. For this reason, a variety of alternatives to this baseline rationalistic model have been proposed since the mid-twentieth century. These include Lindlom's incremental decision making model (1959), Simon's bounded-rationality (1991), Etzioni's mixed scanning (1967), and more recently models involving naturalistic decision making on the part of professionals (see Klein, 1997). One of the themes underlying many of these approaches has been the need to expand the range of goals and improve the search for alternative means to be considered, and to introduce appropriate constraints to simplify the search process. Yet, this interest potentially conflicts with the need to base decisions on the best available scientific evidence and professional approaches to decision making. Trade-offs, whether or not they have been necessary, between these considerations have in fact been observed in a variety of studies (Hudson, 1992).

Efforts to improve public health programmes have historically involved a number of strategies that have been extensively reviewed elsewhere. Most notable is the review of Pallasa et al. (2012) of 181 studies that identified seven broad strategic areas of change: standards and guidelines; organizational structure and governance; human resource knowledge and skill; process re-engineering and technology development; use of incentives; organizational culture; and leadership and management. Their identification of the pros and cons of such approaches form the basis for their arguing for a prescriptive model for the selection of optimal strategies that is contingent on the answers to questions involving an analysis of the causes of performance deficits, feasibility and environmental fit, use of best practices, and organizational capability. Several of these involve the decentralization of decision making, which is a strategy that is increasingly used in contexts involving professional services. Decentralization often accompanies psychiatric deinstitutionalization and typically involves an expansion in the range of stakeholders such as community agencies, professionals, consumers, and families of the mentally ill who seek to influence the service delivery system.

In contrast, Bossert (1998) specifically reviewed research on decentralization in health care in developing nations. He draws on the traditional typology of types of decentralization used in public administration, which include deconcentration, delegation, devolution, and privatization, and focuses on the use of principle agent theory from econometrics, most commonly involving the application of financial incentives as a means for central public health administrations to retain some control over peripheral units or organizations within a newly decentralized service system.

Much of the existent theory and research suggests that integrally connected with the success of deinstitutionalization initiatives is the ability of a nation's mental health authority, such as a ministry of health, to navigate the complexities and tradeoffs involved in shared decision making under an increasingly decentralized structure. Within the mental health field, increasing attention has been paid to incorporating various models of shared decision making as a means of assuring maximal responsiveness to the needs of diverse constituencies (see Ramon, Zisman-Ilani, & Kaminskiy, 2017). One such initiative, involving psychiatric reform and shared decision making, is that of the Czech Republic, one that has faced challenges inherent in its transition from communism that began in 1989, a subject to which we will now turn.

The Transition from Communism. In 1989, citizens of the former Czechoslovakian nation mobilized and peacefully overthrew the communist dictatorship in what has come to be known as the Velvet Revolution. Then, in 1993, the Slovakia region of Czechoslovakia formed its own nation, leaving the current state of the Czech Republic. In 1999, the Czech Republic was admitted to NATO, and in 2003, to the European Union. This transition saw the development of a market economy, with the Czech Republic being recognized as one of the most developed industrialized economies among the newer European Union member states (Alexa et al., 2015). Over the succeeding years, the government transitioned to that of a unitary parliamentary constitutional republic, with democratic-socialist leanings, and with a bicameral parliament, independent judiciary, and both a prime minister and president. Reform and modernization of governmental structures led to the *Act on Regions 129/2000* that devolved many governmental responsibilities to 14 newly formed regions that have been delegated authority in matters related to health care, social services, and various other areas.

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The Czech Republic provides its citizens and residents with a wide range of health and social service benefits (see Nemic, Pavlik, Maly, & Kotherova, 2015). After the Velvet Revolution, the nation reformed the financing of its healthcare system, changing from reliance on taxation to payroll deductions for the funding through seven quasi-public insurance funds which cover virtually all of the population. By 2012, approximately 7.7% of its GDP was devoted to healthcare, below the EU average of 9.6%. This compulsory system, funded from employee deductions and governmental contributions for those not in the labor force, provides for a wide range of inpatient and outpatient benefits, and is overseen by a Ministry of Health. These services are supplemented by various social services, funded through the *Act on Social Services* in 2006 which was enacted with the aim of enhancing the coordination between the health and social service systems, partly by means of flexible care allowances that permit cross-funding of services between the two systems. Yet, many issues remain in the coordination between these systems, including transfer of patients between social care and healthcare facilities, given significant financial incentives for patients to try to stay in health-care facilities, including psychiatric hospitals, even if it is not required by their medical condition (Alexa et al., 2015).

As a former soviet bloc nation, the development of health and social services in the Czech Republic has also confronted and perhaps been delayed by what has been proposed to be a post-communist syndrome, or a propensity for citizens to excessively rely on central authorities for solutions, a scarcity of community organizations, and a minimally developed civic life. This syndrome has been defined as a lack of concept of the citizenship, a lack of identification with the community and withdrawal into the family (Klicperova, Feierabend, & Hofstetter, 1997). Patients were not encouraged to take responsibility of their own health because a sense of personal responsibility and autonomy was not desirable under a totalitarian regime (Srnec & Klicperova-Baker, 1999). Some have emphasized the potential complications that this syndrome poses for reform efforts that assume active involvement of mental health stakeholders (Klicperová-Baker, 2010). However, there has been another research within the Czech Republic that indicates that as early as the late 1990s, this tendency may not be as strong as some have believed, if even present (Klicperová, Feierabend, & Hofstetter, 1997; Petrescu, 2019).

Psychiatric Deinstitutionalization and Initial Reform Initiatives (1990–2012). There is a long-standing recognition within the Czech Republic that its mental health system has been overly reliant on institutional inpatient care (Vevera, 2008; Dlouhy, Cosoveanu, Cizarik, & Hinkov, 2015). It employs a system of 18 public psychiatric hospitals that by 2015 provided 8,833 beds, supplemented by 1,308 acute beds in psychiatric units of general hospitals (see ***Figure 1***). Its psychiatric hospitals are among the largest in Europe, most notably Bohnice Hospital in Prague with 1,360 beds. Between 1990 and 2015, the reduction in inpatient psychiatric beds has been 30%, modest by European standards. Whereas Europe as a whole provided 66.6 beds per 100,000 in 2014, the rate in the Czech Republic that year was 94.1 (computed from WHO Data). This pattern is also supported by a comparative international study that showed that the Czech Republic is one of the few nations that has a significantly higher rate of psychiatric hospitalization than is needed (Hudson, in press). Despite its high rates of hospitalization, the Czech Republic spends only 3.0% of its public health budget on mental health, compared with 6.0% for Europe as a whole (Minutes, Czech Psych Society, Feb. 3, 2016).

Given the now well established patterns of institutionalization in both psychiatric and social services in the Czech Republic that are largely a relic of the communist era, there have been several initiatives since the Velvet Revolution to reform psychiatric care, ones that the Centre for Mental Health Care Development and the Psychiatric Society of the Czech Medical Association (initially through its Section of Social Psychiatry) have played key leadership roles in. In 1992, an informal working group was created that formulated the Framework of Psychiatry (2000). By 2002 this was adopted as a policy statement by the Scientific Council of the Czech Ministry of Health, and came to be known as the National Health Strategy. In 2004, the Ministry formed an implementation committee which published a new report, *Mental Health Care Policy: Roads to Implementation*, largely prepared by the Centre for Mental Health Care Development. This report subsequently led to the *National Psychiatric Programme*, which in 2013 resulted in *The Psychiatric Care Reform Strategy*. These initial efforts unfortunately never gained traction for a variety of reasons, including lack of specific funding and administrative mechanisms, lack of specified milestones, and inadequate adoption by a broad range of inpatient and community stakeholders.

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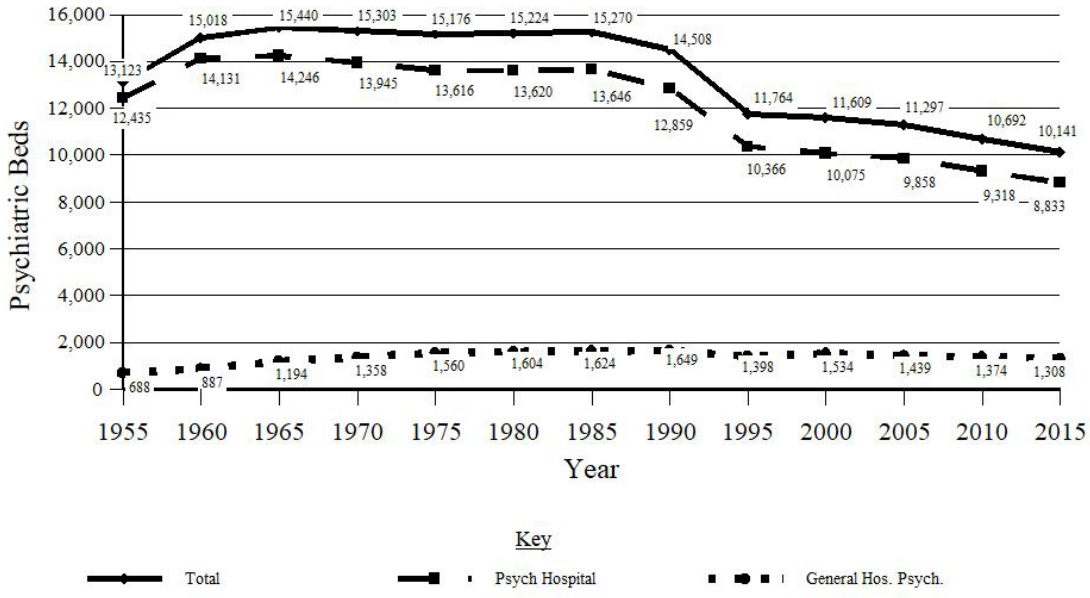
Fig. 1: Trends in Psychiatric Inpatient Care, 1955 to 2015



Source: IHIS (1959–2016)

Current Reform Initiative. The current initiative dates back to October of 2012 when the Czech Minister of Health released the Psychiatric Care Reform Strategy. There had been a widespread recognition that the then current governmental structures, including those for mental health, were overdue for reform (Ochrana, Placek, & Pucek, 2016). The plan proposed at that time emphasized the development of a system of community mental health centers, each which would cover a catchment area of approximately 100,000 persons. It included specific provisions to address the criticisms of the earlier efforts, including lack of financing and administrative plans. The following year, this plan was updated as *Strategy for Reform of Mental Health Care* in 2013.

Most important, it was announced that the initial implementation of the plans would be funded by the European Union's Structural and Investment Funds (ESIF), which included two major components. The Integrated Regional Operational Programme (IROP) would focus on developing the physical infrastructure for both improved hospitals and community clinics, and this would allow for an investment of 2 billion Czech Crowns ($95,880,000). In addition, the Operational Programme Employment would provide 1.35 billion Crowns ($49,586,850) for various wages and operating expenses involving the reform, specifically, those associated with nine projects involving strategy and methodology; network development; humanization of psychiatric care; destigmatization and communication; education and research; legislative changes; interdepartmental cooperation; and prevention. The plan called for the European Union funding to cover approximately 80% of the costs for the initial four years (2017–2021) of the initiative, which is also scheduled to include a second phase from 2021–2035. While improvements in inpatient care are included in the plan, the major emphasis is on the development of the system of community mental health centers, which will be organized around multi-disciplinary community outreach teams, to be supplemented by outpatient, emergency, daytime services, and mobile services, all provided within the context of a balanced and recovery-oriented system of services.

While the outlines of the plan were announced in 2013, it was not until late 2015 that specific arrangements were finalized to begin the initial implementation over the 2016–2017 period. Despite the earlier abortive reform efforts, the current initiative is beginning to be implemented, with new decision-making structures, more detailed plans, and start-up funding. Perhaps one of the most important developments setting the stage for the current initiative was a policy statement, known as the Platform for Deinstitutionalization, which was formulated by a coalition of community mental health groups, and received endorsement by a Czech municipal court in 2017. This brief policy statement defined overarching principles and mandated the development of a community mental health service system in the Czech Republic.

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Research Questions. This study examines the initial period of implementation, 2016–2017. It focuses on changes in decision making during this period, specifically, it addresses the following questions:

1. How have decisions been made in the allocation of public resources for mental health care, to psychiatric hospitals and community mental health programmes, through planning, budgeting, and other management processes? How has this process changed during the initial period of implementation?
2. What are the main principles that have been used to guide the decision making process as it involves the problem of developing a balanced mental health service system?
3. What types of data have been collected and how have they been used in allocative decision making in mental health?
4. What administrative and research methods have been used to support the decision-making process?

METHODS

This study investigates the foregoing questions through an exploratory policy case study, one that employs mixed qualitative and quantitative methods of data collection. Specifically, it draws on a series of interviews with key informants, supplemented by analysis of documents and existing statistical sources. The scope of the study primarily encompasses the Czech nation's public mental health programme, including contracted services involving outpatient, day programmes, psychiatric clubhouses, emergency, residential services, and other community programmes. It examines the consensus building, decision making, planning, and implementation activities carried out over the two years of 2016 and 2017, in the context of the longer-term preparatory activities carried out over the preceding two decades. Data collection for this study was undertaken after review and approval by the human subject's committees at both Salem State University (8/2017) and Charles University (9/2017).

Ten key informants in the Czech Republic were interviewed in the Fall of 2017. A semi-structured interview schedule of approximately an hour in length was used. All interviews were conducted in-person, with seven in English and three in Czech with the aid of a translator. The interview included a variety of questions, which were organized in the following categories: (i) Role(s) and background of the respondent; (ii) organizational context of mental health programme; (iii) mental health service system; (iv) governmental planning processes for mental health; (v) decision-making procedures; (vi) programme evaluation; (vii) criteria and principles used in decision making; (viii) budgeting and financial planning; (ix) roles of non-governmental groups; (x) overall assessment of process and concluding questions. Because of the diverse roles and levels of involvement in the decision making processes, selected subsets of questions were asked of the various respondents. When permission was given by the interviewee, interviews were recorded; otherwise, detailed notes were taken.

In addition, a total of 52 documents were collected either directly from particular respondents or through public sources such as websites of involved organizations. These consisted of reports, newsletters, meeting minutes, legal documents, statistical monographs, memoranda, planning documents, and other materials. These were downloaded and translated with the Google Document Translator, and when necessary, a Czech-English translator checked and corrected the computer generated translations. The translation of each document was then reviewed and systematic notes taken on sections and themes that were pertinent to each of the questions of this study. Any suspected incongruence identified between the English interviews and the translated documents was noted and reviewed, when necessary, with the help of the translator. However, these were found to be of minimal relevance.

Snowball and availability sampling of the interviewees were used. A preliminary list was generated through the Charles University host, and supplemental recommendations were obtained through both the initial interviews, and documents examined. Interviews were sought so as to obtain the perspectives and observations from the following classes of individuals: (i) An administrator from an oversight body involved with mental health programme (1 interviewed); (ii) an administrator in the public mental health authority or department involved with planning and budgeting (1 interviewed); (iii) a psychiatric hospital administrator (1 interviewed); (iv) an administrator from a private NGO involved with community mental health (1 interviewed); (v) hospital direct care professional (1 interviewed); (vi) NGO MH direct care professional (1 interviewed); (vi) a professional involved with psychiatric hospital (1 interviewed); (vii) a professional knowledgeable about any CMHC/NGO accreditation (0 interviewed); (viii) a lawyer who works in mental health law (2 interviewed); (ix) a consumer or patient mental health advocate (2 interviewed); (x) a consumer's family member/mental health advocate (1 interviewed); (xi) a mental health policy specialist who is involved with the local mental health system (1 interviewed); (xii) a legislator active in mental health law (1 interviewed). Because some individuals were active in more

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than one role, there were ten separate individuals interviewed on 11 occasions. Of the 3 officials invited to an interview from two governmental oversight agencies, only one participated. However, other individuals interviewed had first-hand previous experience with both agencies sufficient to provide detailed supplemental observations.

Responses from interviews were coded for key themes, drawn from the questions asked. Whenever possible, patterns of agreement or disagreement were identified and analyzed. In addition, timelines for the characterization of decision processes were constructed when there was sufficient data. Analysis of the patterns of responses was primarily qualitative, guided by the primary questions of the study. Based on the foregoing, a descriptive and analytical narrative was developed and is presented in this article.

As an exploratory case study that utilizes semi-structured interview data and a range of document types, limitations include the fact that it was not possible to demonstrate reliability and validity of the data, or to establish generalizable and causal relationships. Nor is it possible to test for any significant differences in patterns of decision making relative to those that may have resulted from reforms in other nations, either in central Europe or globally. Rather, this methodology permits a heuristic examination of the major patterns of decision making only in the Czech Republic, an identification of questions and hypotheses for further study and implications for ongoing implementation of the Czech reform initiative.

RESULTS

Key Stakeholders and Participants in Decision Making. Stakeholders and participants in the psychiatric reform include both individuals and a variety of formal and informal organizations. These can be divided into three categories, depending on the extent of their involvement: (i) a small core group of participants who are investing considerable time and effort into planning and implementation, and who appear to be influential; (ii) a larger group of occasionally involved individuals who mostly receive updates and infrequently pose questions or sometimes take positions; and, (iii) a considerably larger group of individuals who rarely participate or who are completely uninvolved, but who have a stake in the success of the initiative.

The core group that is most active is reported to include the Minister of Health and three to five high level staff advisors; four to six psychiatric hospital administrators and other members of the Psychiatric Society, including a consultant, and three representatives of the Czech NIMH. Also, of some importance are the directors of three key advocacy and/or service NGOs who have actively participated in advisory groups. Although potentially important, virtually no interviewees cited the Minister of Labor and Social Affairs and his advisors as being part of this core group, despite their considerable responsibilities for institutional social care and services.

With the exceptions of a few of their directors, most representatives of community organizations fall into the second group of occasionally involved stakeholders. These include some of the staff and members of organizations such as Sympathea, a family advocacy group; FOKUS, an organization representing service providers; VIDA, an advocacy group of both providers and consumers; and the Dialogos and Kolumbus consumer advocacy groups. One of the consumers interviewed indicated that only two or three other consumers have been occasionally involved in the decision-making for the psychiatric reform initiative, and only a slightly greater number of family members, although these organizations do include a considerably greater number of members. Reports were received of only one elected official, a member of parliament who has been involved. In the various committees, advisory, and work groups, there are reports that up to 200 individuals participated, but whose involvement has been only occasional, ranging from a single to a few monthly meetings per year. One community advocate complained that:

> There is a big problem in the Czech Republic and it is that there is no direct leadership considering the reform. There are many subjects connected in between one another but there are none and no one who would lead it. I can only think of ---, who has a clear idea about how it should work and is trying for changing it for many years. But I can't say that the reform is connected to one concrete person or organization.

When asked about leadership of the reform, another informant reported that the Ministry of Health had a nominal role, but was not very active, that there is "much corruption", and considerable turn-over of ministers. "A big problem is the low priority given to mental health."

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Regarding the participation of politicians in the reform effort, one active community member stated that,

> I have never met any politician. The board for reform consists only of professionals, doctors, social workers, users of the care and their family members. It is probably right to say that the government doesn't really take the interest in the psychiatric reform, but I can't see that far.

While there is now considerable awareness of the psychiatric reform initiative among the professional mental health community, some patients and families, and some among the general public, most such stakeholders remain part of the third group, those who are uninvolved in decision making, however aware and interested they may be. These include most elected officials and members of the press. One legislator involved stated that he/she was the only such legislator who was actively involved.

Decisions on Implementation. Given the aims of the Psychiatric Reform project, there have been a wide variety of decisions and plans that have needed to be worked out. Of central interest are decisions on the goals of the reform initiative. However, other than reducing psychiatric hospitalization and developing community services, informants consistently explained there are no specific goals for how much psychiatric hospitalization should be reduced. One informant explained:

> I think that each person understands the goals in a different way, but as it is for us, the main goal is the deinstitutionalization. We want to get the help from the big mental hospitals closer to the clients. It means that if someone would find himself in a critical situation, there will be a team which will work intensively with him so he could stay at home in his natural environment. We also think that it is important to change the approach to the treatment. The current system stands mostly on the medication and hospitalization and we would want to bring there some of the alternative methods successfully working abroad. But it is still early to talk about that. Now we have to focus on the deinstitutionalization. There is a visible progress that can be seen in the hospitals, the care is better, they are more open to the clients and they are there for a shorter period of time than they used to be. On the other hand, there are also negative things that were not [there] 10 years ago. For example and maybe the worst of them is that people are over medicated and the use of medication is abused. People became so accustomed to the accessibility of antidepressants that instead of solving the difficult situation in some natural way, they rather go to the doctor for pills. But it is the problem of psychiatry itself, it is a problem of the society.

An important focus has been the configuration of the system of community mental health centers to be established, contracts with existing providers, their service components, funding, administrative, and evaluative mechanisms. Many of these needs were addressed during the development of the standards for these centers, starting with the deliberation of a special workgroup, consideration by the Psychiatric Society, and finally, with the Ministry of Health. One informant explained that, "In planning reforms, there were various small groups, much informal discussion. Core ideas came out. A major focus of discussion was the type of interdisciplinary teams to be used and the standards for them." Also important are plans for changes and enhancements in the system of psychiatric hospitals.

Decision Processes. These are formed out of a wide variety of formal and informal interactions between the participating organizations and individuals. The complexity of these interactions is amplified not only by the variety of such participants, but by the fact that the initiative has involved a negotiation of new decision-making protocols. The specific decision processes involved with the psychiatric reform are also influenced by, on one hand, the broader societal and policy processes and standards involved with the Czech government, and with the European Union and its judicial system; and on the other hand, the personal decision habits of the many individuals involved.

The decision-making structure that was formalized in May 2017 for the psychiatric reform emerged out of deliberations during both the monthly meetings of the Psychiatric Society and meetings between its core leadership and Ministry of Health officials. At its core is a Scientific Council of three lead psychiatrists: the head of the Czech Psychiatric Association, the director of the National Institute of Mental Health, and the director of the Bohnice Psychiatric Hospital – all of whom were appointed by the Minister of Health, and an Executive Committee, or a working committee, which consists of three representatives of the Ministry, seven leaders of the working projects, and nine other members nominated by the Ministry. It is designated to be a permanent executive body that meets regularly (at least once a month, usually once a week) and operationally addresses the management and coordination of all reform activities.

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Also, in mid-2017 the Ministry of Health appointed an Expert Council, consisting of representatives of the Ministry, the Psychiatric Society, and various professional and provider groups. This Council is mandated to be the guarantor of the implementation of the Psychiatric Reform Strategy. It reportably consists of 21 stakeholders and is mandated to meet at least quarterly. Also of some importance is a small international advisory committee consisting of foreign mental health policy experts, including ones from the Netherlands and Italy.

The detailed work of planning the reform process has been divided between seven workgroups: Deinstitutionalization, Mental Health Centers, Multidisciplinary Collaboration, New Service Support, Education, Data and Analytical Support, and Destigmatisation. As of the end of 2017, several of these appeared to be functioning, typically with five to ten members who meet either monthly or every few months, and report to the Executive Committee. For example, the Ministry of Health (MOH), "requested a planning group develop standards, which they worked on for about a year. These ended up being very general, in an effort to gain consensus. They had to first be approved by the Psychiatric Society before the MOH." There have, however, been concerns voiced that responsibilities of the specialized planning groups may have been taken over by the Executive Committee.

Decision processes within these groups appear, based on available minutes and reports, to be semi-formal. For example, the monthly meetings of the Committee of the Psychiatric Society include a variety of reports, of which psychiatric reform matters are often featured. A moderate degree of discussion takes place, concluding in either a consensus decision, or less frequently, a vote. Only occasionally has it been reported that there is disagreement or even a live debate, for example, on the proper response to stigmatization by the press. Another illustration is criticism that was voiced by a workgroup representative to the Committee of the Psychiatric Society for changes in some of the draft standards for the mental health centers. When votes on decisions have been taken, they have rarely been debated. For example, when a contract to use a consultant in psychiatric reform was debated, the decision was a nominally positive one, with 7 in favor, and 4 abstaining. Often, either the chair or a member of the executive committee has been tasked to follow-up on an action that is decided upon and to report back, for example, through meetings with the Ministry of Health or other relevant groups to obtain support for a preferred course of action.

Less detailed information is available on decision-making within the various workgroups since their processes appear to be even more informal, with the decisions of the chair assuming a particularly central role. One informant explained that, "In the task forces, very little actual decision making [takes place]; the chairs usually dominate. These are mostly conducted for dissemination of information." It is evident that in most of these groups, there is considerable deference to the leadership, typically to the chair and a few other leading members, several of whom are reported to be private consultants engaged by the Psychiatric Society. To the extent that their chairs represent the workgroup in superordinate decision groups, such as the Executive Committee, and report back, they assume a decidedly influential position within their domain.

An important dimension of mental health decision making considered in this study involves the allocation of resources between psychiatric hospitals and community services. This process generally lacks transparency and is reported by the informants interviewed to be centralized with few officials in the MOH. In addition, because the reform initiative is primarily utilizing funds from the European Union grant, there has been little pressure to re-allocate hospital funding for community services; thus, decision-making in this arena has been largely incremental and disjointed. At this stage of the initiative, the development of new processes and structures for planning and implementing the reform, as is the focus of this section, has been the primary concern of most stakeholders.

A central question is how decision making processes are changing under the Psychiatric Reform initiative. Historically, since the demise of the communist state, there has been minimal national direction or exercise of national administrative authority in respect to the country's mental health policies. The Ministry of Health has no formal mental health division, with reports that they devote only an equivalent of 0.5 full-time equivalent staff to managing the national mental health programme. Regarding key decisions and public announcements, the Minister of Health is reported to rely heavily on the recommendations of his advisors and the Psychiatric Society. As such, the Psychiatric Society, which is heavily representative of the interests of the public psychiatric hospitals, has been the *de facto* source of mental health policy in respect to inpatient care and some outpatient units in those hospitals. Also, playing an important role are the seven insurance companies that negotiate annual payment agreements with providers, and when necessary, submit these to the MOH for approval. These companies are responsible for a wide range of operational decisions in the approval, allocation, and management of mental health services in the Czech Republic.

Important in operational planning has been the Centre for Mental Health Services Development. With the advent of the massive planning effort for the Psychiatric Reform, the Psychiatric Society, and the various other Councils, committees, and workgroups formed have become active in the development of national mental health policies. In this respect, the national mental health

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programme has moved from a laissez-faire system, largely reliant on the independent discretion of medical hospital personnel, to a nominally participatory system with elements of representative democratic decision making. As such, this is arguably a needed development, however, one for which it is too early to come to definitive conclusions about its effectiveness. It will be important for all interested parties to monitor the extent to which this trend is broadened and institutionalized with better administrative support in the coming years.

The question of whether mental health decision processes are changing under the reform initiative can be answered in the affirmative, but only provisionally given the early date. While the various informants interviewed routinely noted improvements in the level of community participation, of ex-patients, family members, and service providers, they also emphasized that these are limited. For example, one ex-patient stated,

> Well, I think that the most significant thing is the start of psychiatric reform, that the system is already beginning to change and is more patient-friendly then it used to. Another important thing is that the patients, users of psychiatric care are more encouraged to speak out for their needs and rights so them being present at the discussion helps to support the implementation of the reform.

A family member, also active in the reform effort, was asked about her assessment about the progress, and she responded that,

> I think that the biggest positive is, that it has already started to be implemented. It has started up and the centers are now arising even without the money from Ministry of Health. There already are the multidisciplinary teams. Of course, they are facing some problems, but it is understandable because connecting health services and social services is difficult on cooperation, funding, and management. There is also starting to be a discussion about the reduction of the beds in hospitals, also the health insurance companies are more opened for a discussion about changing the system. On the other hand, and some people might disagree with me, it is not transparent. There are things that are not completely clarified. We can take part in deciding about some things but sometimes someone decides something and we are not even told the result. Another problem, which I have already mentioned is the lack of leadership. Nobody guides the whole process, which causes that people are working on something, then they realize that the project is not sensible so they leave it and start working on something else. And in the end, it costs money and time that could be used better and sooner.

A related question involves whether there have been enhancements in the systematization of decision-making in mental health, and as part of this, the extent to which policies are developed and implemented based on empirical evidence and best practices. Prior to the implementation of the current reform initiative, there has been only limited data available to indicate either that decision making was systematic or based on empirical evidence. The beliefs and practices of the various professionals involved are a complex amalgam of professional preferences, impressions about what is supported by the empirical literature, professional training, and trial and error. There are various individual professionals involved who are dedicated researchers who are diligent in drawing on and implementing their understanding of the empirical literature, publishing their analyses, most notably, many staff associated with the National Institute of Mental Health and with the professional programmes in the universities.

> Under the current psychiatric reform initiative, there is to date limited evidence of enhancements in empirically-based decision making. An ex-patient, active in the reform initiative, reported that, "One of our wishes is to evaluate social and health services, for example, in a form of questionnaire before, during and after the service, so [that] we can see if there is some improvement. Unfortunately, we are failing in enforcing this idea, but we will keep trying." Yet, there are occasional reports of improvements in the use of research, for example, of surveys and focus groups used, as there have been for systematic reviews of the professional literature. Consultations with foreign mental health experts have also been undertaken. While basic monitoring statistics on mental health programmes are routinely collected, there is little to show how these have actually been used in the development of policies and programmes. Development of epidemiological estimates of the populations of various diagnostic groups of interest and the resulting needs for psychiatric beds and community services in the nation's service regions will be critical for the efficient and sustainable use of limited resources under the envisioned system. It is also reported that provisions for empirically-based decision making are being planned for the new community mental health centers. For example, a contract has been executed for

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DOI: 10.2478/cejpp-2019-0007

Tab. 1: Decision Making in Czech Psychiatric Reform: Summary of Major Patterns and Changes

Dimension & Indicator	Period		Change
	Pre-Reform Level	During Reform	
I. Community Participation			
Patient and ex-patient	1	2	+
Families of patients	1	2	+
Community providers	2	3	+
Other	1	2	+
II. Rationalization of decision making			
Assessment of needs	1	1	0
System planning and management	2	3	+
Policy/programme evaluation	1	2	0
III. Type of Decision Making	Incremental-Disjointed	Bounded Rationality	

KEY: Summary assessments are made using the following categories; For Levels: 1-Negligible; 2-Partial; 3-Moderate; 4-Comprehensive. For Change: - - Worse; 0 - No discernible change; + - Improvement.

what promises to be a thorough and independent programme evaluations of the new CMH centers, with a range of outcome instruments scheduled, including measures of the quality of life of mental health consumers. One official from the National Institute of Mental Health, explained that, We are involved with the scientific research projects – we design the research, collect data and summarize results of the research. The results of the research are important for showing to the health insurance companies and the government that the interventions are successful, that destigmatization is working and that it is important to continue with it. So, the participation from our side is considerable.

In summary, changes in decision-making processes associated with the reform initiative are, therefore, mixed, but nonetheless clear. Table 1, above, summarizes the major patterns and directions of these changes. Community involvement, in respect to patients and ex-patients, families of consumers, community service providers and others have clearly increased, but only from the negligible to the partial level, and moderate in respect to providers. Although there has been no discernible increase in the assessment of needs and only an initial or partial increase in the evaluation of services, there has been a significant enhancement in system planning efforts, from the partial to moderate levels. Prior to current reform efforts, decision making was clearly both incremental and disjointed in its scope. Both the interviews and documents analyzed clearly indicate that with the intensified planning efforts, that it has moved to greater rationalization, but only within well delimited bounds, mainly within the arena of community mental health service development. Thus, the transition here is towards what can be hypothesized as a type of bounded rationality (Simon, 1991).

Preliminary Outcomes. Data on the actual impact of the reform, including the changes in decision making, on the lives of mentally ill persons will not be available for several years. However, important milestones in the implementation of the reform programme are being achieved. These include the establishment of a working decision structure, as described in the preceding section, but very importantly, the establishment of the initial mental health centers. These include two in Prague, one in Preov, and one in Brno, the South Moravian region. The first new center that opened in 2017 was the Centre for Mental Health in the South Moravian Region, which includes a multidisciplinary team that operates a crisis and an outpatient care center. The team includes a psychiatrist, nurse, social worker, clinical psychologist, peer consultant, and job consultant. Five other centers were approved for implementation from July 2018, with another 25 centers to be contracted for in the beginning of 2019. The standards for these centers, developed and approved over several years, were published in 2016, but are yet to be fully implemented in the initial group of centers. These defined general principles, or guiding values, and included specification of a priority group of clients; assertiveness in the case management

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programme; regionality; collaboration with external agencies; utilization of community resources; collaboration with specific services; multidisciplinarity; use of case management; engaging peer support; work with families; ethics and human rights. Required are field team services, day care, crisis service, psychiatric services, clinical psychologist, psychotherapeutic services, support self-help activities. In addition, many important details of the implementation plans have been worked out, for instance, the support of the new community mental health centers by insurance companies if they adhere to the required standards.

DISCUSSION AND CONCLUSION

After several preliminary and incomplete efforts to reform mental health care in the Czech Republic, the current initiative, which has commenced its implementation during the 2016–2017 period, has already made significant progress. This is due not only to the critical support of the European Union Funds, but very importantly, to a commitment to move toward a model that utilizes shared decision making in the development of a broader system of community care, one that is less reliant on inpatient hospital treatment. The initiative clearly faces important challenges as similar initiatives have faced in many nations. These arise not only out of the difficulties in negotiating competing items on the public agenda that can detract from political and economic support, but also the difficulties of strategically conceptualizing and planning practical means of sustaining public engagement in the initiative, as well as operationalizing the meaning of a balanced service system, moving beyond broad statements of values that most stakeholders can easily agree on.

One of the crosscutting challenges with the initiative's implementation is finding the means, on one hand, for simultaneously inviting and encouraging widespread participation in the planning and oversight of the envisioned system, without unduly politicizing the process, and on the other hand, assuring that decisions are based on the best available empirical evidence, for example, in equitably distributing resources to regions based on psychiatric needs, and in contracting with providers that can demonstrate effectiveness in service delivery. This is no small task, one that in many mental health systems has resulted in tradeoffs and sacrifices in one or the other of these goals, and sometimes both. A key opportunity for the reform initiative in the Czech Republic is not only building on the current very promising start, but actively learning from the many mistakes that other nations have made in earlier attempts at deinstitutionalization and psychiatric reform. Towards this end, the following are several directions, based on the Czech experience to date, that mental health reformers, both within the Czech Republic and in various other nations, may consider in carrying out their reforms:

1. **Mental Health Authority.** Without a clearly mandated, funded, and staffed mental health authority responsible for overseeing both institutional and community mental health, systems inevitably become ossified and dominated by institutional interests. Whereas small nations may have only a single national authority, typically a division of a MOH, medium-sized and larger nations often develop both national and local mental health authorities. Several models might be considered for further development in the Czech Republic, involving a new division of the Ministry of Health devoted to mental health or enhanced responsibilities for its National Institute of Mental Health.
2. **Transparency.** Without detailed and up-to-date data that is regularly published on mental health needs and service performance, efforts of the advocacy community will flounder, or worse, be misdirected. For this reason, responsibility needs to be assigned for dissemination of such data. In some nations, advocacy associations have published regular report cards with easily understandable monitoring and benchmarked statistics and quality ratings that serve this purpose.
3. **Sustainable funding.** With the receipt of only temporary start-up funding from the EU and the development of a new community mental health system, it is essential that a practical plan be legislatively enacted for ongoing funding. Participants in the Czech Republic initiative are attempting to do this through securing a commitment for an increased percentage of the health budget to be devoted to mental health. However, administrations and priorities constantly change; thus, consideration should be also given to developing legislation that clearly guarantees insurance coverage for specific mental health services, based in part on the principles of parity between medical and mental health services. The current system in the Czech Republic for negotiating agreements between insurance companies and providers can be continued as a supplement to such legislative mandates, rather than as a substitute for it.
4. **Workforce Development.** Each nation can benefit from an examination of gaps in its education, training, regulation (certification and licensure), and compensation of the various core mental health professions, most notably, psychiatric

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DOI: 10.2478/cejpp-2019-0007

nursing, psychology, psychiatry, and clinical social work. No single profession can possibly meet all the mental health manpower needs. For example, in the Czech Republic, considerable opportunities exist in preparing post-graduate social workers for positions in mental health organizations, but this will require the active support of the Ministry of Health and the Psychiatric Society.

5. **Service Coordination.** A central need for any national or local mental health authority involves the active coordination of the multiple services, both institutional and community, involved in a balanced service system. Each system needs to provide for not only a system of coordinating services on a client level, typically through assertive case management; but also systems for coordinating on an agency-by-agency level; and on a policy level, including performance contracting. These systems need to be meaningfully linked together, so agencies and policy coordinators can learn from the needs that consumers, case managers, and agency administrators identify.
6. **Integration of Research.** Finally, mental health authorities need to develop the means to systematically integrate the results of research and the best available data into decisions on staff training, agency selection and oversight, and in general, the efficacious targeting of resources. It will be particularly important for any mental health planners who are aiming to shift resources from hospitals to communities, to define operational goals that involve anticipated levels of beds and community service slots that will be required, based on reliable and valid indicators to the extent possible. Consumers and other decision making participants need to be informed and educated regarding this information to assure their optimal decision-making. However, it needs to be recognized that for many decisions, research may not exist, in which case, provisions for identifying professional consensus around best practices should also be honored.

The above are a few of the most important strategies for achieving a balanced mental health system, one of the central goals of the current Czech reform initiative, and of continuing relevance for many nations. Defining its meaning and operationalizing this concept of balance will be an important challenge in the upcoming stages of reform initiatives throughout the world. Central to it will be continued enhancements in decision making, both with respect to programme development and management. Development of such a shared and practical balanced vision can only enhance the commitment and widespread involvement of an informed body of stakeholders.

ACKNOWLEDGEMENTS

The authors would like to acknowledge and thank both the U.S. and Czech Republic Fulbright Commissions for their support of this research; Charles University and its International Committee, Prague, for their generous sponsorship; and for the kind assistance of the various key informants and other individuals for their help with the project that is reported here. And appreciation is given to Monika Dudova, Graduate Assistant, Social Work, Charles University, for her work on this project. The work was supported by the European Regional Development Fund-Project "Creativity and Adaptability as Conditions of the Success of Europe in an Interrelated World" (No. CZ.02.1.01/0.0/0.0/16_019/0000734).

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